Safeguarding and Quality Assurance Unit

Independent conference and reviewing managers

Annual report

April 2012 – March 2013

CONTENTS

1. INTRODUCTION……………………………………………………………………3
1.1Staffing…………………………………………………………………..……...3

2. Part One–Report from Lead Conference and Reviewing Manager……..……3
2.1 Child Protection Planning……………….……………………………………3
2.2 Journey of the child……………………………………………………………..4
2.3 Core Groups……..………………………………………………………………5
2.4 Scrutiny and Challenge…………..……………………………………………6
2.5 Recommendation for Conference and Circulation of Conference Notes……...7
2.6 Advocacy……………………………………………………………………….8
2.7 Multi-Agency Attendance at Conference………………………………….8
2.8 Electronic System……………………………………………………………...9

3. Part Two-Report from Independent Conference and Reviewing Managers …………………………………………………………………………………………9
3.1 Children in care ……………………………………………………………….9
3.2 Increase in Children in Care…………….………………………….………10
3.3 Children and Young People's Wishes and Feelings..……………..….11
3.4 Timely Reviews……………………………...…………….…………………12
3.5 Consistency of IRM for Children in Care……………………………......12
3.6 Agency Decision Maker………………………………………………….…13
3.7 IRO Survey……………….…………………….……………………………13
3.8 Timely Completion of Notes……..…………………………………………..14
3.9 Summary of Key Themes and Issues…………………………………....15

4. Part Three – Additional Work Undertaken by the conference and Reviewing Managers..……………………………………………………………………………16
4.1 Foster Carer Reviews…………………………………………………………16
4.2 Life Appreciation Days……………………………………………………...16
4.3 Disruption Meetings……………………………………………………………17
4.4 Reg 33 Visits……………………………………………………………………17
4.5 LADO……………………………………..17
4.6 Child Sexual Exploitation……………………………………………………..18

5. Looking Forward……………………………………………………………….19
5.1 Child Protection………………………………………………………………19
5.2 Children in Care………………………………………………………………19

1. Introduction

This annual report is set out in three sections:

Part One - report from the Child protection chair

Part Two - report from the Independent reviewing managers

Part Three - refers to additional work undertaken by the Conference and reviewing managers

1.1. Staffing

The Lead conference and reviewing manager is responsible for chairing the child protection conferences, has the role of LADO and manages the Independent Conference and reviewing managers (IRM's).

There are 3 full time Conference and Reviewing managers responsible for reviewing the Children In the Care of Halton Borough Council.

The IRM's are responsible for the following areas of work;

- The reviewing of Children In Care, this is a statutory role to have oversight of children's care plans and are empowered to act on their behalf in challenging the Local Authority.
- LADO - on a rota basis oversight and management of cases concerning allegations against adults working with children.
- The independent review of Child In Need cases.
- Foster carer reviews.
- Regulation 33 visits.
- Charing CP conferences when lead manager is not available.
- Facilitating Life Appreciation days.
- Chairing Disruption meetings.

There are 6 business support officers who support the children in care and child protection conference/reviewing processes.

2. Part One - Report from Lead Conference and Reviewing Manager

2.1 Child Protection Planning

The Lead Conference and Reviewing manager (LCRM) has a caseload which fluctuates month to month from 80 – 126.

The number of children subject to child protection planning has followed a similar pattern to that of the previous reporting year 2011-2012. The increasing and decreasing numbers happens at the same time each year. In quarter one, numbers of children on child protection plans has been below 90 with a steady increase noted through to November and then a sharp decrease again. There appears to be no

reason for this pattern, it does not relate, for example, to outcomes of serious case reviews, or high media coverage on cases from other parts of the country.
In previous reports to Halton Safeguarding Children Board (HSCB) recommendations have been made by the Lead Conference and Reviewing manager to ensure that the children subject to child protection (CP) plans are appropriate and there have been occasions over the last year were conference members have been challenged in decision making to ensure that planning is not a 'just in case' scenario.

