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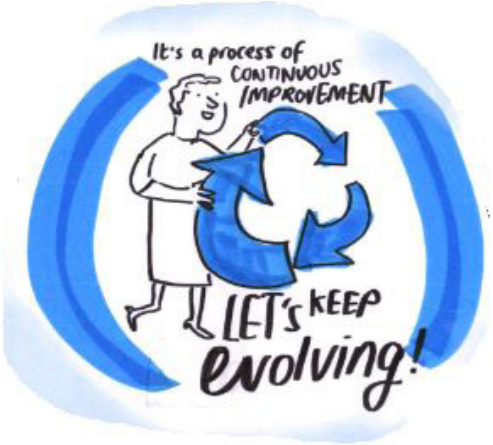
Quality Assurance Framework

Children's Services



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Publication Date: 2 September 2019
Review Date: 2 March 2020

Appendices

Summary and quick guide

'Have we helped the family to achieve their goals?'

This Quality Assurance Framework outlines all of the quality assurance activity in Children's Social Care; providing an overview of the purpose, processes and tools used and how it links together. It is deliberately centred on 5 key areas of activity and the framework provides details of each activity and is an important support and reference tool for managers and practitioners. The Professional Standards & Quality Assurance (PSQA) service will oversee and monitor the impact of the framework and a calendar of quality assurance activity will be agreed. The quarterly QA Report will continue to bring together all work into one place so key learning is identified and the impact of agreed actions are monitored through the Performance & Accountability Cycle.

Our Quality Assurance System enables us to robustly relate performance management data with quality assurance by the use of three simple interrelated questions. How much did we do (service activity), linked to how well did we do it (quality) for families and most importantly out of all that effort did we make a difference (is anyone better off - outcomes for children). Signs of Safety (our Practice Framework) is our means to deliver better outcomes for children and families; it is not an end in itself!

'Nothing about us without us'

The Signs of Safety approach emphasise the need to foster open, honest and respectful relationships with families.

The quality assurance system reinforces this by aligning to these values, by collaboratively working with practitioners and families through the auditing process, feedback and how we understand data and measure performance.

Signs of Safety is fundamentally about the organisation being set up to enable, support and assess practice. At the heart of the framework is the ethos of learning and collaboration whether this is in our direct interactions with families, assessments, supervision, performance monitoring or auditing. The diagram below shows our core quality assurance activities used to understand what difference we are making to children, young people and families in Bexley.

The quality assurance system is formed of five parts that are integral to understanding practice within the organisation:

1. All case auditing is undertaken using a strength based collaborative approach that interrogates essential elements of Signs of Safety practice whilst emphasising learning for the worker and system.

2. Whilst the emphasis on learning is further developed through the Case Management Dashboard that allows for real time feedback. The system aligns Core Data with quality assurance, so that there is effective and meaningful monitoring. The data provides a strategic overview of Signs of Safety performance alongside monthly performance data, performance review and workforce data.

3. Feedback from children, families, staff and other professionals provides for accountability by acting as a critical friend to the system through answering the question "so what?"

4. Practice Leadership provides underpinning support throughout the system from induction to standards of practice and

5. Practice Review keeps the system under review. Finally, all these aspects are analysed together to report on what difference we are making to children, young people and families.

Quality assurance is more than just routinely counting numbers, meeting targets and periodically carrying out audits. Effective quality assurance is dynamic and evolving, where there is an embedded cycle of monitoring, continuous reflection and learning, based on the principle that there is always room for improvement. Quality assurance needs to be owned by everyone in the organisation, managers at all levels need to understand and routinely undertake quality assurance activity on their individual supervisees, teams and service areas. Most importantly, we need to get behind data trends to fully understand the lived experience of those receiving a service from us.

Learning organisations use a range of methods to gather both quantitative and qualitative information from a variety of sources, to measure and analyse the aggregated information against an agreed set of standards. Measuring practice is only purposeful if the loop is closed and the organisation uses the learning to plan and deliver service improvements. As stated above, the learning from our quality assurance activity will be drawn together into a quarterly report and reviewed within our 10-week Performance and Accountability Cycle (Week 5). The diagram below illustrates how our quality assurance activity leads to a continuous cycle of service improvement.

What are our methods of Quality Assurance?

A combination of quantitative and qualitative information allows us to measure standards and outcomes. Quality Assurance is evidenced by the following sources:

Collaborative Case Audits
- Thematic Audits
- Multi-agency Audits
- Quality assuring Education Health & Care Plans

Case Management System & Core Data
- Monthly Performance Data & Performance Review
- Case Management Dashboard
- Manager's and Service Managers Monthly Report
- ChAT

Family and Staff Feedback
- Parent/carer Survey
- Feedback from children and young people
- Feedback from parents/carers
- Compliments and complaints
- Learning and Improvement Partnership
- Social Work Health Check

Practice Leadership
- Signs of Safety Practice Framework & Expectations
- Managers Standards
- Learning & Serious Success Reviews
- Action Learning Sets

Practice Review
- Supervision & Group Supervision
- Child Protection Conference Consultations
- Escalations: Child Protection Conference Chairs, Children Looked After Independent Reviewing Officers
- Practice Week
- Practice Intensive

National & local Inspections
Peer reviews

Values and guiding principles

i. We begin our work with families, driven by the principles of the Children Act 1989, which require local authorities to promote the upbringing of children with their families where this is in their best interests and safe to be so. We therefore practice on the basis that families and children have a right to be together, that parents retain parental responsibility unless their children are adopted and that our work should enable this to happen provided we can establish good enough safety for the children and support for the families. Where we cannot secure safe permanence in the family network, our system is established to act quickly through the courts so that children are able to thrive in new and safer arrangements.

ii. We have worked hard to establish a commitment in practice from social workers and managers, which holds relationships at its core. Our practitioners believe that it is only through trusting relationships between families and themselves that change is possible. We have used 'Signs of Safety' as a practice model to enhance this focus on respectful work where families are supported to identify the best solutions to their difficulties and to follow safety plans that they develop within their family networks.

iii. Relationship based practice, requires a social work environment that supports practice to be as good as it can be. Every social worker and manager has to feel that they can do their best work with the backing of their leaders and an acceptance that error is likely. We have spent a long time discussing in practice, the reality that the behaviour of families can never be predicted fully. This being the case, means that reasoning has to be clear and the rationale for decisions has to be obvious. We call this 'showing your workings out' so that anyone can understand why at the time, the decision was made as it was. If this is clear, then practitioners are protected in practice and blame is less likely.

In addition, we focus on workflow and caseloads. In Bexley – we operate a caseload of 17 children per practitioner in teams where there are no more than 80 children. This enables the team managers to know their children and families well.

iv. Our work is underpinned by strong and consistent management oversight of practice. This comes in many forms, though at the core is a basic requirement that a robust case management system is in place that provides data on demand, throughput and timeliness on all statutory basics and in respect of early help, whilst not statutory, the same is required. Such quantitative data is complemented by collaborative reviews of practice, where managers and practitioners discuss practice in a family together each month. This is a coaching exercise with a focus on learning and improvement,

rather than blame and deficit. Themed reviews of practice are commissioned as required. Case records are required to be up to date at all times. There are additional systems in place for managers to review all open work, specifically where we have commenced or are commencing legal proceedings or children have a child protection or lengthy in need plan. We operate an open conversation policy where all practitioners are encouraged to discuss practice and talk with managers regularly. The Director of children's services and the Lead elected member, review practice on a 10 weekly basis through a performance board.

v. Our starting point in practice is that there will always be ways to do what we do better. We seek feedback from each other and from families regularly and consider that without this, we have no real understanding about the difference we are or are not making. This has taken time to establish but it is now a backbone to our practice environment, with practitioners and managers more willing to seek feedback and to consider the learning that is available from it. We ask for feedback from families in monthly collaborative reviews of practice, we meet them face to face if they have reason to complain and we ask managers to report on family feedback in their monthly reports. We try to learn from all reviews of our practice and seek out additional opportunities to do so – for example from serious case reviews published, from inspection reports and from our children and young people's forums – such as 'positive journeys, junior and senior' which might otherwise be described as our children in care councils. We are moving to trial a new model of learning alongside families in our practice enquiries that will be commissioned by the new safety partnership. We anticipate that this will provide us with an opportunity to meet with families whom we have not served well and to work through what we could have improved. We intend that this will also offer them kindness from us and a chance to work through some of the trauma that our engagement may have exaggerated.

How to use this framework

What does "good" look like?

We all have a role in ensuring our work remains of a high standard and continues to meet the needs of the children, young people, and families we are supporting.

Through our quality assurance activities, together, we will demonstrate that we understand ourselves and the difference we are making to the lives of children, young people, families and carers through good use of data, information, family feedback, compliments and complaints - always asking how we can make things better and being curious and innovative in our practice.

As a **Practitioner**, I will work with families in accordance with Bexley's Signs of Safety Practice Framework and expectations and uphold our values and guiding principles in my practice. When I am unsure, I seek advice from colleagues and when I am worried about practice I will report this. I embrace learning and the opportunity to develop my practice. If I am involved in a collaborative case audit, I will complete the self-assessment prior to meeting with the auditor and take responsibility for progressing relevant actions from the audit.

As a **Team Manager**, I maintain oversight of casework through regular case file audits and supervision to ensure recordings are contemporaneous, evidenced based, use the Signs of Safety framework, and demonstrate how practice enhances the child's safety, life experience, education, and family networks. I ensure practitioner's work remains of a good standard by undertaking practice observations and providing feedback. I review written records provide feedback to workers on areas to develop. I adhere to the Managers Standards and escalate concerns when safe practice may be compromised. I provide an overview of the performance of my team in the monthly manager's report which enables me to share good practice and highlight any difficulties.

As a **Leader**, I lead and embrace change with a sense of confidence, optimism and creativity, seeking to understand the challenges and focussing on the opportunities (part of our Leadership Pledge). I recognise that we won't always get things right first time. Together we will reflect and learn when things go wrong, remaining calm and adaptable in complex and challenging situations. I am a confident leader of system learning. I am visible and approachable, seeking and listening to other people's thoughts and showing that we take into account different perspectives when making decisions and taking action. I lead by example and live our values in all that we do, encouraging others to do the same. Our policies and procedures will be transparent, consistently led by us and always improving the quality of our practice.

1. Collaborative Case Audit

Signs of Safety is built on the ideal of ***'nothing about us, without us'***; it is a participatory approach where assessment is in partnership with those who are assessed. The auditing system mirrors this dynamic through the collaborative case audit. The practitioner learns from what has gone well and applies their best thinking about what can be further developed, creating much more ownership over what further work will be undertaken.

1.1 Audit Process

The annual schedule of auditing activity will routinely contribute to measuring core areas of practice:

- Assessments of need and risk to children and young people
- Assessments of adult carers
- Safety planning and the effectiveness of intervention
- Direct working relationships with children, young people & their families
- Partnership working and effectiveness of multi-agency meetings & reviews
- How we use plain language in report writing and case recording to make it understandable to families
- Management oversight and decision making (includes supervision)

Auditing Activity is undertaken as follows:

Frequency	Activity	Responsibility
Daily	Checking and authorising a range of activities and reports on the LiquidLogic - ICS system	Team Managers
Weekly	Real time understanding of practice through the Case Management Dashboard	Practitioners
	Monitoring and routinely reporting performance in performance meetings, including using the Case Management Dashboard	Team Managers
Monthly	Self-assessment to inform monthly online case file audit	Practitioners
	Routine schedule of core practice area and case file auditing for each social worker	Team Managers
	Directly observing practitioners carrying out direct work with families or partner agencies as part of online case audit	
	Monthly Performance Report completed	
	Moderation of case file audits	Service & Senior Managers and/or Independent Reviewers*
	Review of Mananager Performance Report and Complete Service Managers Monthly Report	Service & Senior Managers

* This includes: Independent Reviewing Officers, Child Protection Conference Chairs, Consultant Social Workers, Heads of Service, and Deputy Director of CSC.

The expectation is that all case file auditing is undertaken collaboratively with staff and family feedback is sought following each case file audit.

The audit programme aims to:

- Provide assurances that practice positively influences outcomes for all vulnerable children and young people;
- Take into account the requirements of inspection bodies;
- Involve all children's social care staff in continuously seeking to improve their practice;
- Ensure consistency of practice across children's social care and specifically the use and deployment of our Signs of Safety practice framework;
- Embed a culture of learning, confident practice and feedback;
- Identify areas of practice improvement to inform the performance conversation and appraisal process.

1.2 Audit Tools

Signs of Safety is built on the ideal of ***'nothing about us, without us'***; it is a participatory approach where assessment is in partnership with those who are assessed. The auditing system mirrors this dynamic through the collaborative case audit. Scaling questions are used in the audit tools to facilitate a discussion that enables the worker to be supported to analyse and assess the quality of work and application of their Signs of Safety practice. Within the collaborative discussion the auditor and worker can agree next steps specific to the case audited. This means that the practitioner learns from what has gone well and applies their best thinking about what can be further developed, creating much more ownership over what further work will be undertaken.

Audit Forms: LiquidLogic – All case audit forms can be found on the LiquidLogic system:

- Collaborative Case Audit form – designed to audit all case file work that is held on a child, following the audit process (see Fig.1.3 Audit Process).
- Practice Observation form.

1.3 Audit Guidance

The following step process is provided as a guide to completing case audits in most circumstances, there may be situations that fall outside of this process and additional guidance can be sought from the Head of Service PSQA.

Fig. 1.3 Audit Process

Steps:

1. Case allocation: to auditor by business support (via spreadsheet) for audit in each service

- The file to be audited is for a child or young person within another team.
- The spreadsheet indicates the auditor, child/young person, allocated worker (and Staying Together worker if applicable); therefore, all managers will know what case files in their team are being audited and by whom.
- The auditor will need to set a meeting with the practitioner (and Staying Together worker if applicable) and request that they complete the self-assessment questions prior to meeting with the auditor.

If Staying Together are involved, the auditor contacts the Staying Together worker in the same way as they would the practitioner who's case is being audited and invite them both to meet with the auditor for the collaborative case audit.

- The auditor is responsible for their own preparation prior to the audit and should be familiar with the case being audited.

2. Practitioner preparation: The practitioner (and Staying Together worker if applicable) should complete the self-assessment questions at the start of the audit form on LiquidLogic and provide these to the auditor at the start of the audit meeting. The preparation questions are designed to support the practitioner(s) to think about what difference their work has made to the child, young person or young adult and to what extent they have used Signs of Safety in their work. This should be considered in relation to the Signs of Safety Practice Framework and Expectations.

3. Collaborative audit: The auditor should then meet with the practitioner of the case (and Staying Together worker if applicable). This enables the effectiveness of the Staying Together intervention to be explored in the context of the wider case and supports joint working, communication and planning next steps between the Staying Together practitioner and allocated worker. The auditor should ask all questions to the practitioner and Staying Together worker. Both practitioners contribute to the audit. The practitioner(s) should have completed the self-assessment questions prior to meeting with the auditor. During the collaborative case audit meeting, areas of impact should be evidenced with a reference of where this can be found on the child/young person's file e.g. 'direct work uploaded on 01/04/19'. Sample scaling questions have been provided which should be asked by the auditor to the practitioner(s) to support this process. This supports the collaborative aspect of auditing in Signs of Safety, whilst maintaining standardisation for a large auditing process. There are also prescribed follow-up questions to make sense of the scaling judgement; the auditor and practitioner(s) should agree on areas of strength and this should also be evidenced with a reference of where this can be found on the child/young person's file. The scaling questions should provide additional information to the overall audit, as the questions are designed to evidence quality of practice in Signs of Safety. Actions should be agreed during the scaling process on areas to develop, as the worker is asked to think about how they can create further impact for the child / young person / young adult and their family.

4. Grading: The auditor and practitioner(s) are required to scale each area of practice in the audit form on a scale 0-10 based on the practitioner's view, although the auditor must be reassured that there is evidence to back up the strengths that the practitioner has described. The auditor should record in rationale their view. The auditor's final grading is tied to the Ofsted judgements (see below). The final grading should consider both evidence seen by the auditor in reviewing the file alongside the practitioner and information gained from the collaborative scaling with the worker. Grading Outstanding should be given when 'good' has been reached and surpassed.

Scaling	Ofsted Grade
0 – 2	Inadequate
3 – 5	Requires improvement
6	Good

5. Feedback: Obtaining feedback from children, families and professionals that we work with, is essential to the auditing process and reflects the strong focus in Signs of Safety of 'nothing about us, without us'. Feedback should be sought from children of appropriate age and understanding and from families. The same questions can be repeated for different family members. The feedback section has been taken from work undertaken by researchers at King's College London, used as part of the Signs of Safety national evaluation. This style of questioning will enable measuring of responses overtime. Feedback from other professionals should also be sought, particularly in cases where a professional is to act as a lead professional, or who due to the child's circumstances has significant involvement.

