Safeguarding Children in Care

Gloucestershire Safeguarding Children Board Audit

What did we do?

The 'light touch' audit was done over 2 days in December 2015, to examined **what multi agency partners are doing to safeguard children in care – and how well.**

At the time of the audit there were **569** Children in Care. The audit set out to examine the quality and impact of safeguarding practice, using 12 cases as a 'window into the system' to revisit the findings of the same GSCB audit done in March 2011.

Cases included children across an age range from birth to 18; Children whose IRO had raised a safeguarding concern; children whose care had been considered as part of Allegations Management; and children thought to be at risk of Child Sexual Exploitation.

Who did we involve?

The audit was done by the **GSCB Multi Agency Quality Assurance Sub Group**.

Auditors were from a range of agencies represented on the GSCB, including **Gloucestershire County Council** (Children's Social Care, Fostering and the Virtual School); the **2gether NHS Foundation Trust**; **Gloucestershire Care Services**; the **Police**; and **education facing professionals** from the GSCB Business Unit. **Independent Reviewing Officers (IROs)** were also invited to give feedback in person or through a phone interview. Audit results were triangulated against feedback from **social workers, education settings, Virtual School staff** and contextual data.

Findings will be discussed with the **GSCB** and the **Children in Care Council.**

What did we look for?

The audit focussed on four key lines of enquiry. based on the definition of safeguarding in **"**Working Together to Safeguard Children 2015";

1) **Protection from maltreatment**
2) **Preventing impairment of the child's health and development**
3) **Making sure the child is growing up in safe and effective care and**
4) **Taking action to enable the child to have the best outcomes.**

Within each of these headings the audit tool was also designed to focus on areas of good practice or concern highlighted in the previous audit of 12 Children in Care in March 2011.

The audit also reflected on the **quality of the relationship** between the young person & the professionals providing support, informed by feedback sought from professionals involved in the case, the Independent Reviewing Officer, and recorded feedback from the child or young person.

What did we find?

- **In 7 out of 12 cases** there were significant improvements in outcomes for the child,– eg permanence secured from birth, removed from significant harm; timely application of court process; mother and baby placed together, removed from unsafe home life and worked with to create stability; significant educational progress made
- **In 4 out of 12** cases there had been some improvement, with more work needed - eg continued persistence where a child was going missing, with clear risk management actions and relationship based practice; actions to address the emotional needs of children with attachment disorder affecting current well being; and trying to stabilise the situation for a young person who had had 4 foster placements, where a specialist placement the young person but the long term prognosis is not clear.
- **In one case** we had not yet made a difference - a young person severely damaged by disorganised attachment disorder. Persistence in this case was evident but stability of attachment or placement not secured. When in secure unit he is safe but each time has more freedom, vulnerabilities.
- Compared to the previous GSCB audit there was more evidence of **multi-agency participation**, particularly between health and social care; more evidence of **persistence** where children go missing from care; increased evidence of good **assessments** of various types, with room for improvement; the same evidence of the complexities where **young people with complex needs** demonstrate risky behaviour; and lack of early attention to **permanence** within care planning.

What **Top Five Areas of Good Practice** did we celebrate?

1. **The child's voice** was seen to be informing assessment, planning and review. There was also some very good engagement work by schools which are well placed to provide important attachments that can help buffer children from the negative effects of insecure attachment on educational achievement.

2. **Risk Management** was being contributed to by good information sharing and multi agency participation; for example co-ordination of evidence and analysis to inform a court order; regular risk management meetings in school to safeguard a vulnerable young person; a co-ordinated approach to engaging a young person at risk of Child Sexual Exploitation; and the Allegations Management process being followed appropriately. Assessments showed better evidence of informing plans; we saw for example detailed parenting assessments and sibling assessments that contributed important information to risk management and planning.

3. **Quality Assurance** mechanisms were in place, with clear evidence of Independent Reviewing Officers keeping an eye on progress between reviews, raising concerns and setting clear deadlines for the issues to be addressed.

4. **Tailor made support** was evidenced, for example through substance misuse and sexual health advice; detailed Personal Educational Plans; 'raising attainment' plans; and detailed support set out in Pathway Plans for older children.

5. **The quality of the relationship** between the young person and those providing support could be seen clearly in feedback from 8 of the 12 children. For example, about feeling safe, happy, listened to. 1 too young to comment, 1 was ambivalent, 2 wanted to return to a parent. Constructive relationships between professionals were also evidenced in case records or feedback for the audit, with some healthy mutual challenge included.

What **Top Five Areas for Improvement** did we see?

1. The audit findings suggest that further work is needed to keep strengthening **practice around permanence planning**, with the need to form clear Permanence Plans by the second Looked After Child Review (at four months) and ensuring consistently robust challenge that continues till resolution where there is a risk of delay.

2. There could have been **stronger evidence of a health plan** incorporated into the child's care plan; health assessments were in evidence, the majority of good quality, but the transference in a meaningful way to the Care Plan without divulging unhelpful levels of intimate detail was unclear. This is understood to be an area of current focus and discussion between Independent Reviewing Officers and the Named Nurse for Children in care.

3. There could be more use of **Reflective Professionals Meetings** on 'stuck' issues; although good multi agency working was seen in the records of various meetings and described by practitioners, there was lack of evidence of securing protected, reflective discussion time for cases where complex issues were being faced.

4. Some children **could well have been received into care earlier** – the auditors acknowledge this may be with the benefit of hindsight, however a number of cases included practitioner or IRO reflection that we could have worked harder to engage with parents earlier on or brought into care earlier on.

5. Practitioners continue to need additional **advice, support and evidence-based tools to work with hard to engage adolescents** where limited progress is being made to offset the impact of previous abuse or neglect. Knowledge-sharing and practice development in this area is a current focus across a number of agencies.

What are our **Top Three Tips,** for Practitioners and Leaders across the Safeguarding Partnership?

1. Work together to support and expect a **focus on permanence** for children in care (legal, physical, psychological or emotional), from the outset.
2. Promote and expect a stronger focus on confirming **clear evidence of health plans** for Children in Care, drawn at an appropriate and sensitive level into the overall Care Plan.
3. Find out about new developments in **engaging with children in young people**, including the GCC Resource Library of direct work tools; the Innovations Programme work on restorative approaches to working with older children; and the use of the MOMO app to keep making it easier for children to share their views and get involved in decision making.