In order to ensure that each professional has a rationale for their decision and is able to articulate this to the family, Professionals are asked 'why?' they have made that decision. This ensures conference members consider their decisions carefully and are able to justify their rationale. This promotes clears identification of risks within plans and ensures a number of outcomes;

- CP plans in place are appropriate and focus on children who are experiencing or are likely to experience significant harm.
- It makes it clearer what the outcomes for children should be and what issues need to be addressed.
- It promotes peer challenge and discussion and allows for agencies to reach a consensus or at least understand the finale decision better.
- It requires professionals to evidence the concerns and explain to parents the actual impact on their children of a continued behaviour or lack of action.
- It promotes the understanding for families and professionals that parents need to improve their parenting, and have a realistic understanding of the standard of care to be afforded to their children.
- It makes the decisions about risks as multi-agency responsibility.

Parents are encouraged and supported to offer their views, about whether they believe that their children are at risk of harm and whether they understand concerns raised. Some parents initially resist the view that their children are at risk but on occasions, especially at review conferences they will agree that the care provided or the impact of their behaviour\lack of protection does warrant child protection planning.

2.2 <u>Journey of the child</u>

In order to determine the level of risk and significant harm, each child must be viewed individually. Each child's experience must be considered in conjunction with their resilience, understanding and their experiences day to day.

The Safeguarding Unit has over the last year strived to improve the understanding and demonstration of the 'child's journey' in conference. This is achieved by the chair asking directly 'how does the concern impact on the child, what is the short term and long term impact on the child and what does the child think about their life'

In order to achieve this conference members are asked to relate their concerns to an actual experience for the child and then this is summarised to the family in the meeting.

For example; (This is not an actual case but reflects some of the issues that are discussed in conference)

Chrissie is 8, she is frequently late for school by up to an hour, hungry on occasions and has head lice causing sores. She experiences enuresis which in turn can mean she smells of urine. Her uniform is dirty and does not fit well, she dislikes school, has few friends and has not had her hearing test or eye screening due to non-attendance.

Parents are first asked to talk about their child; likes and dislikes, routines and hobbies, problems and difficulties. This has a number of benefits. Firstly parents feel that their voice is heard not last but first. They are able to give conference members an understanding of what happens in the house, this can reduce anxieties for parents.

Professionals are then asked individually for their information. They are required to interpret this information for parents in order to ensure that the risks are clear and why this results in significant harm.

Professionals and parents then have an understanding, not always an agreement, about what needs to change and why.

The future steps within child protection planning needs to be to develop a more child and parent focused plan that supports the information given to them at conference. The SGU need to consider developing a tool that parents and children can understand and which plots the progress of the family in reducing the risk. By doing this and having a visual aid it may help improve effective understanding and planning, prioritising the risks and ensuring outcome focused and risk based planning, it would also help parents to understand how the changes were made so that they can maintain them.

Currently the numbers of children on Plans is 86. This number fluctuates. The number of plans reduced to 66 in April which is exceptionally low, both in term of the national average per population and also as a reflection of Halton's previous figures. Due to the concerns regarding this it was proposed in the Safeguarding Unit's quarterly report that there be some interrogation of cases within the early intervention service to ensure that they were being managed at the right level. It was also requested that there be the same scrutiny over CIN cases to ensure that they were being escalated appropriately. The recommendations were accepted and the outcome shared with the safeguarding Unit.

2.3 Core Groups

The core groups are fundamental in achieving the outcomes above and assessing a parents motivation and capacity to change in order to reduce risks. The journey of the child and the family as a whole should be clearly documented so that the parents can see the impact of the changes and improve motivation to maintain changes.

Attendance at core groups from partner agencies appears to be good. It is apparent in many conferences that partner agencies and individual professionals have a

thorough knowledge of the families that they work with. There have been a few occasions were a partner agency has advised that they did not attend core group because they did not know when they were. It is important that partner agencies also take responsibility for core group meetings and in the event that they have not attended a core group they should contact the social worker to enquire about the date for core group. It is not always evident in these cases that this happens.