6. **Actions:** Actions need to be clearly identified at the end of the audit form in the action box with timescales for completion. Immediate actions to improve to 'Good' must be recorded.

7. **Follow-up:** It is the responsibility of the auditor to follow-up in 5 working days with the manager and case note, what action has been taken since the audit was completed.

Additionally:

- The manager and practitioner will review the audit in supervision and a management oversight note will record the discussion and timeframe for action on identified issues. Actions will be reviewed in the subsequent supervision (or sooner, if the identified timescale is such that it requires a more urgent action) to ensure tasks are completed.
- Auditors should check with the relevant line manager if a recent practice observation has been undertaken of the practitioner in practice with the case audit. A practice observation is not expected to take place as part of every audit. However, a practice observation should be undertaken if the audit forms part of practice week (see 5.4) or in cases where the auditor has found the work to be inadequate, when it should be included as an action.

Inadequate Audits

In situations where a case file has been deemed inadequate, the auditor will email the worker, team manager, service manager, Head of Service and Assistant Director of Children Services to advise of the outcome and what actions are needed to improve the case to 'Good'.

- Immediate tasks will be actioned within 24 hours
- Management oversight note will record case direction and tasks
- As above, audit will be reviewed in supervision and recorded on case file
- Where there are performance issues related to the audit, this will be recorded in personal supervision notes

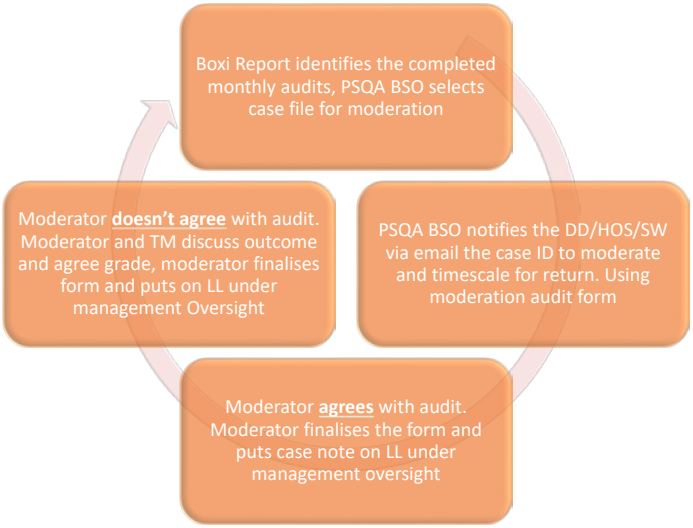


Fig. 1.4 Moderation Process

Moderation Audits

- A list of cases audited over the last 6 months is run by Strategy, Performance, and Insight. Cases are allocated to moderators (Consultant Social Workers, Child Protection Conference Chairs, Independent Reviewing Officers, Service Managers, Heads of Service, and Deputy Director of CSC) by Professional Standards and Quality Assurance
- All moderation audits must include scaling as well as feedback comments which identify areas of good practice and areas for development
- Moderator will ascertain and document if actions were completed as identified in audit and record on audit form
- Additional actions need to be clearly identified in action box on audit form with timescales
- Moderator records agreement or disagreement with audit
- If moderator agrees with audit, form is finalised and a management oversight case note is recorded
- Moderator emails worker and manager to advise moderation has been completed
- If moderator disagrees with audit they will meet with auditor to discuss outcome and agree a grading. This can also provide a learning opportunity to reflect on areas of strength and areas to develop in auditing practice.
- If the case remains inadequate or there are outstanding actions, moderator will email worker, team manager, and service manager to ensure tasks are actioned within 24 hours
- Manager will write management oversight case note to record direction, action, timescale, and completion of tasks
- All moderations will be reviewed in supervision and recorded on the case file
- Where there are performance issues related to the moderation, this will be recorded in personal supervision notes (worker and manager)
- Head of Service - Professional Standards and Quality Assurance will be advised of moderations graded as inadequate

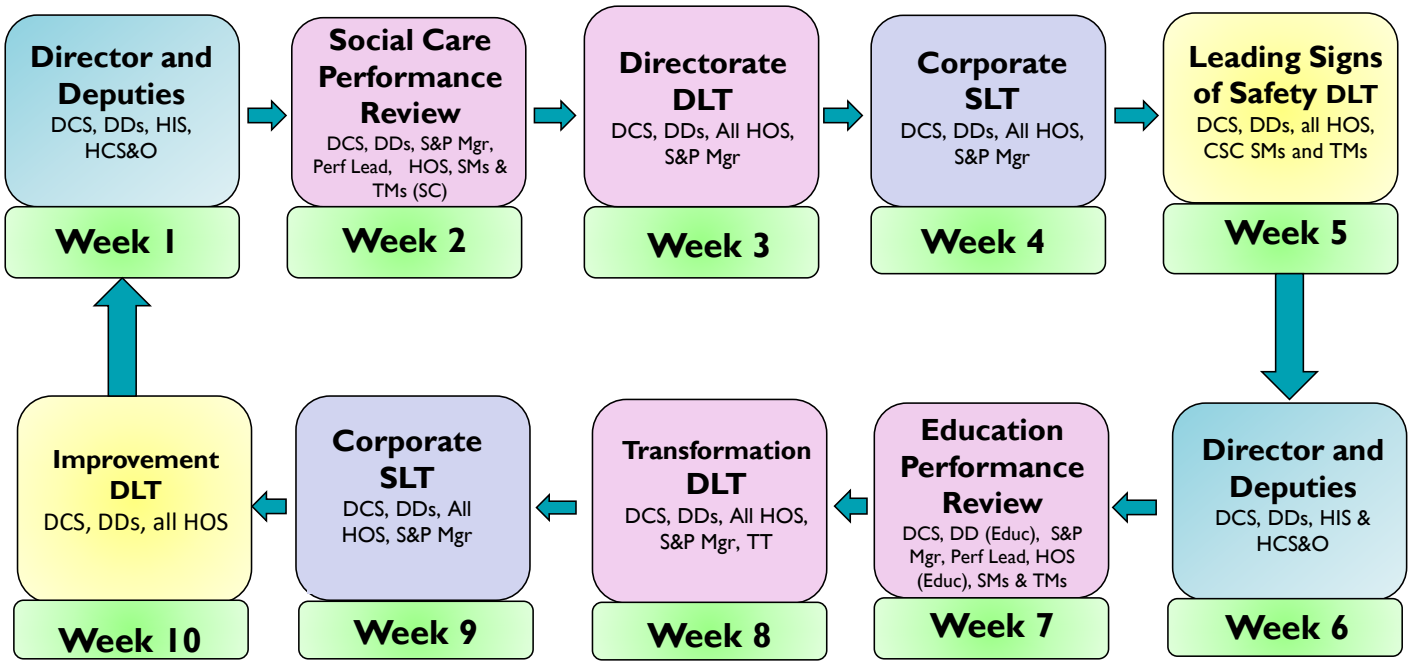
The PSQA team and Service Manager must be informed of all audits or moderations graded inadequate.

Team Managers are responsible for reviewing the audit findings and recommendations and outlining actions to be completed to bring the case up to expected practice standards. Audit actions should be regularly reviewed in supervision until the Team Manager is satisfied the case meets expected practice standards.

Service Managers are responsible for reviewing the audit findings and recommendations of any audit graded inadequate and must be satisfied the actions outlined by the Team Manager are sufficient to bring the case up expected practice standards within a reasonable period. Head of Service and Assistant Director of Children Services, will also be informed of an inadequate audit and what action is being taken, including timescales.

Themes from auditing are reported monthly and quarterly as part of an overall quality assurance report provided by the PSQA Head of Service and team to the Senior Leadership Team and shared with Service and Team Managers in the process of the performance and accountability cycle. The highlights and overall themes will be shared with key stakeholders e.g. Bexley Safeguarding Partnership for Children and Young People, Councillors and the Chief Executive.

Fig 1.5 - Performance & Accountability Cycle 2018-22



KEY:

DCS	Director of Children's Services
DDs	Deputy Directors - Social Care and Education
HIS	Head of Improvement Support
HCS & O	Head of Children's Strategy and Operations
S&P Mgr	Strategy & Performance Manager
Perf Lead	Senior Performance and Data and Analyst
HOS (SC)	Head of Social Care
HOS (Educ)	Head of Educational achievement and inclusion
All HOS	Head of Service
SMs	Service Managers
TMs	Team Members
TT	Transformation Team

Sharing Good News and Leadership Pledge on Agenda for week 1, 4, 5, 6, 8 & 9

Hints and Tips for Collaborative Case Audits

Using the Audit Tool to evidence we are delivering to the practice standards

1. General principles of practice (Signs of Safety)

Bexley uses Signs of Safety as its social work practice model. This is a strengths-based approach to working children and families.

By using Signs of Safety, we have a way of working across the service that everybody understands where we share a common language and a consistent application of risk and safety. This helps social workers and other professionals to better work together, reflect, think and talk about cases.

The help provided to families is respectful, purposeful and based on strong professional judgements and decisions.

The emphasis is on helping families rather than 'intervening'. The focus is shifted from a way of working where professionals are considered to be the experts to a constructive, relationship-based model of helping parents to change.

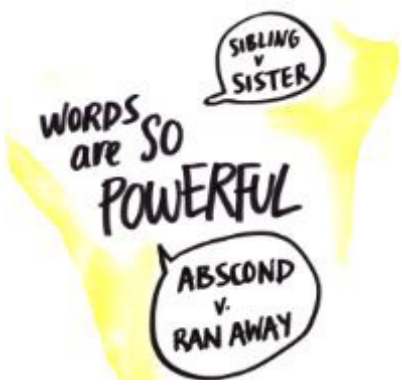
Whilst there is an emphasis on the strengths in the child's network, the child's safety is always the focus of any help provided.

Signs of Safety is a whole system approach which is applied to all aspects of social work practice and social workers should reflect using the model in their direct work with families and their practice overall.

Work with families is carried out from a stance of appreciative inquiry and being professionally curious, applying a questioning approach.

Social workers and managers should use the Signs of Safety questioning approach: Elicit Amplify, Reflect, and Start over (EARS). They should also use the case mapping to discuss and think about cases.

All case recording should be consistent with the Signs of Safety model, addressing what is working well, what is not working well and what the next steps are.



2. Child focussed work with children and young people – Wishes and Feelings evidenced

Working in a child centred way is an essential part of good social work practice. Communicating and listening to children and young people helps social workers understand what life is like for them and what needs to change to increase their safety and promote their wellbeing and development.

Social workers need to understand what difference the help has made to the child or young person and what has improved for them.

The child or young person's views and wishes are central to good social work practice and alongside the views of the parents, carers and other key professionals, are considered in all aspects of the help and support offered to the family.

Feedback should be sought from parents and carers about their views of how helpful the support they are receiving is and this information will inform and influence how services are provided.

Using Signs of Safety, there is a focus on direct work with children, not only to establish their wishes and feelings but also to fully involve the child in an age-appropriate way in the family safety planning.

Social workers promote meaningful relationship-based practice with children and young people and this informs all aspects of their work with families.

Direct work should be carried out according to the age and level of understanding of the child, explaining what is happening and why.

Children and young people should be seen regularly and the work undertaken recorded on LiquidLogic.

A variety of direct work tools and activities should be used to work with children and this should include direct observations of very young children.

Direct work tools should be uploaded to the child's file.

Social workers should work with children alone wherever possible and in settings where they feel comfortable and that are child-friendly.

Children and young people should be involved as much as possible in the decisions being made and the help being offered.

Assessments (Includes genograms and chronologies)

The purpose of the assessment is the understand what is happening in the child's life, exploring how they are cared for by the adults around them and how their health, education and wellbeing needs are being met. The Signs of Safety framework are used to identify what's going well, the presence of dangers and what we may be worried about. The SW will analyse the information gathered and come to a professional judgement about whether or not

the child/ren are presently safe and predict the likelihood of this remaining the same or changing in the future.

The assessment will be undertaken in partnership with the child and families, with their full agreement and participation. If this is not possible, the reasons will be clearly recorded.

The family history is critical to understanding and predicting the present and future, therefore every assessment will include a chronology which highlights key events in the child's life. The chronology will be routinely updated whilst the case remains open.

The child's perspective, wishes and feelings are central to the assessment. Each of the children in the family will be seen and spoken to separately and on their own by the SW in the child's first language, if this is not appropriate or possible, the reasons will be clearly recorded.

The assessment will explore the child's whole family, friend ship & community network to identify Signs of Safety and danger. Every assessment will include a genogram which highlights key people in the child's life. The genogram will be routinely updated whilst the case remains open.

The assessment is holistic and therefore requires information sharing from a number of sources, by all those involved in the child and family. Multi-agency checks will be undertaken to contribute to the assessment.

The length of time it takes and depth of the assessment will be determined by the complexity of the child's situation and the level of need. However, all assessments should be completed and the final report shared with family within 45 days of receipt of the referral.

The assessment will identify what needs to happen next and what, if any, help or services the family need, which will inform the child's plan. The family should not need to wait for the assessment to be completed in order to receive the help and services they require.

3. Plans for and visits to children who are receiving help and Children's Services support

A child will have either a child in need, child protection, care or pathway plan. The plan will be written using Signs of Safety to provide all that are involved in that plan are clear of its purpose.

The plan is a tool for helping the family and social worker measure progress, how the child's circumstances are changing and should be written in plain English.

Plans will be regularly updated as the child's circumstances changes and significant events occur and revisited regularly at review meetings, either Child in Need, Child Protection Conferences or Looked After Children reviews.

Visits will be purposeful and will include some direct work with the child and will refer to progress being made against the child's plan.

4. Management Oversight and Case Supervision

Management oversight and supervision support a learning culture and provide a setting for case reflection, discussion and challenge.

Supervision has three main elements - line management, professional development and casework oversight.

Supervision has a direct impact on the outcomes for children and families and is key to improving practice with children and families.

Managers should ensure that supervision takes place regularly and is prioritised and on time.

Managers should plan supervision sessions based on an agreed agenda.

Social workers should prepare for supervision and think about cases and issues they wish to discuss.

Individual supervision is recorded for each member of staff and kept on their supervision file.

Casework supervision is recorded on LiquidLogic for each child in a family.

Managers should ensure key decisions about casework outside of formal supervision are recorded on case notes on LiquidLogic.

Supervision sessions should be booked in advance for up to six months and be 90-120 minutes in duration.

Supervision should take place at a minimum of every four weeks for experienced staff. Newly qualified staff should be supervised weekly for at least six months, then fortnightly for a further six months.

From Inadequate to Good

The tables below provide an overview of the type of quality that is required to meet the categories of Good, Requires Improvement and Inadequate. This is a guide to support consistency but should not be used as a checklist of the only activity that would take place. Outstanding should be considered as a case where the standard of Good has not only be reached but surpassed.

Good looks like…

Contact / Referral	Contact / Referral showed clear understanding of when appropriate to refer to social care.	Contact / Referral on agreed format, containing all relevant information and clarity with regard to reason for referral.	Contact / Referral responded to promptly (within 24 hours) and decisions appropriate to identified need.	Decision making takes accounts of previous referrals / contacts.	What are we worried about: harm and complicating factors and what's working well: strengths and safety are recorded with specific behavioural detail.	Manager's risk analysis, scaling, next steps and rationale for decision evidenced and appropriate for referral information and history.	Evidence recorded on LiquidLogic to demonstrate case allocated to qualified social worker promptly and clear expectations of what is required are recorded.	
Basic Information	LL recording is contemporaneous, concise and analytical and provides sufficient detail to ensure effective safeguarding and focussed planning at all times.	LL records indicate that practitioner and managers have reviewed and quality assured records.	Danger statements, safety goals, and scaling are evident on file and address specific behaviours.	Case recordings are written in plain, jargon free language that would enable a service user to understand their story.	Files for looked after children include a recent photo.			
Assessment	Assessment clearly identifies strengths and areas of concern, provides a detailed analysis and includes all members of the household.	Assessment is of a good quality and identifies a clear plan with relevant analysis of strengths, needs and risk.	Assessments are written in plain, jargon free language that is understandable to parents / carers with explicit explanations of worries / danger, strengths and safety. Identifies whether appropriate to work as CIN/CP or NFA or FWB.	Assessment includes some analysis regarding multi-agency context and this information is used to inform decision making.	Child seen alone (where appropriate), spoken to and their views recorded and reflected in assessment.	Assessment demonstrates a sense of the child. There is evidence of direct work undertaken with the child to ascertain what life is like for them.	Diversity and disability issues addressed and support to address any challenges arising out of diversity and disability.	Assessments reviewed and signed by Manager within timescales. Evidence of some quality assurance by Manager.	Assessment shared with parents / carers promptly and feedback sought.	Outcome of the assessment is shared with parents / carers and child / young person (appropriate to age and under-standing). Feedback is sought.
Planning	There is evidence to show that the Plan is making a positive difference to the child's life.	The plan shows evidence of a good understanding of the child's needs and how these will be met, within clear timescales.	The plan clearly outlines the day to day actions that parents and carers will undertake to ensure the child's safety and wellbeing (and is not a list of services to attend).	There is strong evidence of the child and family involvement in the development of the plan. This should include family network meetings; outlining family and friend support with specific actions for supporting the child's safety and wellbeing.	The plan is progressing and meeting the child's needs. Where there is evidence the plan is not meeting the child's needs, the reasons for this are explored and changes made if needed.	The case file recording tells the child's story and evidences progress.		
Review	Plan (Child in Need, Child Protection, Looked After Children has been reviewed in accordance with statutory/ procedural requirements and is responsive to the child/YP's changing needs.	Reviews are convened to allow maximum attendance of family and professionals. Where this is not appropriate, views sought and feedback is given regularly.	Children are actively involved where they have the ability to do so, including attending meetings or chairing their own reviews.	Records of reviews are comprehensive and provide detailed analysis of the issues and actions that are required to meet outcomes, including timescales.	Chronology is up to date and analytical. It shows all key points in the child's / YP's life and is easy to follow.			
Management Oversight	Supervision has been taking place in accordance with supervision policy and is responsive to social worker's needs.	Supervision is reflective, analytical and evidences issues which have been raised. It sets clear parameters regarding required actions, contingencies, and outstanding work, addressing timescales effectively.	Supervision reviews actions of previous supervision and these are completed.	Records up to date and fit for purpose.	There is evidence of reflective tools such as appreciative inquiry or case mapping.			