Attendees at conferences have also raised issues that the records of a core group and the detailed CP plan are not circulated in a timely way .This has also been identified via the auditing of practice. Children's social care has invested in increased admin support for the social work tams to support the timely circulation of minutes.

Within Halton all core groups undertaken also review the assessment of risk for the children within the family and this informs the decisions made by the core group regarding how the plan should proceed. There is evidence within core group of changes being made to the plan to reflect areas of concern. For example a core group recognised that risks to the children of injury was increasing due to a family pet. The core group as a consequence included within the plan that the animal would need to leave the property in order for the children to be safe. Core group then presented to conference the progress in achieving this in order to reduce the risk of physical harm to the children.

2.4 Scrutiny and challenge

Children subject to child protection planning are those considered to be suffering or at risk of significant harm. In order to ensure progress of plans and identify drift the conference chair has an important role to scrutinise each child's plan, the reduction in risks to the child and multi- agency working.

The CP chair raises with Children's Social Care managers any concerns as they arise. Challenges are often around decision making or practice issues, for example a report not being available to the family and chair prior to conference. One example of this was where a conference was cancelled due to the parents not having had sight of the conference report prior to the day of conference. When they read through the report they disputed actions in the plan. On this occasion the meeting was adjourned due to a significant discrepancy that would likely impact on decision making.

There is a formal dispute process, which is used in cases where there is not a satisfactory resolution reached to an issue raised or were the concern constitutes a significant error in judgement or decision that results in a child being in a situation of risk unaddressed or that is increased. It is important that the resolution process is used correctly and efforts are made to resolve an issue prior to escalation. For example; an instance were two children were received into care for a short period of time. The decision was made to return the children from the safe placement to the home where the care afforded to the children was not good enough. In light of the challenge an agreement was made that the children would remain in the care of the local authority until a return to the family home did not result in them being at risk of significant harm. This matter was resolved quickly via formal discussions with senior

manager, an agreement reached that resulted in the escalation process not being used.

The SGU plays an important role is raising standards and challenging however it is also instrumental in supporting social workers wherever possible to improve the practice and service delivery, this requires the SGU to recognise what professionals do well and share this with those workers and their managers.

2.5 Recommendation for Conference and circulation of Conference notes

Conference recommendations are sent out to all agencies within 24 hours of the conference, there has been only one instance in the reporting year that this has not happened and this was just prior to the Christmas holidays. Prior to future 'office closure' recommendations will be circulated prior to Chair leaving the office via Secure email to all partner agencies.

In the OFSTED inspection of Safeguarding and Looked after Children services in 2011 it was identified that the distribution of child protection conference notes was not always timely and whilst there had been at the time of the inspection an improvement it was identified by OFSTED as an area for improvement.

The SGU is requested to complete and distribute all conference notes within 15 days of the date of the conference. This has not been achieved consistently during 2012/13. Issues around notes relates to capacity and administrative support. During periods of sickness for staff and annual leave, cover is not provided and due to the small numbers of staff in the SGU this can impact significantly.

The unit has implemented a new monitoring system, and performance will now be reported quarterly to the LSCB.

2.6 Advocacy

The advocacy services was provided by Barnardo's during 2012/2013 and supports all young people, where appropriate, who have contact with services including those children subject to child protection planning. The numbers of children who had been referred to the advocacy service was low, as a result the SGU and the advocacy service agreed that the conference chair would refer all those young people identified as requiring support from the service directly to the advocate.

However there were a number of issues with this and whilst it initially appeared to be working there were concerns raised by the advocate regarding consent. It was therefore agreed that the service would be notified of all initial conferences were there was a child over the age of 5 years. The advocate would attend to have a brief discussion with parents prior to the meeting to obtain consent. Again whilst off to a positive start unfortunately the attendance by the advocate was not maintained by the service and therefore it failed to have the desired effect in supporting the views by capturing the most vulnerable young people.

At the end of the reporting year it was confirmed that the contract for advocacy services would be put out to tender.