Requires Improvement look like…

Contact / Referral	Contact / Referral gave enough evidence that it was appropriate to refer to social care.			Contact / Referral gives some indication of areas of strength and safety for family but lacks behavioural detail.		Contact / Referral on agreed format, but not all relevant information recorded.		Contact / Referral acted on promptly (within 24 hours) and appropriately		Indication that referrals/contacts reviewed.		
Basic Information	LL recording is contemporaneous, concise and sets out clear plans, which are measureable and understandable			Danger statements, safety goals, and scaling are evident on file but not clear and concise addressing specific behaviours			LL records provide some evidence of quality assurance activity on records		Case file recording is of sufficient quality to enable the file to be easily understood by the child / young person if they were to access their file.			
Assessment	Assessment identifies some strengths and safety and areas of concern, analysis is limited and may not include key members of the household (including fathers and partners)	Assessment identifies a plan which does not fully address risk/need.		There is some consideration of family/friends network support, but this not fully explored to enlist their help and support for the child/family	Assessment includes some information from other agencies	Evident the child has been seen and spoken to but there is not a clear record of their lived experience, wishes and feelings, or what they say they need to feel safe	Some evidence of direct work with the child including use of SoS tools (as appropriate)	Assessments reviewed and signed by Manager within timescales	Diversity and disability issues considered but not deeply explored	Assessment uses some jargon and is not fully written with the family as the intended readers	Assessment and outcome of assessment shared with parents/ carers and child/young person (appropriate to age and understanding)	
Planning	An up-to-date Care plan is in place (including a PEP, health plan, placement plan and permanency plan for looked after children), setting out the child/YP's needs and how they will be met.	The plan is reviewed regularly and within statutory timescales.	The plan is more focused on tasks and services rather than "who, within the family and friends network, will do what in the children's day to day life to keep them safe and well"	There is some consideration of family/friends network support, but this is not fully explored to enlist their help and support for the child/family		There is evidence to show that the child/ YP, their parents/ family, and carers have been provided with a copy of the care plan.	Recording indicates that the plan is having some positive impact on the child and family; consideration is giving to amending the plan to better meet the child's needs	Social worker has visited in accordance with procedure/ statutory timescales and there is evidence that the child / YP has been seen on their own	Case file recording meets required standards.	Pathway plan (where appropriate) is in place		
Review	Plan (CIN, CP or Looked After) have been reviewed in accordance with statutory/procedural requirements			Parents/carers/child/YP and professionals are invited to reviews.		Review meetings are focussed on the child/YP's needs		Records of reviews are in place, setting out key information, including recommendations and some actions		Chronology is evident and has been kept up to date, some events are not clear and have been pasted in		
Management Oversight	Supervision has been taking place in accordance with supervision policy	There is some evidence of using Signs of Safety (i.e. three columns) but not an in-depth analysis using the framework		Supervision decisions are recorded on the child's electronic file but limited evidence of reflection and evaluation of work carried out.		Records mostly up to date and fit for purpose	Supervision reviews actions of previous supervision but there is limited evidence to suggest that this has prevented drift.			There is evidence the plan is being reviewed, but effectiveness and impact not fully explored.		

Inadequate look like…

Contact / Referral	Contact /Referral had some gaps with vital information missing or should have been made earlier.		Areas of strength/safety box is left blank (it is highly unlikely that a child/family has no strengths to be noted)			Consent is missing when it would be reasonable for it to have been obtained or rationale for not obtaining consent is not documented.		No evidence to indicate consideration been given to previous contacts/referrals			No risk analysis evident and rationale for decision making not recorded	
Basic Information	LL recording is out of date, unfocussed, and does not provide sufficiently clear information to support decision making.			Danger statements, safety goals, and scaling are not recorded on file			No evidence of quality assurance activity on the child's LL records			Case file recording is difficult to understand, inconsistent, or incomplete		
Assessment	Assessment does not identify strengths and areas of concern and provides little or no analysis.	Does not include all members of family.	Risk to child not considered.	Assessment uses jargon (i.e. developmental milestones, inappropriate behaviour, significant harm) and is not written in language that is plain and clear to parents/carers.		Assessment does not outline a clear plan.	Doesn't identify if CP/CIN appropriate.	No multi-agency context to referral included, despite clear indication that other agencies are involved.	No evidence to suggest child seen, or where they have been seen, no evidence to suggest that they have been spoken to on their own.		No evidence of diversity or disability issues having been considered. Assessments not signed off by Manager.	Assessment not shared with family. Assessment outcome not shared with family.
Planning	There is no up-to-date care plan – including the absence of any of the following (PEP, Health Plan, Placement Plan, Permanency Plan (from 2nd LAC review)	The plan is a list of tasks to complete and places to go rather than a plan of who will do what in the child's day to day life to help them be safe and well	Family network meetings have not taken place as part of assessment or planning	The plan has not been reviewed despite this being required.		Where required, there is no evidence of a pathway plan.	There is no evidence of the child/ YP, their family, or network (when appropriate) being involved in planning and/or decision-making	The plan is drifting and not being progressed			There is no or insufficient evidence to demonstrate that the child / YP is being visited.	Recording on LL case file is limited/ absent with respect to key issues, including visits to the child
Review	Plan (CIN, CP or looked after) has not been reviewed in accordance with Statutory/ procedural requirements	Key family members / child / YP or professionals are sometimes not invited to review meetings.		Review meetings are not meeting the child's needs and do not act to encourage the child/YP's engagement		Review records are insufficiently detailed to enable clear planning and action		Safety plan is not reviewed on each visit to ensure it is being enacted to meet the child's need for safety or is not revised if not meeting the need (after exploring issues of what is getting in the way)			Chronology is non-existent or contains cut and pasted records that are not relevant to the purpose of the chronology	
Management Oversight	Supervision has not been taking place in accordance with supervision policy.	Supervision records do not provide outline of decision making, have no evidence of reflection or analysis and/or fail to address concerns.	Supervision has not been effective in ensuring referrals and actions are effectively progressed.			Lack of recorded QA activity.	Supervision does not include the principles of Signs of Safety nor is there an expectation of work being undertaken within the framework, including SoS tools (as appropriate to each child/family)		Safety/risk, harm/danger, and day to day safety not clearly reviewed/ recorded		Supervision is directive only and does not use appreciative inquiry and solution focused questioning	

1.4 Multi-Agency Audits

Introduction

The Bexley Safeguarding Partnership for Children and Young People undertakes various types of multi-agency audits including:

- Audits recommended by the Learning from Practice Group (this might include cases which do not meet the criteria for a local safeguarding child safeguarding practice review but where there are lessons for multi-agency practice);
- Audits as part of the partnership's key priorities and learning hub approach
- Audits to assess the impact of previous changes made to multi-agency practice in Bexley

Depending on the type of audit, the approach taken and process for each will differ.

What is a multi-agency audit and how do we do approach them in Bexley?

A multi-agency audit is an opportunity to consider cases involving more than one agency where there are areas for potential learning and future multi-agency practice improvement. In Bexley, they are led and facilitated by the Safeguarding Partnership's Practice Review and Learning Manager. The audit team includes the Designated / Deputy Designated Nurse, Bexley Clinical Commissioning Group and a representative from Professional Standards and Quality Assurance Children's Social Care. Depending on the nature of the audit, other agencies may be invited to be a part of the audit team.

The audit process relies on both historical and current information. Audits will generally cover a 12-month period although this can be adapted on a case-by-case basis if necessary. It is recognised that staff and personnel involved in any one case can change over a 12-month period. This may result in a practitioner who has only been involved for part of that time and for limited periods being invited to contribute. The audit templates sent ahead of reflective discussions (referred to below) are designed to capture information from files and direct knowledge or experience of the case. If a case is identified for audit then it is expected that the allocated worker at the time will be responsible jointly with their line manager's input, to provide as much detail as possible and to attend audit discussions so that any remaining questions and/or recommendations can be understood and acted on as soon as possible.

What is a reflective practice discussion?

The Safeguarding Partnership Board has agreed an approach to multi-agency auditing which involves practitioners directly involved a case coming together for a reflective practice discussion. Practitioners may wish to participate with their supervisor and or manager and this should be discussed if necessary as soon as an invitation is received. The operations team will copy invitations to managers and/or supervisors in the first instance provided they have accurate and up to date details of those involved. The benefit of managers and/or supervisors attending audits if at all able is that it is a reflective learning opportunity and also a way to participate in planning and developing recommendations to improve future multi-agency practice in Bexley. It also provides for an additional layer of support to the practitioner in taking actions forward. The audit process is not designed to apportion blame. These events will be facilitated to ensure everyone feels supported throughout the process, and that learning is captured in a positive and respectful manner.

[1] Under the Children Act 2004, as amended by the Children and Social Work Act 2017 and Chapter 3 of Working Together 2018, the three safeguarding partners in each local area (the police, clinical commissioning group and local authority) must make arrangements for working together, and with other partners locally, to safeguard and promote the welfare of all children in their area. In Bexley, this is the Bexley Safeguarding Partnership for Children and Young People, established in October 2018.

Completion of audit tools

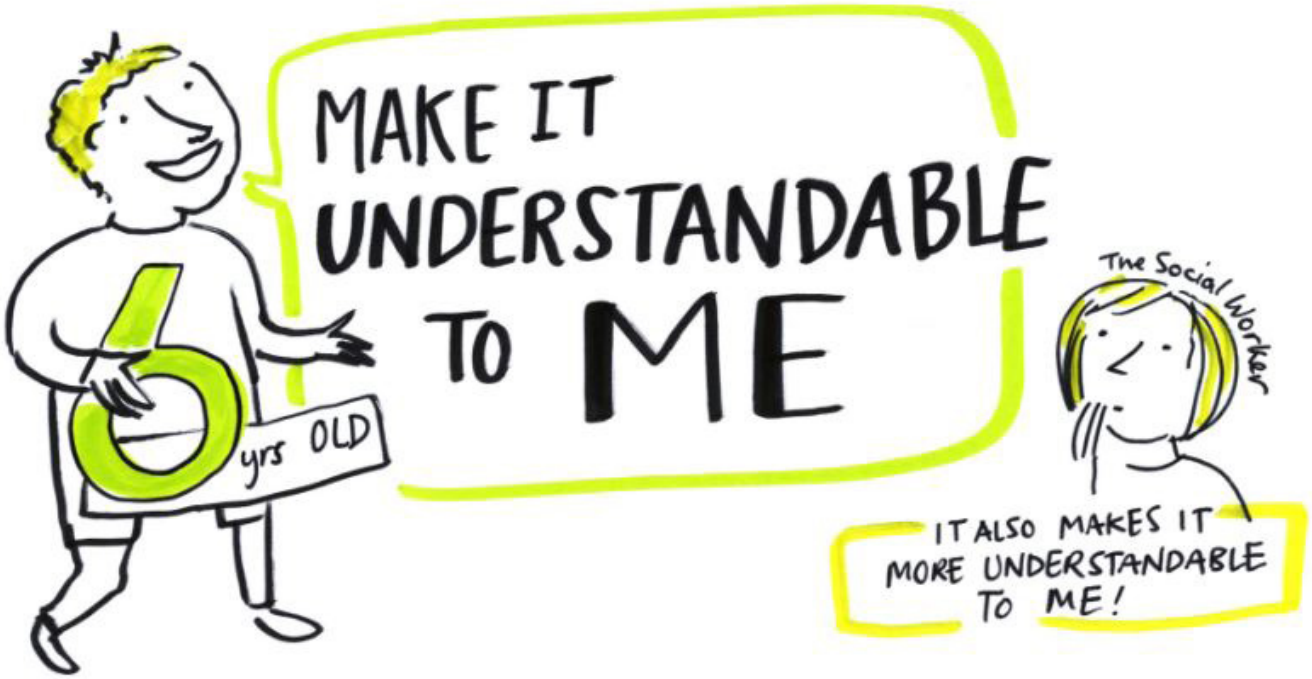
In advance of the reflective practice discussion, the practitioners directly involved in the case are asked to complete a multi-agency audit tool and send this back to the safeguarding partnership operations team via secure email / Egress. The timescales for completion of audit forms are key to ensuring that audits are well prepared and to ensure that reflective discussions are informed by as much background information as possible. The partnership operations team will send out deadlines for audit forms to be completed and they respectfully ask that practitioners and/or line managers keep them updated if there is likely to be any delay so that the partnership can prepare in advance. The partnership operations team will try to provide as much notice as possible ahead of the reflective discussion to ensure there is minimal impact on existing priorities.

If you are invited to take part in a multi-agency audit and complete the audit tool, please ensure you discuss this request with your line manager / designated safeguarding lead before submitting your audit form.

1.5 Quality assuring of Education, Health & Care Plans

Education, Health and Care Plans (EHCP) are quality assured through the Inclusion & Statutory Assessment service. The process of auditing these plans differs from the auditing process outlined above. Auditing of the EHCP plan is to assess the quality of EHCP plan not the actual work of the practitioner. This is because the plans are based on work received by others within the education department and system. All auditing is undertaken by a multi-agency group consisting of Senco's, SEN Governors and Head Teachers from schools, Therapy Leads, Early Leads, Practitioners, Further Education Practitioners, Social Workers, and Heads of Services within Education. The group will also meet on a quarterly basis. Parents and young people who have direct personal experience of the system will also assist in this quality assurance programme, but do not them and young people.

The audits are the analysed by the Head of Special Educational Needs and Disability service who produces a quarterly report that is scrutinised through the Performance and management accountability cycle at weeks 6 and 7 the Education Performance Review meeting (see Fig 1.5).



2. Case Management Dashboard & Core Data

Regular and detailed scrutiny of performance data is at the heart of keeping track of progress and alerting managers to issues at an early stage before they become serious concerns. Scrutiny of performance data is a core function of team managers, assistant team managers service managers through to senior officers and Elected Members. A robust performance regime will inform other types of scrutiny, for example through audit, and will contribute to organisational learning.

2.1 Case Management Dashboard

There are eight core aspects of Signs of Safety practice that together, create a robust and effective method of working with families (see Fig. 2.1). The case management dashboard [which will be embedded in LiquidLogic] provides an at-a-glance reference to practitioners of the Signs of Safety activity completed, or yet to be completed with families. The dashboard data can also be reported from to support management oversight of practice, and provide an indication at a strategic level, of areas of practice where more support is required. The Case Management Dashboard report is produced on a monthly basis and circulated with the Monthly Performance Data (MPD) and ChAT. The report is then reviewed at Week 2: Social Care Performance Review. Whilst the dashboard is in development by LiquidLogic, the Children's Performance Team, Strategy, Performance and Insight team will provide key Signs of Safety data in the Monthly Performance Data (MPD).

2.2 Continuous Improvement Work

Our Case Management System (CMS) provided by LiquidLogic supports practitioners to record their work in line with our adopted practice model - Signs of Safety. Staff are encouraged to share improvement ideas with our LCS & EHM Product Manager, Lesley Tabrett, Lesley.Tabrett@bexley.gov.uk. Changes can be agreed at SMT with the exception of licenced forms (Signs of Safety) which require approval from the Signs of Safety LiquidLogic user group. The effectiveness of the CMS is monitored through Heads of Service, who will routinely gather feedback from users, either informally or formally through survey responses. This is then raised through both the Signs of Safety Board, chaired by the director children services or through the Senior Leadership Team as part of the performance and accountability cycle.

Fig. 2.1 Dashboard Measures

Mapping with Family (parent/carer experience)	**Three Houses or equivalent** (child's experience)	**Danger Statement, Safety Goal and Safety Scale** (analysis and judgement)	**Words & Pictures**	**Family Network Meeting**	**Safety Plan**

2.3 Monthly Performance Data & Performance Review

The Monthly Performance Data (MPD), is issued twelve times a year by the Children's Performance Team, Strategy, Performance and Insight, p&pcsc@bexley.gov.uk. The MPD comprises data for all service areas within children's services as well as demographics. Open contacts, assessments, child protection plans, children looked after, supervision and caseloads are all reported on.

The report includes an exception report, detailing an overview of data that requires the closet scrutiny. Heads of Service and Service Managers are responsible for dealing with, and responding to, any items listed in the 'Other' box on the exceptions page.

The MPD is scrutinised as part of the Performance and Accountability cycle – Week 2. This is a ½ day session that requires attendance of Team Managers, Service Managers and HoS. It is chaired by the Director and Assistant Director of Children Services. The meeting is about providing a space to provide a critical friend to performance and ensures accountability to the lead council member for children services.

The performance review offers opportunities to discuss what's working well in team and service performance, highlight what is worrying to teams and the system as a whole, whilst working on next steps and expectations to improve. Managers are expected to be clear about their own team's performance, taking ownership and responsibility for this. Alongside their service manager they will lead on how improvements, if necessary are required to improve performance. This should be done by asking critical questions through appreciative inquiry of colleagues, where team performance is meeting or surpassing expectations, so that learning is shared.

The MPD is issued via e-mail and managers who are not in receipt of the MPD should contact the Children's Performance Team and request to be added to the distribution list.

2.4 Manager's and Service Managers Monthly Report

As part of the performance cycle, all team managers are required to complete a monthly report. Team managers should scrutinise the Monthly Performance Data and ChAT tool and consider impact on their team and service. They should also ensure that they understand and comment on the exceptions report and any incorrect data and what action has been taken to correct this. The monthly report also requires managers to comment on quality of practice, specifically complex cases, supervision – including any outstanding supervision showing within the performance report and actions taken. Finally, team managers should record workforce & professional development, for themselves and team whilst including if they are involved in Action Learning Sets and the impact of these. Team training data can be accessed through the EVOLVE system and is further reported on within the performance and reviewing cycle (week 2). Training and performance data relating to Signs of Safety practice is reported on through the performance and reviewing cycle (week 5).

Team Managers are required to complete the Monthly Manager's Report and this requirement forms part of the Managers Standards – 'Governance & Accountability - Prepare a monthly managers performance report as required in the accountability cycle, submitting it on time and to a high standard'. The report should include explanations for the current exceptions, and provide it to their Service Manager (cc HoS) the date for when this must be completed will be provided when the MPD is issued. At the same time a copy should also be emailed to leadershipsupportteam@bexley.gov.uk.

Service Managers should then email their own Service Managers a summary report to the same inbox (cc HoS) the date for when this must be completed will be provided when the MPD is issued. The Service Managers Monthly Report, should report on reflections on previous month performance with comparison to current month reporting analysing exceptions noted within the MPD and DCS scrutiny questions, learning from allegations, complaints, and audits. It should also comment on complex cases: based on team managers reporting, are we doing enough to keep children safe?

2.5 ChAT

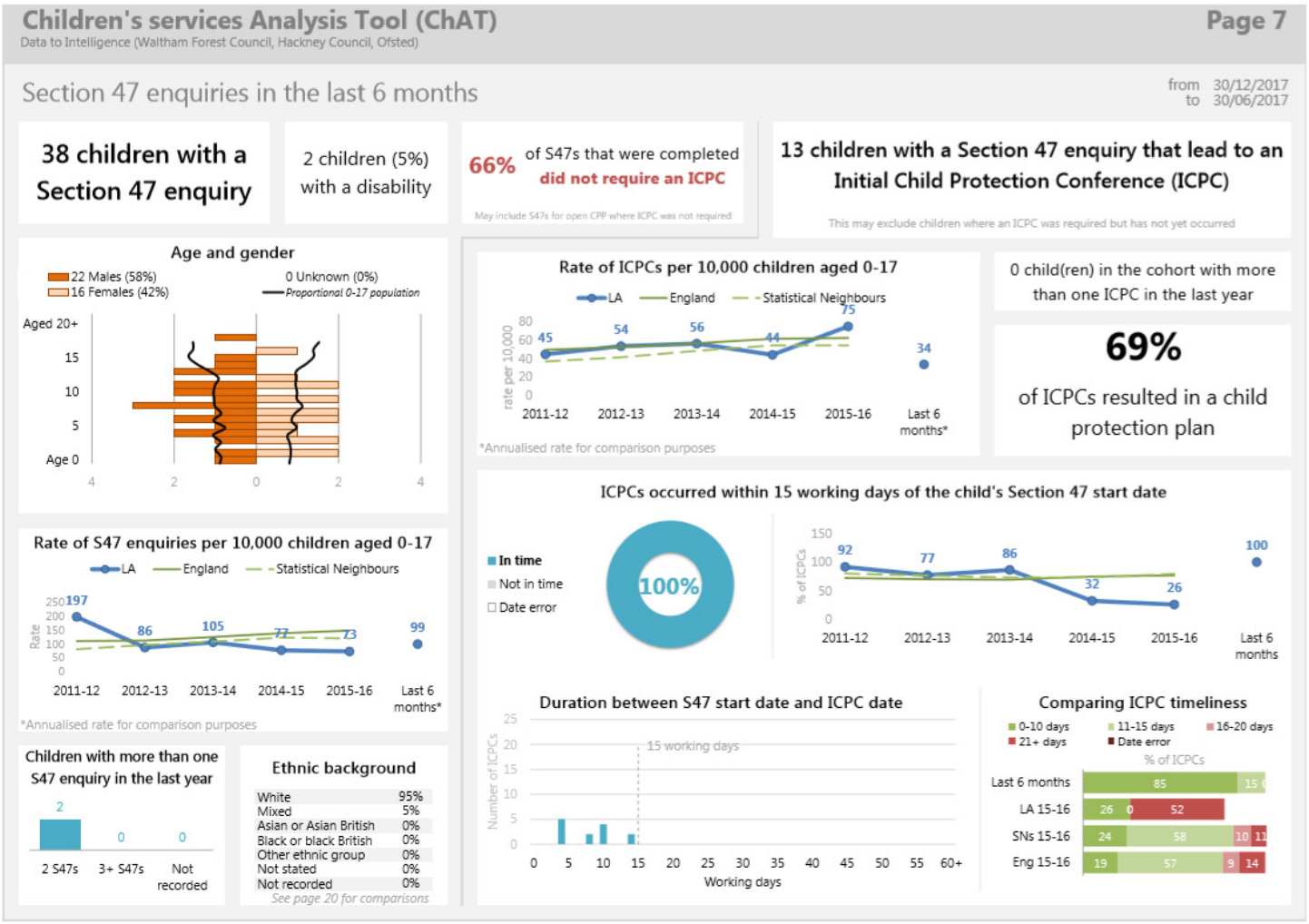
The Children's services Analysis Tool, or ChAT, was developed as a part of the collaborative 'Data to Intelligence' project between Waltham Forest Council, Hackney Council, and Ofsted for the use of local authorities to improve performance management of children's services.

ChAT transforms child-level data and benchmarking statistics into a visual report that covers all areas of children's social care. It enables managers, service managers and our senior leadership team to understand trends so that we can get ahead of the curve and see how Bexley compares statistically nationally and to neighbouring local authorities. The wide scope and in-depth analysis of ChAT makes it a both a useful tool to

prepare for an Ofsted inspection, as well as add value to existing performance management tools and reports.

All managers at all grades are expected to review the ChAT tool alongside monthly performance data and should devote the same scrutiny in understanding what the data will mean for their service. ChAT uses a variety of clear and simple visualisations that are easy to understand, and a consistent structure that is easy to follow and to spot areas of focus or concern. It focus data around, children looked after, children in need, subject to assessment, care leavers and child protection. Relevant information is grouped together on a page to maximize information absorbed at a glance. For example, child protection data is grouped as statistics on s47's and child protection conferences. When reviewed it is possible to quickly and easily see whole numbers and percentages of s47's progressing from inquiry to child protection conference. If numbers/percentage of s47's is high but do not progress to child protection conference, then a hypothesis can be drawn; such as too many children are subjected to a s47 inquiry. Further investigation through auditing and review can then be undertaken and corrective action taken.

Example of the ChAT tool data set:



3. Family and Staff Feedback

We seek feedback from children, young people and families to help us learn about the quality of help received. We also seek feedback from staff around confidence with practice and the organisational culture, and feedback from partners. Feedback is obtained through a variety of methods and collected at different points in time, however findings are always analysed and lead to actions to improve and design our services.

3.1 Children and Families

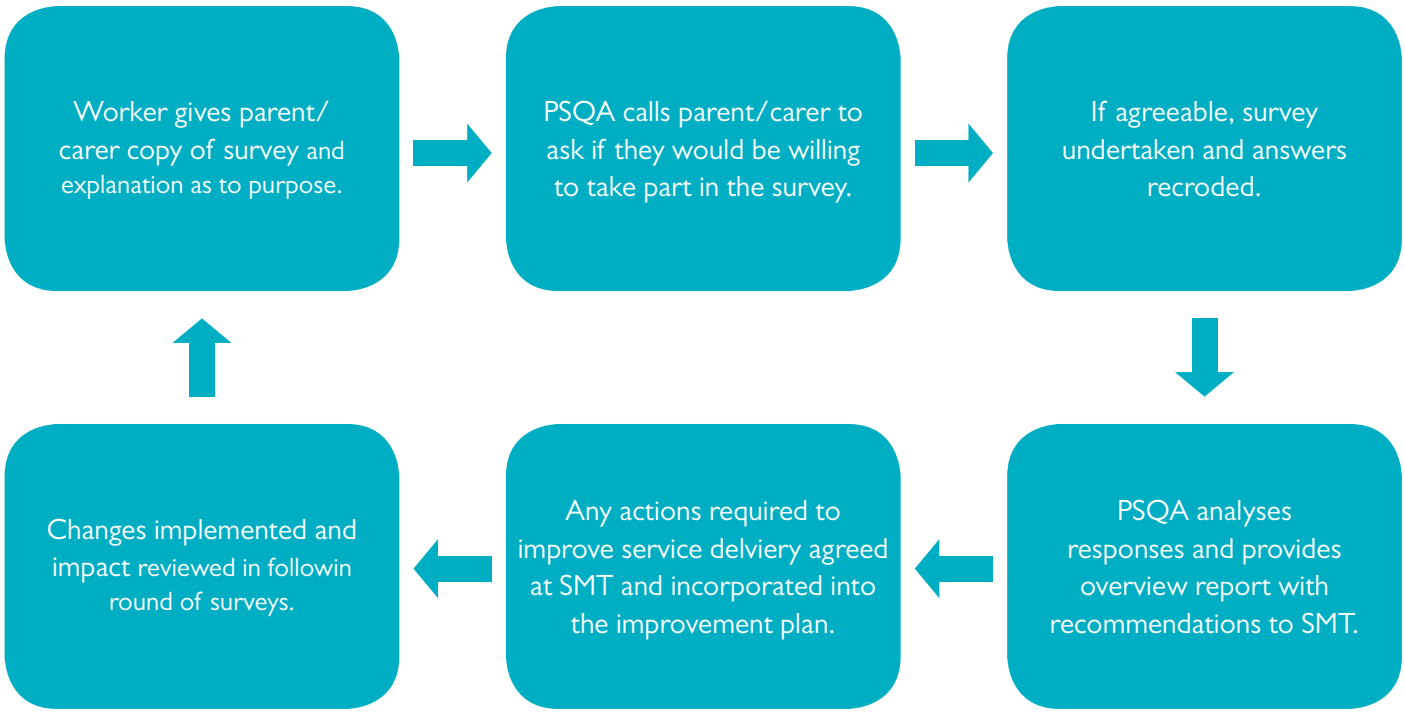
3.1.1 Parent/carer survey (service wide)

The survey focuses on the parent/carer's experience of working with their worker. It does not request any personal details pertaining to the family or the worker. It asks questions that capture the extent to which the principles and disciplines of Signs of Safety are reflected in the practice, and the presence of other factors that have been identified as contributing to successful helping relationships.

The survey is comprised of nine statements which parent/carer's are asked to rate from strongly agree to strongly disagree. At the end of the survey, parent/carer's are given the opportunity to comment freely on their experience and are asked what one thing they would change about the way their worker worked with them, and if they have anything else they would like to add.

The survey is carried out over a two week period once a year. The survey is administered by the Professional Standards & Quality Assurance (PSQA) Service however a hard copy of the survey, along with an explanation of its purpose is first handed to parent/carer's by their worker to give them time to make an informed decision as to whether they would like to take part prior to receiving a call from a member of the PSQA Service. The parent/carer can decline to take part at any stage.

Results tell us that in order to achieve the best response rates and gather the most representative and robust findings, this method is the most successful. The survey design is in line with the Research Ethics Policy of the London School of Economics (available here).



3.1.2 Feedback from children and young people

We ask children and young people regularly, if we are making a difference to their lives and ask what they would like us to do differently. Direct feedback from children and young people is obtained as part of monthly collaborative case audits. In addition to this, children and young people may be asked to provide feedback via the Children's Services Feedback form. The Children with Disabilities Team seek and obtain feedback using creative tools to work with children who have different ways of communicating. Children and young people may also be asked share their feedback when their child protection plan ends - Children and families experience of Child Protection Conferences.

Children and young people who are looked after by us have additional opportunities to provide feedback around their looked after review meetings and personal education plans: Tell us what you think about your looked after review meeting and Experience of looked after children and young people in their PEP. Children and young people can also provide feedback at Monday Club by speaking to a Social Worker, Independent Reviewing Officer or our Young Director. Alternatively, a child or young person can use the worry dragon at Monday Club by writing down their worries which will be followed up and fed back to their foster carer / social worker. Children and young people can also share their feedback through Positive Journeys or directly to the Young Director.

The Fostering Service also collects feedback from children and young people in external placements as part of the annual QA visit to the provider, and on Foster Carers by children and young people in their care, and birth children, as part of their annual review. The Leaving Care Team have developed a bespoke feedback from for young people which can be completed in person or over the phone. Further detail around how we promote and learn from feedback from children and young people who are looked after can be found in the Looked After Children & Leaving Care Strategy 2017-2020.

Children and young people involved within the Special Educational Needs service are offered the opportunity to feedback on the quality of the service they receive. The information is considered at management and senior management level, where themes are collated for the quarterly quality assurance report.

Targeted Youth Support use a questionnaire to enable young people to feedback on the quality of service and experience they have received from the practitioner and service. These are reviewed by managers through the monthly manger's reporting system and by the Head of Special Educational Needs and Disability service within their quarterly audit report.

3.1.3 Feedback from parents/carers

The Children's Services Feedback form is sent to families by the Referral & Assessment Service or may be handed to families by their worker during a visit. Completed forms are uploaded onto LiquidLogic. The Family Support & Child Protection Service contact families on a monthly basis by phone to obtain feedback and record this onto LiquidLogic.

Feedback forms are provided at each child protection conference and looked after review (Parent/Foster Carer/Adopters Consultation Form and Parent/Foster Carer Feedback Form). The Service Manager reviews the feedback provided and if there are any worries, this is followed up with a telephone call. As mentioned at 3.1.2, a new form is being trialled to seek feedback from parents/carers when the child protection plan for their child ends. This helps us to understand what the child protection conference process was like for families, and if our relationship helped the family through their difficulties and to make the changes needed for their child to no longer need a child protection plan - Children and families experience of Child Protection Conferences.

Family Feedback Forms are routinely given to parents/carers by the Children with Disabilities Service during visits and meetings. Completed feedback forms are uploaded onto the child's record on LiquidLogic. In addition to this, commissioned services such as SNAP and Crossroads also collect feedback and share this with the Children with Disabilities Service.

Parents known to the Special Educational Needs service, receive a questionnaire at the end of the statutory 20 week assessment process for an Education, Health & Care Plan (EHCP). The Special Educational Needs service also run a survey on a yearly basis to assess the impact of the services they provide. This is sent anonymously in the Summer school term, although families are able to request a call-back from the service to talk through answers in detail or explore issues more thoroughly.

The Fostering Service seeks feedback from all those involved in the Fostering Panel and as part of the Foster Carers Annual Review. Themes are presented in the Fostering IROs Annual Report. The Adoption Team also collect feedback from prospective adopters at the preparation stage and throughout their adoption journey.

3.1.4 Compliments and complaints

We take a positive approach to complaints and value them as an important form of feedback on our services. We aim to learn from feedback and use the lessons learned as a means to continuously improve and review the services we offer and respond positively to families' needs and expectations. Most complaints are dealt with under the Bexley Corporate Complaints Procedure however some may be dealt with under the Children's Social Care Statutory Complaints Procedure.