Over the next year it is expected that the new advocacy service will be pro-active in ensuring that the young people in need of an advocate receive this support and are identified in a timely manner.

The role of the advocate will also need to be reconsidered as currently the advocate service attends conferences providing the wishes and views of the young people. However in many of these instances the social worker is able to and should be undertaking this piece of work. The advocacy service for young people subject to child protection plans should be far more challenging of the local authority and the SGU, it is hoped that this will happen in the future.

The advocate should be able to actively raise issues and ensure that the child's at the centre of the plan, that the plan listens to the child's needs and acts upon these were appropriate and challenges the process when it fails to ensure outcome focused planning for the young people. In addition the advocate should be working with the SGU to ensure wherever possible the child is involved in the meeting or has the opportunity to meet with the chair prior to the day of the meeting to discuss the risks, strengths and progress for them in their home life but also to contribute to the development of the plan and monitoring the plan.

Advocacy for parents attending Child Protection Conferences has also been improved. It is a priority of the conference chair to ensure that parents understand the process, risks and what needs to change in order to ensure positive changes for children and young people. The Lead Conference and Reviewing Manager has prioritised this and will have a discussion with parents about their right to an advocate and has postponed conferences when she is of the view that a parent needs an advocate.

2.7 Multi-agency attendance at conferences

Multi-agency attendance is good with a strong commitment shown to all conferences in particular by health visitors, school health advisors, midwifery colleagues and police.

The dedicated police officer attending conferences is due to retire in July 2013, as yet a new person has not been identified to replace her. This consistent attendance by an officer provides detailed information sharing. There have been occasions where the police have identified additional risks and been able to obtain and share information that has impacted on the outcome of conference. For example a report from the hospital sent to the police, about a car accident identified that a perpetrator of violence was also present despite the parent denying this to be the case.

Attendance by staff from Nursery's varies and when staff do not attend, apologies and reports are often not submitted to the SGU. They are contacted individually and advised of their responsibilities in CP planning.

Attendance at conference by agencies working with domestic violence is poor and the SGU does not receive apologies or reports. There are specific issues regarding attendance from the Independent Domestic Violence Association (IDVA) and

Women's aid which is about staffing. It has been agreed between the Lead conference and reviewing manager and manager to explore how this can be improved.

GP attendance and provisions of reports to conference remains very low. There are some GP's practices that consistently provide reports to conference but there are many that do not. In order to improve this, GP's receive a letter reminding them of the next conference but this has not significantly improved reporting and therefore it will be considered whether this practice should continue next year.

When exploring ways to improve attendance of GPs, a number of suggestions were made such as Skyping, however this was ruled out due to it not being secure, telephone conferencing was another suggestion however the benefits of this could not be identified as it would require the same amount of time as attendance at the meeting and therefore it would be more beneficial to have them attend in person. It was suggested that the times of conference change to 11:30 as this would make it easier for GP's due to surgery times. This is not possible as it would reduce the number of meetings that could be held in a day. The issue will continue to be discussed in order to find a positive solution.

2.8 Electronic System

Halton Children's social care operates an electronic system called Carefirst 6. The System has been introduced to each department at differing times. Unfortunately the SGU have read only access to the system which creates many difficulties.

It is currently not possible for the challenges made by the SGU to be recorded on the child's record, therefore the quality assurance role of the SGU is not visible. Conference notes are not currently attached to the child's electronic file so every child currently on a CP plan also has a paper file. The child protection plan produced within 24 hours also is not attached to the child's file, this means that the SGU has to also send the plan to the Emergency Duty Team (EDT) by email. Currently social workers have to retype the CP plan twice within the core group notes which is time consuming and leaves a margin of error to occur.

There has been agreement for the SGU's access to the system to be prioritised and the deadline given is October 2013.

3.0 Part Two – Report from Independent Conference and Reviewing Managers

3.1 Children In Care

At the end of the reporting period there were 136 children in the care of the local authority. 419 statutory reviews were undertaken in the year.

The numbers of children coming into care has steadily increased and shows no signs of reducing. The recent spike in numbers is due to large sibling groups coming into care.