An annual report provides information on complaints about our children's social care services. Senior managers and the head of complaints hold meetings throughout the year to discuss corrective actions and identify learning opportunities. Senior managers also disseminated all learning to social care staff to ensure they change practices and procedures where necessary.

3.1.5 Learning and Improvement Partnership

The Bexley Safeguarding Partnership for Children and Young People are leading on a new initiative where parents, children and staff give feedback and help to make improvement decisions through 'families and children learning circle'. The families and children learning circle informs (quarterly), staff conferences and QA reports.

3.2 Staff

3.2.1 Social Work Health Check

The Social Work Health Check is designed to help organisations assess the 'health' of their service, to continue to develop areas of strength, and to identify and improve areas of development. We use this tool to help us understand the current climate and functioning in Bexley and to help us develop the service.

The Social Work Health Check tool is a key element of the Standards for Employers of social workers and the Social Work Task Force recommended that it should be completed annually to enable employers to assess whether the practice conditions and working environment of the social work workforce are safe, effective, caring, responsive and well-led.

The staff survey has three sections. Section One is for those who are involved in direct work with families and asks about their confidence in using the various Signs of Safety methods. This gives a measure of the extent to which confident use of the whole process of Signs of Safety engagement with families is being developed in local authorities.

Section Two measures organisational culture using the Safety Attitudes Questionnaire developed in the aviation and health sectors where extensive research has identified organisational factors that make mistakes more or less likely. The research in other high-risk sectors has illustrated how improving safety is not simply a matter of better training for front line workers but also of modifying the work environment so that it is easier to work well and harder to make mistakes (or for mistakes to go unnoticed).

The third section has open-ended questions to allow the workforce to feedback their opinions and worries about the implementation of Signs of Safety. It uses the three key Signs of Safety questions: 'what's worrying you; what's working well; what needs to change?'

Process

The social work health check is administered in the most efficient way possible to achieve a good response rate using an online software tool. It is an easy task for staff to follow a link to the survey and complete online. The survey contains questions about the person's role which then take them either to the practitioner version or manager version.

The health check findings are analysed by the PSQA service alongside results from previous years to monitor trends and understand the impact of previous improvement plans. A report is produced outlining the themes. This is shared across children services and is scrutinised by senior management and by the lead council member. A next steps plan is developed to action how the services can implement changes that will support improvements. Staff are encouraged to be a part of this process, through staff conference and dedicated health check feedback sessions.

3.2.2 Celebrating Good Practice

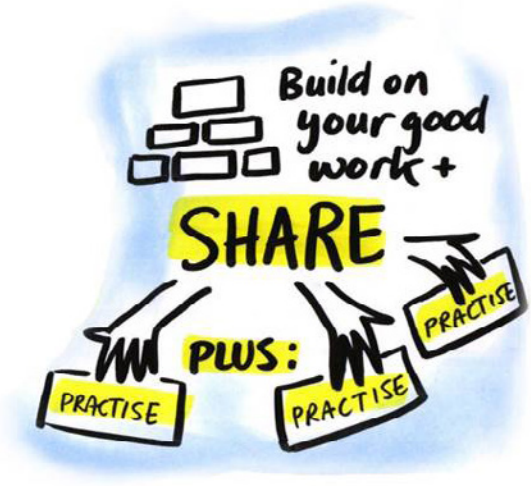
We celebrate the success, dedication, and hard work of children's social care staff across the entire service and awards are made at the March staff conference. Recognition is also given to 'Employee of the Month' in the Children's Service Leadership Message and staff are invited to a 'going the extra mile' breakfast with the Director and senior leaders in recognition of their excellent work.

The Bexley's Staff Thanks and Recognition Scheme (STARS) provides another way for us to say 'thank you' and recognise the people who make an exceptional contribution through their hard work and dedication, or who have achieved something outstanding.

Excellent examples of direct work with children, young people and their families are showcased in the monthly Signs of Safety Newsletter as a 'sparkling moment'. The direct work is explained, anonymised and saved on the shared drive for all to access.

3.2.3 Partners

Direct feedback from partners is obtained as part of monthly collaborative case audits and through the Bexley Safeguarding Partnership for Children and Young People.



4. Practice Leadership

Quality assurance starts with the recruitment of a high quality workforce and individual practitioners are therefore central to delivering high quality services. The quality of everybody's individual contribution to keeping children and young people safe and promoting their welfare is the foundation stone of the framework. In return through the quality assurance framework there is a commitment to providing staff with effective induction, supervision, appraisal, and professional development.

4.1 Induction

Children's services has its own induction process and handbook that supports a wider corporate induction but does not replace this. Both induction programs should be followed for staff joining Bexley children services. New practitioners to Bexley children services are automatically informed and booked a place on the children's services induction day; via business support officers in Professional Standards and Quality Assurance, who receive regular updates from Human Resources.

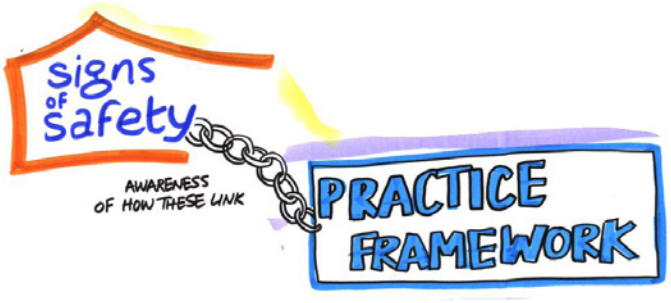
The induction day provides staff with an opportunity to meet Stephen Kitchman, Director of Children Services and here from services and teams within the children's services directorate. This is supported by an induction handbook that staff receive as part of the induction day, alongside copies of the Signs of Safety Practice Framework & Expectations document, Effective Support Document and leadership Pledge. The induction handbook contains an induction checklist that should be used by the line manager and practitioner to plan and fulfil the minimum requirement of a good induction.

Feedback on Induction

Induction is very important to ensuring that staff feel confident, committed and valued by our organisation and to ensure this induction is quality assured in a number of ways. The induction day is a mandatory training event for staff so is quality assured as a training event through the training feedback process. Further to this, all mandatory training numbers are monitored and feedback provided by either the Head of Service or Service Manager in Professional Standards and Quality Assurance at the Performance Review (week 2 – Performance & Review Cycle). Both the staff member and their line manager must sign the induction checklist; this should then be placed in the staff member's personnel record.

All new employees are subject to a period of probation of up to 6 months. All staff are expected to establish your suitability and line manager will monitor staff progress and suitability. The corporate probationary staff procedure sets out the process to be followed to establish that newly appointed employees satisfy the requirements of the post to which they have been appointed. This procedure applies to all new entrants to children's services with the exception of Teachers and Youth and Community Workers who are covered by separate, nationally agreed procedures and Newly Qualified Social workers (NQSW) who will be covered by the Council's Assessed and Supported Year in Employment (ASYE) covering their first 12 months in post.

Finally, Professional Standards & Quality Assurance are responsible for sending each new staff member a short evaluation questionnaire after 3 months (see below). This can be completed on line. The results of this are used to both improve the overall induction process for all and ensure that individuals have received the required standard of induction. If the required standard has not been reached then the Head of Professional Standards & Quality Assurance will take corrective action with the appropriate Head of Service.



4.2 Signs of Safety Practice Framework & Expectations

The purpose of the Signs of Safety Practice Framework & Expectations is to set out the practice expectations for each part of the service so that everyone is clear about what good Signs of Safety practice looks like in Bexley and so that everyone knows what is expected of them as they carry out their work with children and families.

The document has been developed collaboratively with practitioners and managers, with the underlying philosophy that those closest to the front line are in the most unique position to inform the organisation about what works. Senior managers have been engaged in the process of setting clear, non-negotiable 'bottom lines' for their service areas. These must be maintained in practice and should be reported on through team managers monthly reporting as part of 'Quality of practice' (see also section 4.2).

The framework document should be clearly understood by all those who undertake audits at any stage of practice. Any questions arising from the Signs of Safety Practice Framework & Expectations and for periodic updates should be directed to the Signs of Safety Practice Lead within Professional Standards and Quality Assurance. The document can be found through Tri-X.

4.3 Managers Standards

Children's services manager's standards have been developed to support all managers in children services to deliver a competent standard, maintain Bexley's values and support personal development for managers and their team.

The standards are made up of nine core domains:

1. Promoting and governing excellent professional practice including the use of Signs of Safety
2. Focusing always on the experiences of and feedback from children and young people and other partners
3. Governance and accountability
4. Managing resources
5. Equality, diversity and inclusion
6. Systems and processes to promote communication
7. Using feedback
8. Multi-disciplinary working and relationships with partners
9. Professional development

Bexley Management Standards can be found on Tri-X

The standards help both PSQA and team managers to quality assure the work we do and supports the work of others, creating consistency in practice, a learning environment and leadership. The standards support a self-assessment approach to competency. Managers should apply the self-assessment on a quarterly basis and which is reviewed within personal supervision. Demonstrating overall competency to the standards will form part of the appraisal system, which includes a yearly performance management meeting this is a 1:1 discussion with their line manager during April/May. This meeting should include how managers have demonstrated the standards through the self-assessment. The PSQA service holds responsibility for ensuring that the Management Standards are regularly update and that the standards are followed.

4.4 Learning & Serious Success Reviews

The purpose of an internal learning or serious success review is to enable practitioners to reflect on the quality of their work with children, young people and families to learn from their own practice and other's within Bexley Children's Social Care. Emerging themes will enable us to identify what works well and what could be done differently to improve the quality of social work practice and outcomes for children. The outcome of the learning/ serious success review should be captured in a briefing note to be shared with practitioners across the service in team meetings and other appropriate information sharing forums. The learning/serious success review supports Bexley's vision of developing and promoting a learning culture across the service; it is not an opportunity to apportion blame to individuals.

Review Process

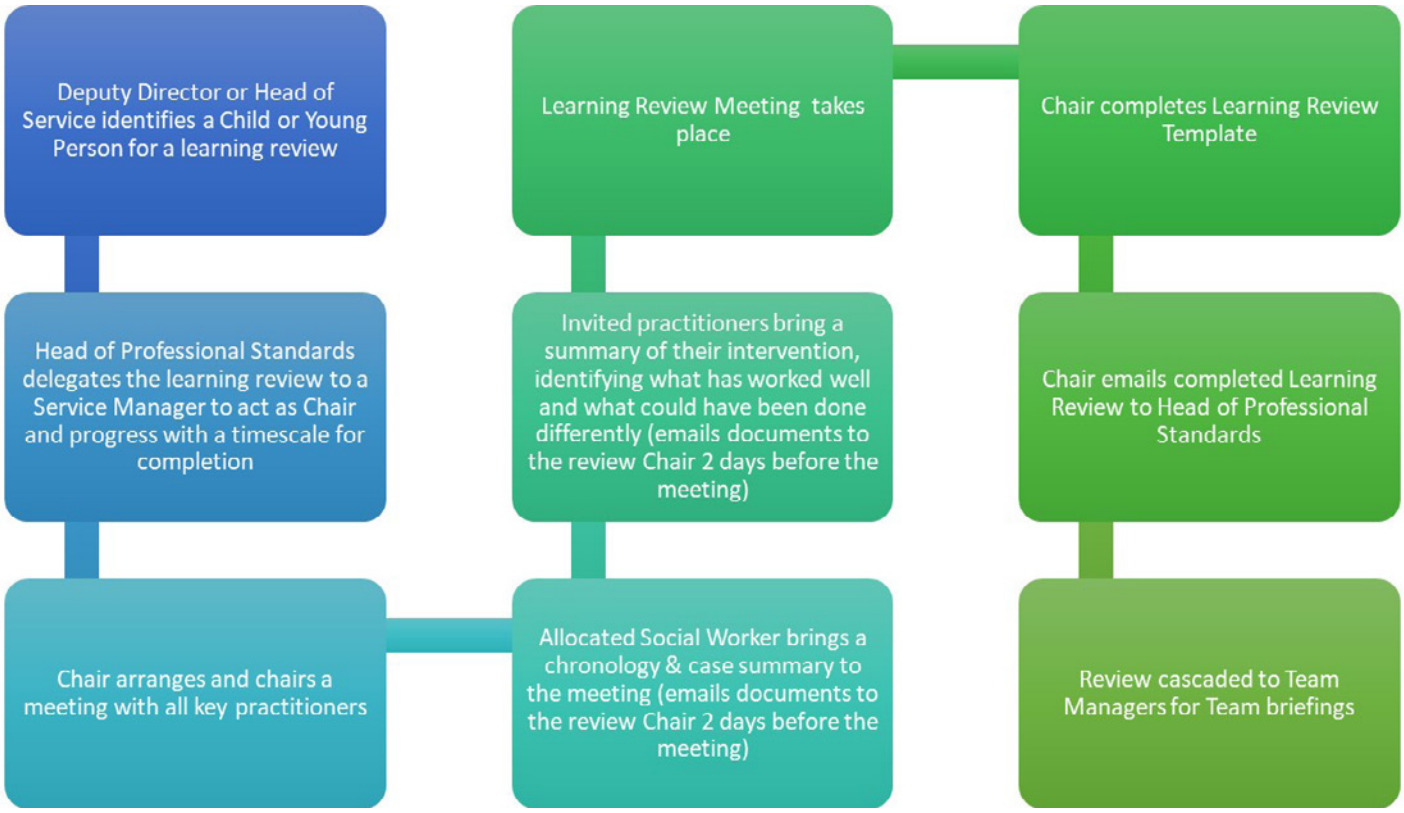


Fig 5.4 - Review Process

Review Meeting

- The review should take between 1 – 1 ½ hours. To run the review, you will need three sheets of flipchart paper and couple of flipchart pens.
- Prepare a landscape sheet of flip chart paper in four columns as shown below:

What is going well?	What are we worried about - practice pitfalls?	When did this happen?	How can we learn from this? What can be done differently?

The review should be concluded by looking at the practice pitfalls and when they occurred on the child's timeline and journey through the service. The chair will identify the learning points and capture these in a briefing note for managers and practitioners. The briefing note must set out, a case summary, what worked well, areas of development and key learning. (Appendix e - Serious Success Reviews / Learning Review Template)

4.5 Action Learning Sets

Purpose

As part of Signs of Safety implementation and delivering Bexley's success measures, Team Managers, Assistant Team Managers and Practitioners have the opportunity to join Action Learning Sets that develop and sustain Signs of Safety practice. ALS are grounded in adult learning and can be powerful forums to acquire long lasting problem solving skills; promote leadership, accountability, provide challenge and learning and develop achievable plans.

Process

Action learning sets are made up of between 6 to 8 participants who meet with a facilitator from Professional Standards & Quality Assurance. Sessions are for up to 3 hours meeting for 5 or 6 sessions over a 6 or 12-month period, depending on need and subject. Most learning sets will be peers who work at similar levels of responsibility. The facilitator's role is to introduce models of understanding to support thinking and re-framing dilemmas. Action Learning sets work together on a subject that will support their work, role and service delivery. Each session involves a member of the set presenting a challenge within the subject to the group (45mins). Such as developing group supervision to create learning opportunities for staff. The group listens and only asks open questions, the presenter then comes up with their own action plan. Motivation and commitment is driven by the group coming together to hold each other to account on actions taken away.

All managers will have an opportunity to be part of an learning set, although not all managers will be involved in an action learning set at the same time. This is due the number of available facilitators, the intensive nature of action learning and the need to provide continuity of service. Action learning sets for practitioners have been developed for those practitioners who are acting as practice champions or have completed Signs of Safety 5-day advance training.

4 or 5 action learning sets will take place each year on a rolling programme, offering opportunities for up to 30 participants per year.

Expectations

Attendance at groups are pivotal to their success. Members of a set must attend. Commitment should be based on supporting colleagues and the group, rather than setting mandatory expectations. However, if participants and direct line managers do not themselves see value and give them priority then there is a significant risk of failure, one person could take the group out if they are not committed.

If you are part of an action learning set your manager has given permission and should support you to attend all sessions. Dates for sessions will be agreed in advance. Only by agreement between the relevant Head of Service and Head of Service for Professional Standards & Quality Assurance are staff able to be given exceptions from attendance within an action learning set.

Action learning sets will provide impact and solutions to the delivery of services, subjects for learning sets will be agreed by the senior leadership through advice from PSQA. Action learning sets will work on areas of practice that require further development as highlighted within training, practice development, complaints and audit themes. PSQA will support how action learning sets implement actions that any set agrees need to be taken forward.

4.6 What to do when practice feels compromised

Making decisions around the safety and well-being of children are difficult, especially when there can be varying views on what is in a child's best interest. It is why as much assessment, planning, and collaboration as possible should always be done in order to try to achieve the safest and best outcomes for the children and families we serve. It is expected that disagreements will arise from time to time and these will be explored in various ways such as in supervision, review meetings, and in decision making panels.

The vast majority of these can usually be resolved when managers and practitioners foster a culture of respectful challenge and reflection on cases. Occasionally, significant areas of disagreement can arise and often leave practitioners and some managers feeling conflicted between acting in what they believe is in the best interest of a child versus not wanting to "rock the boat" or upset their line managers.

To support this there is an escalations procedure led by the Principal Child & Family Social Worker (PCFSW). The aim of the procedure is to provide a means for the PCFSW, practitioners or managers to escalate issues in order to ensure they are carefully considered to avoid drift and delay or compromising the safety and well-being of the children we support. Escalations are about protecting children, not about hurting friendships and should be delivered with compassion.

It is expected that all persons who raise or hear concerns raised through this procedure will do so in a manner that fosters respectful challenge and supports professional disagreement. No repercussions or disciplinary action should be considered against those who raise concerns in line with this procedure who are acting in good faith with the best interests of a child's safety and well-being in mind. Where there are concerns that relate to a culture of unsafe or unprofessional practice, or where a person believes they are being treated in an unfair or discriminatory manner, they may consider raising those matters concurrently to this procedure under the Bexley's Whistleblowing or Employee Resolution procedures.

Further information can be obtained through the Children's Services Escalation procedure and corporate HR Whistle Blowing Policy.

5. Practice Review

Senior leadership and managers working together to develop critically reflective practice that equally shares responsibility for risk in a balanced way through supervision, appreciative inquiry, consultations, escalations and practice learning.

5.1 Supervision & Group Supervision

Effective supervision can help staff feel valued, prepared, supported and committed and also improves retention. Lack of supervision can result in work overload, stress, sickness, absence, as well as reduction in competence and confidence. The most effective supervision is focused on skills rather than therapeutic support or adherence to procedures. Supervision is a process for integrating thinking, feeling and action, it is an inextricable part of the assessment, planning, intervention and review process through which effective services are delivered.

Individual supervision can be formal, taking place in a pre-arranged meeting, or informal by way of unplanned discussions between a social worker/personal advisor/ family support worker and a senior practitioner/manager. Group supervision is designed to assist teams to become more agile and confident in action learning, building habits to move quickly from gathering information to analysis and judgement.

Individual and group supervision is formed of four standards (fig 6.1) and all case-holding practitioners should receive 1.5 to 2 hours, weekly for the first 4 weeks, fortnightly for the following 4 weeks then no less than every 4 weeks thereafter. All non-case holding practitioners should receive 1.5 to 2 hours no less than every 4 weeks. Group supervision should take place every 2-4 weeks. This includes case mapping.

Fig. 5.1.1 – Four Standards of Individual Supervision

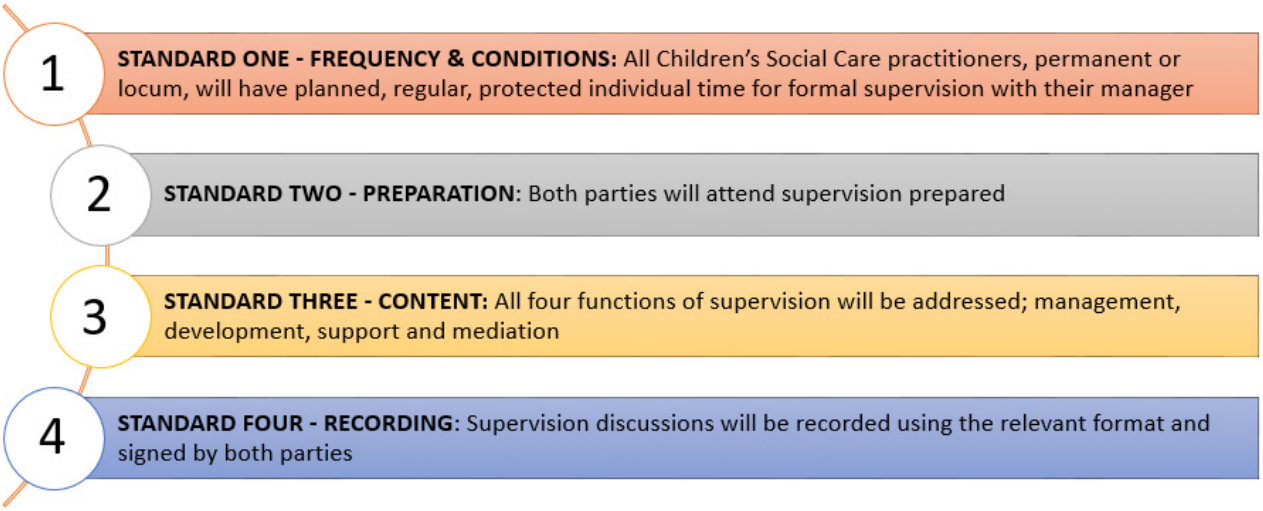
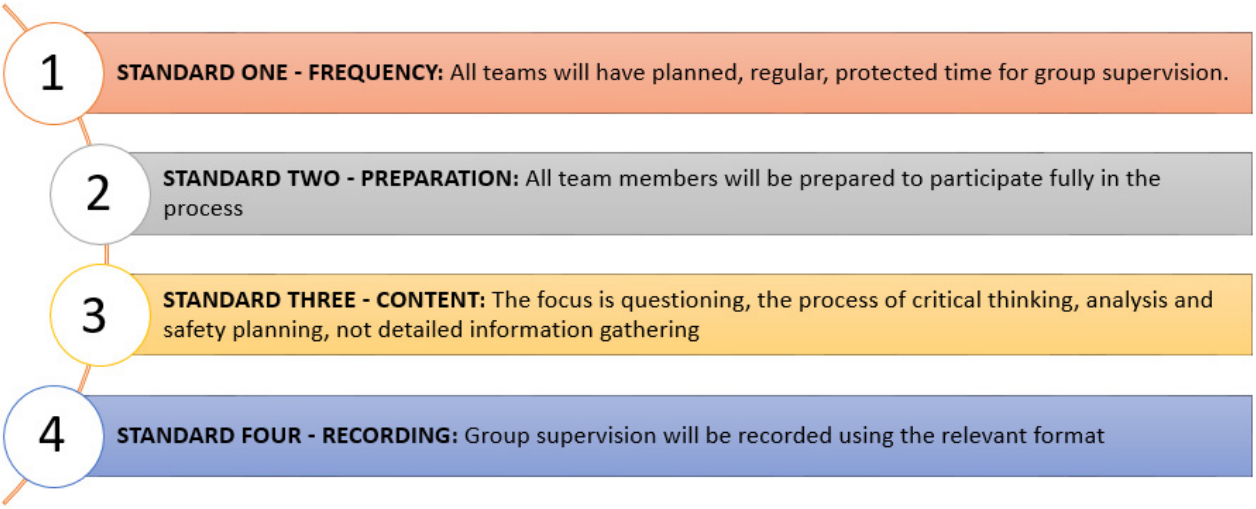


Fig. 5.1.2 – Four Standards of Group Supervision



Quality assuring supervision

a) Supervisees who believe they are not receiving supervision (individual & group) in accordance with the standards above, must draw it to the attention of their supervisor and/or an appropriate person. An appropriate person could be a next level manager within the service.

b) The management accountability framework requires that team manager's provide a monthly report on the frequency of direct observations, individual and group supervision in their team. To enable the senior management team to monitor that standard one is being met.

c) Supervision records will be viewed at a minimum, bi-monthly and subject to quality assurance audits by senior managers, internal auditors, externally commissioned auditors and/or OFSTED inspectors. Auditing enables the senior management team to monitor that standards two, three and four are being met.

d) Group supervision will be periodically observed by senior managers, internal auditors, externally commissioned auditors and/or OFSTED inspectors. Auditing enables the senior management team to monitor that standards two, three and four are being met.

Appreciative Inquiry

Appreciative inquiry is imbedded within the Bexley Signs of Safety practice framework and should form part of both individual and group supervision using the EARS approach as well as in Quality Assurance. Appreciative Inquiry helps practitioners learn from what has gone well, what affect Signs of Safety has had on their work and what could they do differently next time.

Elicit:
First Question - the organising question for whole conversation

Amplify:
Behavioural Detail - What would you see/hear

Reflect:
Explore meaning

Start Over:
If the conversation slows, start another organising question

Using EARS in Appreciative Inquiry

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Elicit	Amplify	Reflect	Start-Over
Working Well / Proudest Work			
Thinking about your work what's the piece of work you feel proudest of in the last month? **Tell me about a challenging situation and how you came over it?** **What would you say is the most positive thing you have done?** **What is the biggest difference you have seen in your work since using Signs of Safety in Bexley?**	■ Use 5Ws and H: Who, What, When, Where, Why and How ■ Who else was involved? ■ What would they say they noticed about you after this event? ■ Bring out 'I' not 'We' – what did you do? ■ What we are worried will happen to the child if nothing changes? ■ If I had been, there what would I have seen? ■ Who was involved in this with you? ■ What happened that makes you most proud of this work? ■ Who knows about this work that you respect? What would that person say was most important about this piece of work? ■ What are the most important things you did to make this happen? ■ What was the hardest thing you had to do to achieve this success? ■ Who helped you do this? How did they help? ■ What would they say was most important about what you did? ■ What was the most important difference that happened because of this piece of work? ■ What would be the most important example you can think of when you have seen that difference happening in your work? ■ How have you gone about bringing the difference into your work? ■ What happened that most pleased you from doing that? ■ What was the hardest thing you had to do to be successful in doing this? ■ Who else has been a part of this? ■ Did someone else help you with doing this? How did they help? ■ What would (your manager, service manager, colleague) say they have noticed has changed in your work? ■ What have you seen in others that has told you this is making a difference? ■ What would (your manager, service manager, colleague) say has been most helpful to them about what you've been doing? ■ How do you think the change you have made has made a difference for the direct work with parents and children?	■ When you think about this piece of work that you are proud of what is the biggest learning for you? ■ When you think about what you have achieved what have you learned about yourself as a professional doing this work? ■ What has surprised you about what you have been able to achieve? ■ What difference did it make for x? ■ What learning did you have that you could use in other situations? ■ When you think about this change in your work what's the biggest learning for you? ■ What have you learned about how you want to lead the use of Signs of Safety from this change?	Allow the conversation to flow, but try and think about when you have used amplifying and reflecting questions. You can re-start with a further eliciting question Look for other examples with behaviour and meaning detail And what else has gone well?
Quality Assurance			
Whether informal or formal and however it is structured, what is the best example of quality assurance/improvement work you have been involved with?	■ Who was involved? What was the situation? What was the QA work focusing on? ■ What was it about this QA/improvement work that makes it the best improvement work you have been involved with? ■ What exactly did this improvement work improve? ■ What would . . . (practitioners and other professionals) involved say was most valuable for them about being involved in this QA work? ■ What were the most difficult dynamics/issues that were handled well in this QA process? Who did what to manage those issue/dynamics well? ■ The people whose work was the subject of the QA/improvement work could have been anxious in fact probably were to some extent, what would they say were the most important things that were done that got them genuinely engaged in the process? ■ If the family (parents/children/extended family) were to have observed this improvement/QA process what would they say was most important about this work that believe would actually make a difference in the services they would receive? ■ What are the most important things you have done to lead this improvement work? ■ What would the practitioners say was most important to them about how you lead them in this work?	■ You said this was the best QA work you have been involved in so that means there's probably heaps to learn from reflecting on it. Having thought about it more and dug in the detail of the work pick the one thing that right now strikes you as the biggest learning for you about how to best do genuine QA work in children's services?	Allow the conversation to flow, but try and think about when you have used amplifying and reflecting questions. You can re-start with a further eliciting question. Look for other examples with behaviour and meaning detail And what else has gone well?
Biggest Difference			
What is the biggest difference you have seen in your work since using Signs of Safety in Bexley?	■ What would be the most important example you can think of when you have seen that difference happening in your work? ■ How have you gone about bringing the difference into your work? ■ What happened that most pleased you from doing that? ■ What was the hardest thing you had to do to be successful in doing this? ■ Who else has been a part of this? ■ Did someone else help you with doing this? How did they help? ■ What would (your manager, service manager, colleague) say they have noticed has changed in your work? ■ What have you seen in others that has told you this is making a difference? ■ What would (your manager, service manager, colleague) say has been most helpful to them about what you've been doing? ■ How do you think the change you have made has made a difference for the direct work with parents and children?	■ When you think about this change in your work what's the biggest learning for you? ■ What have you learned about how you want to lead the use of Signs of Safety from this change?	Allow the conversation to flow, but try and think about when you have used amplifying and reflecting questions. You can re-start with a further eliciting question. Look for other examples with behaviour and meaning detail And what else has gone well?

Practice Framework Reflective Tool

Alongside appreciative inquiry, practitioners and managers are encouraged to use the practice framework reflective tool which can be found within the Signs of Safety Practice Framework & Expectations pages 34-43. The tool is based on Marie Connolly's (2007) 'Practice Frameworks: Conceptual Maps to Guide Interventions in Child Welfare'. The tool was developed in Bexley and brings together the principles that underpin our work in Bexley with clusters of reflective questions that aim to support reflection on the quality of practice relating to each principle. The tool brings together the values and principles that underpin the work in Bexley, with questions that 'prompt' thinking and reflection on practice and tools that enable practitioners to carry out the work. It is anticipated that social workers and their managers will use this tool to reflect on case work individually or in individual or group supervision.

Signs of Safety Reflective Supervision Tool

To support the supervision experience and to promote a reflective space for practitioners a bespoke reflective supervision tool has been produced. The tool enables managers to use solution focused and trauma informed questioning to help practitioners understand risk, safety and create plans for children, young people and young adults. The tool can be used by all areas of children services.

Reflective Supervision Tool can be found on tri.x

5.2 Child Protection Conference Consultations

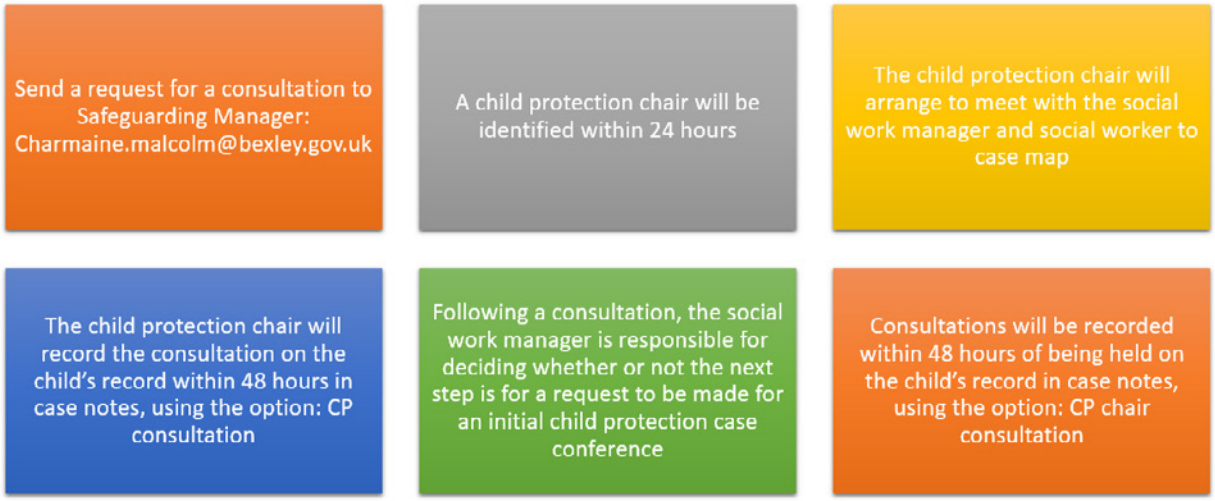
Our expectation is that all initial child protection case conferences are held, as early as possible once we have reasonable cause to believe that a child is suffering or is likely to suffer significant harm. The timing of this conference should depend on the urgency of the case and respond to the needs of the child and the nature and severity of the harm they may be facing. It can never be any later than 15 working days from the date of the strategy discussion where the decision was made to conduct a Section 47 child protection enquiry. It is therefore important for the social worker to inform the conference and review team of the need to book the conference no later than the next day following the strategy discussion.

Best practice suggests that Social Workers and their managers are to always have a consultation with the child protection conference chair. The consultation can happen either before or after the conference has been booked. In this consultation, child protection chairs will always check that danger statements have been developed with the family; that the assessment (mapping) has been developed and shared with the family, and that the social worker has engaged the family's support network to develop a safety plan for the child.

A consultation with a child protection chair is an opportunity for a social work manager and social worker to spend time with an experienced practitioner to discuss complicating factors; that may be affecting our ability to understand the experiences of children and their families. The consultation is an opportunity to explore the information you have, understand the gaps and help you to think about what the best next steps may be to work with the children and their family.

A consultation is also useful to help you think about how to plan and prepare for an initial/review child protection conference (direct work, sharing reports). Thinking about how we can include children and their families is very important for us to help them understand the worries we share. It is also important for us to help children and their families understand what will happen in a child protection conference and make sure; that the experience is comfortable and helpful to improve experiences of children we are worried about.

Fig 5.2.1 – CP Consultation Process (full details of the Child Protection Conference consultations procedure can be found on tri.x)



A consultation is also useful to help you think about how to plan and prepare for an initial/review child protection conference (direct work, sharing reports). Thinking about how we can include children and their families is very important for us to help them understand the worries we share. It is also important for us to help children and their families understand what will happen in a child protection conference and make sure; that the experience is comfortable and helpful to improve experiences of children we are worried about.

5.3 Escalations: Child Protection Conference Chairs, Children Looked After Independent Reviewing Officers & Fostering Independent Reviewing Officers

Child Protection Conference Chairs

We have an escalation procedure for child protection conference chairs that states what the expected practice and quality of service provision will be for the children and families we support. Where a chair does not believe the expected practice or quality of service has been provided, or where they have safeguarding concerns for a child, the chair will seek to discuss the concerns with the social worker and their manager as part of the escalation procedure.

Once the escalation has been raised, the CP Chair can consider requests from managers for further time to provide a resolution to the escalation, before further escalation to the next stage.

In addition to the conference chair's escalation procedure, there are other procedures that permit children, families, and multi-agency professionals to make complaints, challenge decisions, or escalate concerns in regards to the quality of support or practice provided by social workers and child protection conference chairs.

Fig. 5.3.1 - Escalations are managed through a 4-stage process

Once the escalation has been raised, the CP Chair can consider requests from managers for further time to provide a resolution to the escalation, before further escalation to the next stage.

Children we care for - Independent Reviewing Officers

If escalations are required for children in our care (Children Looked After) then Independent Reviewing Officers (IRO), must follow procedures laid out in the IRO Handbook is the Statutory Guidance, in force from April 2011 which amends Section 118 of the Adoption and Children Act 2002 and Section 26 of the Children Act 1989. The Guidance covers the following key areas:

Fig. 5.3.2 – IRO Process

Informal dispute resolution process

- Where problems are identified in relations to a child's case, for example in relation to care planning, the implementation of the care plan or decisions relating to it, resources or poor practice, the IRO, will in the first instance, seek to resolve the issue informally with the social worker or the social worker's managers. The IRO should place a record of this initial informal resolution process on the children's file

Formal dispute resolution process

- Involves escalating the matter in dispute through a number of levels of seniority within the department with identified timescales for a response at each stage. The IRO may bypass any stage and progress the dispute to the level s/he considers most appropriate.

What constitutes a reason for raising initiating the dispute resolution process

- 'Where the IRO is of the view that the responsible authority:
- Has failed to address the needs of the child set out in the revised plan; and/or
- Has failed to review the case in accordance with the regulations; and/or
- Has failed to implement effectively any decision made at a review; or
- Is otherwise in breach of its duties to the child in any significant way.

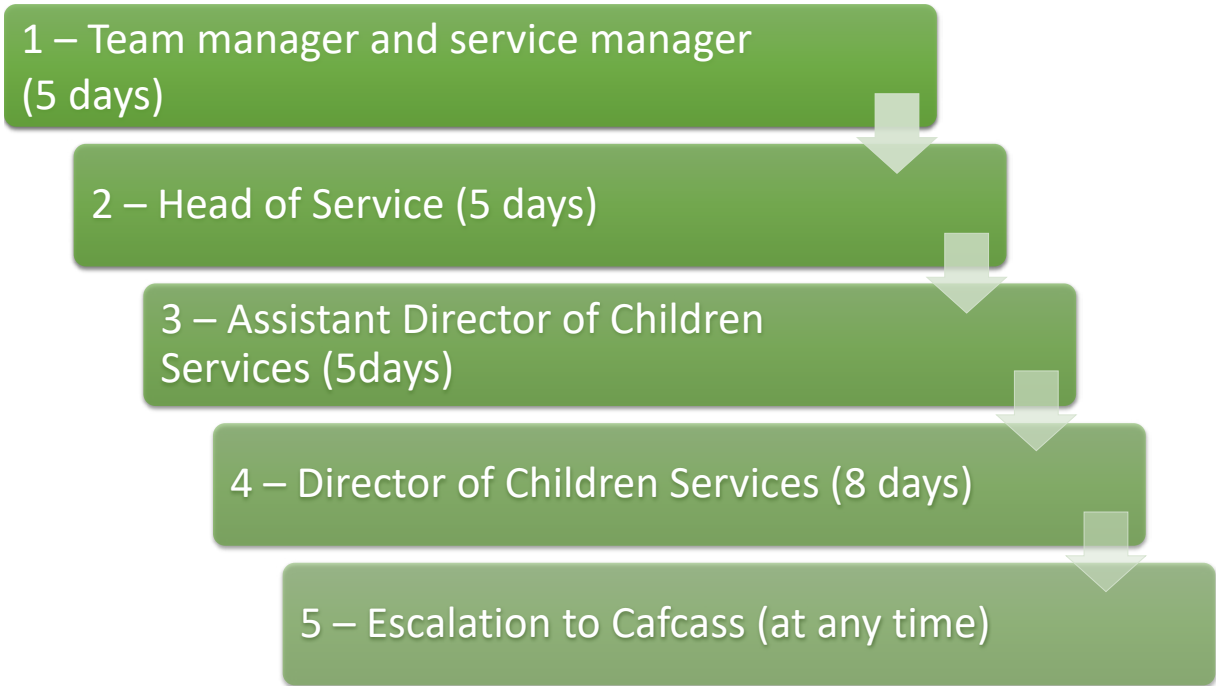
Referral to Cafcass

- The IRO has the power to refer the matter to Cafcass at any point in the dispute resolution process (regulation 45)

Complaints

- Instigating the formal dispute resolution process by an IRO does not exclude a child or another adult on the child's behalf taking separate action which could include; making a formal complaint and/or making an application to the courts

Fig. 5.3.3 – Escalations are managed through a 5 stage process



Once the escalation has been raised, the IRO can consider requests from managers for further time to provide a resolution to the escalation, before further escalation to the next stage. The IRO has a duty to inform the child of their rights and assist in obtaining an advocate and/or legal representation. The IRO will also consult and keep informed the child and other relevant persons at each stage of the escalation process as appropriate.

Fostering Independent Reviewing Officer

Regulation 28 of the Fostering Services (England) Regulations 2011 requires fostering services to review the approval of foster carers within a year of approval, and thereafter whenever necessary but at intervals of not more than a year.
Fostering Independent Reviewing Officers (FIRO) are to produce a written report of the review, which must set out whether the foster carer and their household continue to be suitable to foster and, if so, whether the terms of their approval continue to be appropriate. National Minimum Standard (NMS) 20.6 sets out that reviews should include an appraisal of a carer's performance, consideration of training and development needs and a review of the carer's personal development plan. Standard 13.9 emphasises that areas of concern or need for additional support that are identified between reviews should be addressed at that time and should not wait until a planned review. Assessment and approval of foster carers: Amendments to the Children Act 1989 Guidance and Regulations Volume 4 (July 2013) provides statutory guidance regarding reviews and terminations of approval. One of the key functions of the FIRO is to resolve problems arising out of the fostering caring process. It is expected that FIROs establish positive working relationships with the fostering service. Where problems are identified in relations to a foster carers care arrangement, for example in relation to the provision of care to children and young people, resources to support the care arrangement or poor practice, the FIRO, will in the first instance, seek to resolve the issue informally with the supervising social worker or the fostering manager. The FIRO should place a record of this initial informal resolution process on the foster carers file in a case note.

Formal dispute resolution process

If the informal dispute resolution process is not resolved in a timescale that is appropriate to the foster carers and or child's needs, the FIRO should consider raising a formal escalation through LCS. This will involve escalating the matter in dispute through a number of levels of seniority within the department with identified timescales for a response at each stage. The FIRO may bypass any stage and progress the dispute to the level s/he considers most appropriate.

Team Manager/Service Manager	5 days (Stage 1)
Head of Service	5 days (Stage 2)
Assistant Director	5 days (Stage 3)
Director	8 days (Stage 4)

Once the escalation has been raised, the FIRO can consider requests from managers for further time to provide a resolution to the escalation, before further escalation to the next stage. The FIRO will also consult and keep informed the foster carer and other relevant persons at each stage of the escalation process as appropriate.

5.4 Practice Week

The purpose of Practice Week is to spend a week focusing on supportive oversight, coaching and learning about the quality of our practice. It also gives an opportunity to complete targeted or themed audit and inspection work. Practice Week, is led by the Principal Social Worker and the PSQA team who provide support and challenge on frontline practice - what's going well, areas for development and what we need to do even better to improve outcomes for children and families. Practice week takes place every six months.

Practice week uses the collaborative case audit process, to complete a large number of audits during the week. Managers and senior managers including the Director of Children's Services will complete these. Feedback from children and families, on the quality and impact of the work. Direct observation of practice this involves observation of direct work and review meetings where young people are present. Observations will also be made of supervision and group supervision. Multi-disciplinary audits including contact with different professionals involved with children, young people and young adults and partner agencies to explore joint learning.

A report and feedback will be produced and provided to practitioners, senior leaders and managers. This encompasses, audit results, key learnings, what's working well and areas of development. Key aspects then form part of the quarterly assurance report, which is scrutinised through the performance cycle.

5.5 Practice Intensive

The Practice Intensive is linked to the Signs of Safety framework for Bexley. The purpose is to intensively look at Signs of Safety application and how it supports social work practice. A practice intensive is used to test decision making points across children services, although only one or two decision making points will be worked with at any one time. Types of practice intensive would be:

- decision to assess (s17)
- decision to undertake child protection investigation (s47)
- decision to accommodate
- decision to return home
- decision making with children we care for
- decision for a child protection plan
- decision making with children at risk of sexual exploitation
- decision making with children who go missing
- decision making with children leaving care
- decision making with children with disabilities and/or special educational needs

A practice intensive will take place over 2-3 days depending on need. Each practice intensive will be designed between the relevant head of service and the Signs of Safety Practice Lead, with support from colleagues within PSQA. A typical practice intensive would see the Signs of Safety team and PSQA leading groups of managers and practitioners each day in group supervision, case mapping, using the Harm Analysis Matrix, and applying Signs of Safety analytics to open cases. Practitioners will have opportunities to learn from each other, and develop skills and confidence in structuring danger statements, safety goals and scaling questions.

The Practice Intensive supports Children's Services values as a learning organisation; creating an opportunity for all staff to learn from each other and benefit from experienced Signs of Safety trainers.

Although all Practice Intensive's will have an element of an auditing function, by reviewing decision-making, it does not form part of Bexley's auditing framework and there is no grading of work within the Practice Intensive. A Signs of Safety Practice Intensive will be run twice yearly as part of a Practice Week and will include all service areas depending on decision-making and partner agencies will be invited to take part. A practice intensive will focus throughout on 'what is keeping this child safe right now?' as this helps see safety planning as a process not an outcome. There will be 'break out' mappings for any unsure decision making in cases if appropriate/ relevant. All work within a Practice Intensive will be managed through a questioning approach; using questions to get each practitioner to think together within and through the decision-making points.

Key questions include:

1. What are the adult/adolescent's behaviours that are most worrying?
2. As a result of the behaviours what is the harm that has been caused to the children in their care or (for the adolescent) to themselves?
3. If nothing changes in the family, what are you most worried will happen to the children?
4. What are the things you have seen or heard (or read on this file) that are considered Existing Strengths or demonstrate there is Existing Safety (protective factors)?
5. Other considerations in this file (e.g. length of time since initial referral)

6. What difference are we making to children, young people and families?

We will end where we started, that any quality assurance system needs to support answering the "so what" question i.e. we have delivered so many services to so many families but has the quality of the service improved measurable outcomes for children over time? Outcomes Based Accountability or OBA (Mark Friedman, Trying Hard is Not Good Enough, 2005) provides a disciplined way of working to assure practice by triangulating three simple questions. It sits well with our framework as specific activity and measures relate to these questions. Quality practice does not naturally occur, it has to be built around a clear culture of performance accountability and practice leadership, where managers are clear about their quality assurance responsibilities so it becomes integral to the "day job". The following diagram provides an example of the three questions and how they fit together.

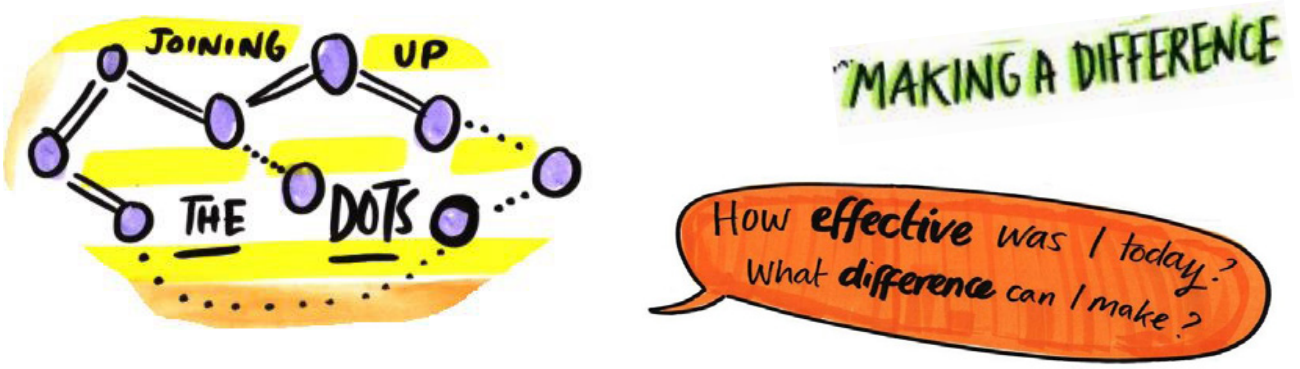


Fig 6.1 How the Bexley Quality Assurance system interconnects.

	QUANTITY	QUALITY
EFFORT	How much did we do? Activity and typical measures: The ChAT and MPD provides data and trends on how many children and families we offer services too.	How well did we do it? Activity and typical measures: Our child and family feedback form and Signs of Safety practice audit provides data and % trends on whether we are delivering our practice framework to the right standard and treating families well (customer satisfaction)
Is anyone better off (OUTCOMES)?		
EFFECT	Activity and typical measures: Relates to the numbers of children and families that we are measuring outcomes; set against specific areas of outcome improvement (see opposite).	Activity and typical measures: Our use of scalable questions through feedback and audit enables to track distance travelled and whether life has changed for children (what's helping and hindering). This can also be supplemented by the use of questionnaires and appreciative enquiry. Typically, our outcome focus will be on % measurable improvements in children's safety, behaviour, circumstances and their care arrangements.

Appendix a)

Children's Services Collaborative Case Audit

Guidance

This is the collaborative case audit tool to be used in all audits across Children's Social Care. The collaborative case audit tool seeks to provide a window into practice with a family and provide a supportive learning opportunity for practitioners' to develop their practice. Please refer to the Quality Assurance Framework on tri.x to support your use of this document.

Auditor
The expectation of managers is to undertake a collaborative review of practice once a month. This is a requirement of your professional employment in Bexley. Audits must be completed collaboratively with the practitioner. Collaborative case audits are focused on learning and improvement, rather than blame and deficit. Actions are the responsibility of the auditor to follow up with the practitioner's line manager.

*In situations where the audit judgement has been graded as **inadequate**, the auditor will email the worker, team manager, service manager, head of service and deputy director.

- Outstanding tasks will be actioned within 24 hours.
- Management oversight note will record case direction and tasks.
- Audit will be reviewed in supervision and recorded on case file.
- Where there are performance issues, this will be recorded in personal supervision notes.

The collaborative case audit is structured around the following 6 Section:

Section 1: Case demographics
Dates of collaborative case audit - provides basic details of the audit. A practice observation is not expected as part of every audit, however this should be undertaken if the audit forms part of Practice Week or in cases where the auditor has found the work to be inadequate.
Personal details - provides context to the child/young person's records being audited and enables themes to be better understood.

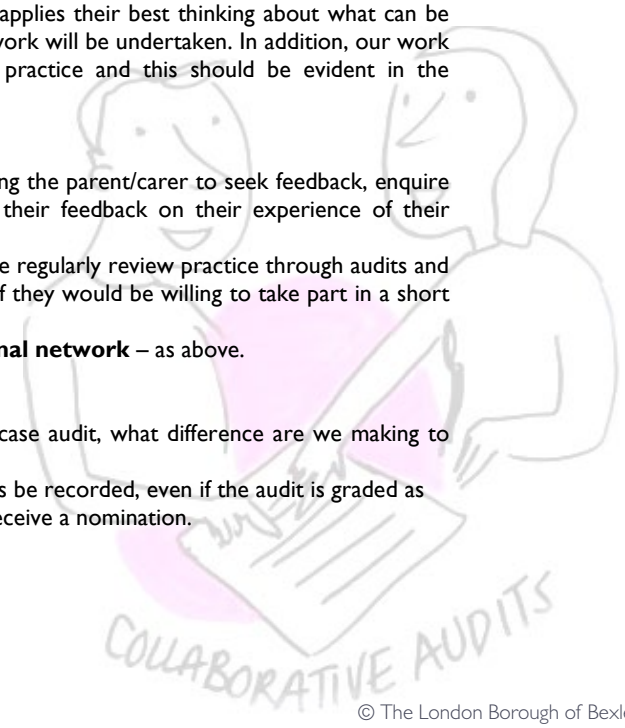
Section 2: Practitioner preparation (to be undertaken prior to meeting with auditor)
These questions provide an opportunity for self-reflection by the practitioner (and Staying Together worker if currently supporting the family) prior to undertaking the collaborative aspect of the audit with the auditor.

Section 3: Case file health check
The auditor should review the child/young person's record and complete these questions prior to meeting with the practitioner.

Section 4: Areas of practice (must be completed with the practitioner/s)
Each question focuses on a key area of practice highlighted in **bold**. The auditor should record what evidence they have seen under 'Signs of Impact'. The auditor should then ask the practitioner the scaling questions to facilitate a discussion that enables the practitioner to be supported to analyse and assess the quality of work and application of their Signs of Safety practice. Within the collaborative discussion, the auditor and practitioner can agree next steps. This means that the practitioner learns from what has gone well and applies their best thinking about what can be further developed, creating much more ownership over what further work will be undertaken. In addition, our work is underpinned by strong and consistent management oversight of practice and this should be evident in the child/young person's records.

Section 5: Feedback
Feedback from the child/young person/young adult - when calling the parent/carer to seek feedback, enquire if the child/young person/young adult would be willing to also give their feedback on their experience of their worker.
Feedback from the family - call the parent/carer and explain that we regularly review practice through audits and seek feedback from families on their experience of their worker. Ask if they would be willing to take part in a short telephone survey.
Feedback from a member identified in the family or professional network – as above.

Section 6: Audit Outcome
Overall rating of case audit - having completed the collaborative case audit, what difference are we making to this child/young person/young adult?
Actions - what needs to happen / next steps? Actions must always be recorded, even if the audit is graded as good, this may be to share the good practice at a staff conference or receive a nomination.



Section 1: Case demographics

Dates of collaborative case audit

Date the referral was received	
Collaborative case audit commenced	
Collaborative case audit completed	
Has a practice observation been undertaken in connection with this audit or is one required?	
Name of Auditor	
Name of Practitioner	
Name of Manager	
Name of Staying Together Practitioner (if applicable) Collaborative case audit to be undertaken jointly with the Staying Together Practitioner and allocated worker.	

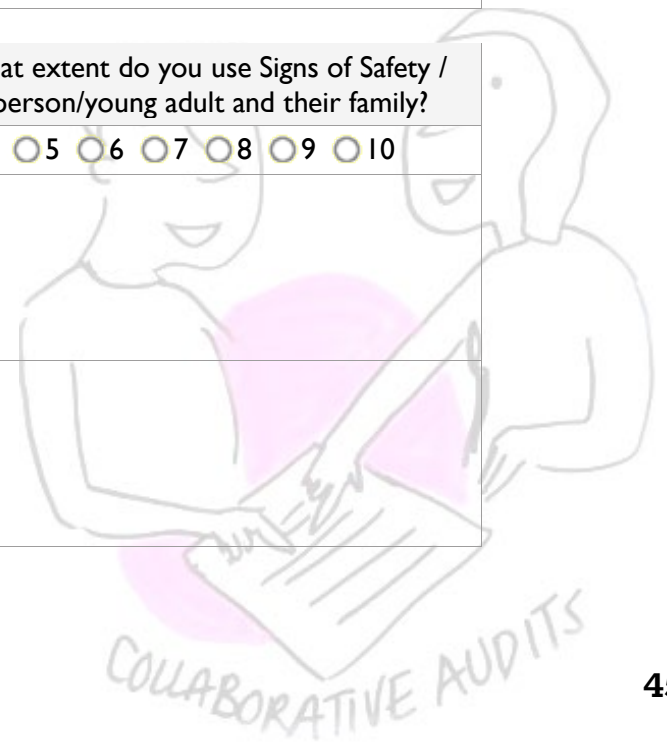
Personal details

LiquidLogic ID Number	Date of Birth	Gender	Ethnicity	Language

Section 2: Practitioner preparation (to be undertaken prior to meeting with auditor)

i) Using a scale where 0 = no difference and 10 = significant difference – what difference have you as a practitioner made in relation to this child/young person/young adult?	
Practitioner scaling	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	

ii) Using a scale where 0 = never and 10 = always use - to what extent do you use Signs of Safety / Signs of Wellbeing / Signs of Success with this child/young person/young adult and their family?	
Practitioner scaling	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	



Section 3: Case file health check

1. Is all the **demographic information** accurate and up to date? (including professional involvements)	Areas of Strength	Areas to Develop
Auditor rating	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

2. **Case summary** is up to date, giving a clear picture of what life is like for the child / young person / young adult.	Areas of Strength	Areas to Develop
Auditor rating	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

3. **Chronology** includes relevant information of significant events.	Areas of Strength	Areas to Develop
Auditor rating	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

4. Overall quality of the **written records** (case note, reports, statements, also Staying Together Family Plan and closure statement).	Areas of Strength	Areas to Develop
Auditor rating	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

5. The family have a **copy of the plan**	Areas of Strength	Areas to Develop
Auditor rating	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

Section 4: Areas of practice (must be completed with the practitioner/s)

6. Clear **purpose** for the work is evident within the case record. Parent/carer and child/young person/young adult are aware of the purpose.	
Signs of Impact	
Suggested Scaling Question: *On a scale of 0 to 10 where 10 means if I asked the family or child/young person/young adult they would talk about a shared purpose with us and 0 means they would share an opposing purpose. Where would you rate this?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move	Areas to Develop

up on the scale? And what difference will this make for the child/young person/young adult?	
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

7. Danger Statements/Safety Goals & Child in Need Safety Plan / Child Protection Safety Plan / FWB Safety Plan / Staying Together Safety Plan / Children in our care Safety Plan are **clear to the child and family**.	
Signs of Impact	
Suggested Scaling Question: *Rate the written documents on a scale of 0 to 10 where 10 means the documents share specific behavioural detail with descriptions of the actual behaviour, observation and who observed. And 0 means the language is very general and relates to jargon such as 'violent incidents', 'neglect' 'poor attachment' 'mentally ill' 'loving' 'good contact' 'comes to appointments' etc. with no supporting detail of the adult behaviour and its impact on the child/young person/young adult?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

8. The **worries described are understood** by everybody.	
Signs of Impact	
Suggested Scaling Question: *On a scale of 0 to 10 where 10 means the safety scale has been crafted to fit the detail of the particular situation and clearly connects the danger statement and safety goal and this is understood by everyone even if they don't all fully agree and 0 means the safety scale is just the standard one and the danger statement and safety goal are underdeveloped, use jargon and are unclear where do you rate this today?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

9. The plan (FWB/CIN/CP/CLA/PP) is clear and describes **who will do what and when to keep the child/young person/young adult safe** specific to the danger/worry and safety/wellbeing goals / family plan (or equivalent).	
Signs of Impact	
Suggested Scaling Question: *On a scale of 0–10 where 10 means there is clear evidence that the professionals have a good working relationship that is focus on their strengths and are able to share the worries that have to be addressed with the child/young person/young adult, parents and support people, and 0 is I doubt we're relating to them in any way that is involving them where would you scale the working relationship?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

10. The **parent/carer is involved** in the development and progress of the plan and/or assessment and has a copy?	
Signs of Impact	
Suggested Scaling Question: *If we showed the written documents (assessments & plans) to the family or most important person supporting the child/young person/young adult and were to ask them where would they rate the documents from 10 we may not agree with everything about this but we understand it and 0 is I know it's about us but I can't understand any of what's in the documents, where would that person rate the written documents?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

11. The **family support network has been identified** and is fully participating in the plan - All naturally connected people involved are relevant to the child / young person/ young adult and are listed with their relationship and their involvement with them is clear.

Signs of Impact

Suggested Scaling Question: *On a scale of 0 to 10 where 10 is we've done everything we can think of to find all relevant extended family, including on the father's side and people who have a natural connection to the child/young person/young adult and 0 is we may have asked once or twice but really haven't followed through, where would you rate this?*

What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

12. A version of the plan in **collaboration with the child/young person/young adult** and they have a copy they can understand.

Signs of Impact

Suggested Scaling Question: *On a scale of 0-10 where 10 means we've worked with and involved the child/young person/young adult in every way possible to complete the safety plan and they would say they understand what's happening and have been involved throughout and 0 means they know they have a worker but they couldn't say why they have a plan and for what purpose where do you think they would rate the practice in this case?*

What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

13. **Quality of the direct work** with the child/young person/young adult during the visits.

Signs of Impact

Suggested Scaling Question: *On a scale of 0 to 10 where 10 means we've worked with and involved the child/young person/young adult in every way possible throughout the case and they would say they understand what's happening and have been involved throughout and 0 means they know children's services has been involved but they couldn't say why or for what purpose where do you think they would rate the practice in this case?*

What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Deveop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

14. The place where the child/young person/young adult lives is **safe, secure and stable**.
Signs of Impact
Suggested Scaling Question: *On a scale of 0 to 10 where 10 is this child/young person/young adult lives someone where they would say they feels safe, with adults if they are not a birth parent or relative who are sensitive, consistent, reliable and knows them well and 0 is this child/young person/young adult has no stability, is frequently being moved either by a parent or through the care system, different adults frequently come in and out of their lives.*

What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

15. Is there evidence that there is **safety over time** as expressed in the safety plan?
Signs of Impact
Suggested Scaling Question: *If I was to ask the parents (the strongest person on the support network, the professional with the best connection to the family) on a scale of 0 to 10 to rate the safety plan from 10 which means this plan makes complete sense to me, we can and will do it and it will make sure and show everyone the child/young person/young adult is/are safe and 0 is this plan makes no sense to me and I/the parents will say they and we will do it but really we're just saying that because they/we feel we have to and none of it will happen where would they rate this plan?*

What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for	Areas to Develop

the child/young person/young adult?	
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

16. The **next steps are clear** and the right thing to do to keep this child/young person/young adult safe (and at home) and there is evidence to support this.	
Signs of Impact	
Suggested Scaling Question: *If the (child/young person/young adult, mother, father, grandmother, uncle, older sister, most important person supporting the child/young person/ young adult, parent/carer) looked at the safety scale where would they rate it from 10 they would say 1 'get it' and that's going to help all of us know where we stand in what we're doing and with Children's Services and 0 this makes no sense to me where would they rate it?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strengrh
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

17. There is **clear critical thinking and analysis** throughout the process.	
Signs of Impact	
Suggested Scaling Question: *On a scale of 0 to 10 where 10 means I have been able to show my workings out and this is seen in plans, assessments, contacts and visits. It is clear and decisions are attributable to specific behavioural detail such as within the danger statement and safety goal and these are clearly connected by a safety scale and 0 means there is little or no analysis, the safety scale is just the standard one and the language is very general and the plan is really a list of services which although may be important are not linked to what behaviour by the parent it is seeking to address. Where would you scale today?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Areas of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

18. All key **professionals** are clear about their role in contributing and supporting the plan.	
Signs of Impact	
Suggested Scaling Question: *On a scale of 0 to 10 where 10 means we've created a network of support by working with and involving everyone possible to support the child/young person/young adult and the professionals working with them, would feel that they play a valued part of the plan to keep this child/young person/young adult safe and developing well and 0 means they know that the child/young person/young adult has an allocated worker but they couldn't say why they know they have a plan and for what purpose but don't play a part in it, where do you think they would rate the practice in this case?*	
What worked well, to make you scale in this way? And what difference has this made to the child/young person/young adult?	Area of Strength
What would need to happen to move up on the scale? And what difference will this make for the child/young person/young adult?	Areas to Develop
Collaborative Scale	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Auditor Rationale	

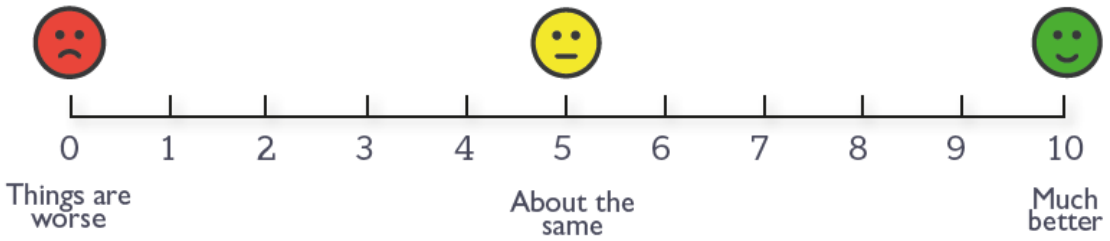
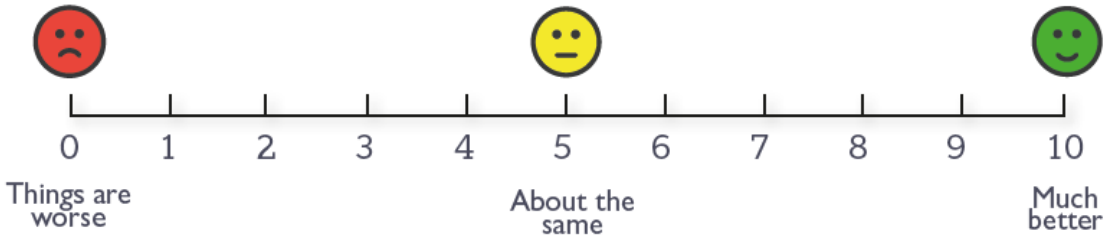
19. Overall quality of management oversight		
Areas of Strength	Areas to Develop	Signs of Impact
Auditor rating	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

Section 5: Feedback

You **must** seek feedback from the family and where possible, direct feedback from the child/young person/young adult (subject to agreement from the parent/carer or young adult).

Feedback from the child/young person/young adult

Date of Contact	
Name of child / young person	
Do you know the name of the worker who is working with your family?	
How often do you see him/her?	
Do you know why the worker is trying to help you?	
What difference has your worker made in helping you and the people who are important to you?	
What do you like about your worker?	
Are there things your worker could do better?	

How helpful were we to the people who are important to you?

How much better supported or safer do you feel now?


Feedback from the family

Date of contact	
Role of family member	
What is going well? What could be done differently? What has made a difference?	

Feedback questions	Strongly disagree ... Strongly agree
1. My worker listens to me in a way that shows they want to really understand my family.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
2. My worker does what they say they will do.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
3. My worker notices what's working well in my family regarding the care, safety and wellbeing of my child/ren.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
4. My worker has been clear with me about how they see the concerns about my family situation.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
5. My worker and I agree on what we are concerned about.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
6. I have felt involved in making plans about what to do.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

7. My worker has spent time with my child/ren and has listened to what they say about the problems and what should happen.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
8. My worker has made sure my child/ren fully understood what's being done to help them.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
9. My worker cares that we solve our problems.	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

If you could change one things about how our work with you, what would it be?
Finally, is there anything else you would like to tell us?

Feedback from a member identified in the family or professional network

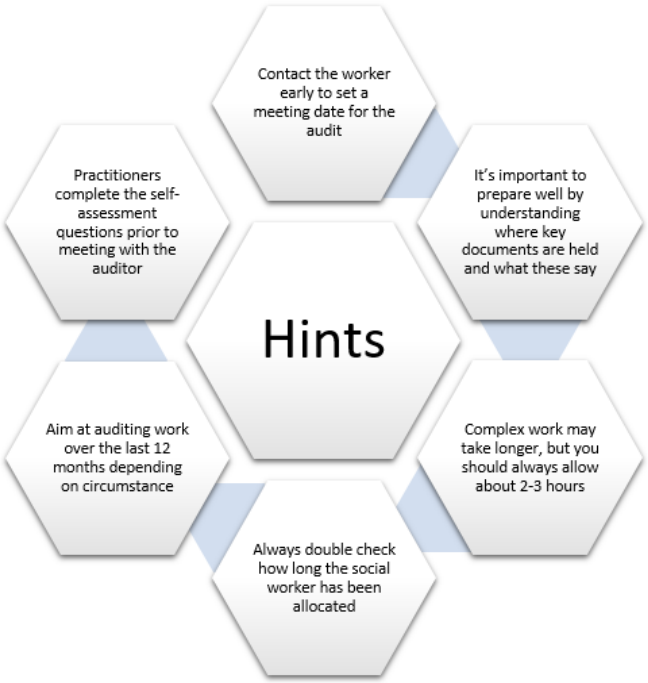
Date of contact	
Name and role	
What is going well? What could be done differently? What has made a difference?	

Section 6: Audit Outcome

Overall rating of case audit			
Signs of Impact			
Auditor rating	Inadequate	Requires Improvement	Good
	○0 ○1 ○2	○3 ○4 ○5	○6

Actions - what needs to happen / next steps?

Action	Who	When



Notes

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