Each IRM maintains a caseload that falls below 70 as advised by the IRO "handbook" which is nationally recognised practice guidance. They do however have other responsibilities referred to in this report.

The IRMs must provide close scrutiny and oversight of the child's care plan and ensure that the participation of children is a priority. The IRM must have the provision of independent legal advice, this is provided via reciprocal arrangements with Cheshire West & Chester Services.

The IRMs also review all the Pathway Plans for 'Relevant' young people under Children (Leaving Care) legislation. These are young people living in semi-independent provision with support between the age of 16-18. All young people once they reach 16 years and 3 months old have to have a Pathway Assessment and Pathway Plan completed to identify how they will be supported until they reach age 21 or 24 if they continue into higher education.

IRMs review children receiving short breaks, these are children with complex needs. The purpose of this service is to enable the child to have some quality time and the opportunity to socialise and have fun with other young people away from the family home, and to provide a break for families from caring responsibilities. There are currently nine Short Break arrangements being reviewed and four Pathway Plans.

The legislation has changed regarding young people on remand. They are regarded as children in care when on remand and consequently IRMs review these young people. None have yet been undertaken although one young person in care who was remanded to custody was reviewed.

3.2 Increase in children in care

The numbers of children coming into care is steadily rising and whilst sudden jumps in numbers is often attributed to sibling groups, there continues to be a rise with 25 new entrants between January 2013 and March 31st 2013. It is apparent that not all children coming into care have been subject to child protection planning. Whilst there will be, on occasion times when children do come straight into care due to individual circumstances, more scrutiny is required regarding the increase in numbers and whether it relates to children's additional needs and risk not being identified early enough. It is proposed by the Safeguarding Unit that early intervention services review their cases to ensure that cases are referred to Children's Social Care in a timely manner. It is also proposed that Principal Managers review Child In Need cases to ensure that any concerns raised are escalated to Child Protection Conferences when appropriate. This will be completed by selecting those cases who have had a CAF for 12 months plus and CIN cases were involvement has been on-going for 26 weeks plus. The SGU will also focus on independently reviewing cases where a CIN plan has been in place for 26 weeks plus.

The age group is also rising. There are an increasing number of teenagers being received into care due to Missing from Home (MFH) episodes. One young person who was admitted to care, was immediately placed in secure accommodation. One was placed in an out of borough placement from which he was returned to a local

supported placement. The number of children looked after via a voluntary agreement with parents is high and represents the older age range of young people entering care.

These young people require more monitoring and often more frequent reviews due to changes in placement or risky behaviours. This can present a challenge in terms of care planning. It is important that the decision for a child to become looked after is made at the right time and for the right reasons and that consideration is given to the need for a Child Protection plan. It is important that receiving children into care happens because it is not possible for children to remain at home either because of the risk to them or because parents are unable to keep them safe. Child protection planning is an important step in supporting families to make the changes themselves prior to considering the need for the child to be removed from a parent's care.

A recent Missing from Home meeting confirmed the need for a Child Protection Conference in the event of the young person not being found within agreed timescales. It became apparent from the strategy and conference discussions that Children's Social Care had been supporting this young person and her family as a 'child in need' for a significantly long period of time prior to a Missing From Home meeting being arranged. Although Child in Need meetings had been arranged, key professionals had not always been present at these meetings making it impossible to develop an effective multi-agency plan. The issue for this young person was that she was drifting around family members and groups of adults who posed a risk to children which increased her risk of sexual exploitation. There appeared to be limited shared intelligence about this activity until these discussions took place. The learning from this is that Children's Social Care have accepted the importance of following Missing from Home procedures when there is significant lack of engagement from the child or family members.

The Pre-Proceedings Protocol is now in place within Cheshire and Merseyside Courts. This is designed to simplify procedures and minimise delay for children within the court process. The Protocol restricts proceedings to a maximum of 26 weeks for the proceedings to conclude. The success of this protocol will depend on Local Authorities being prepared prior to going to court and having all evidence, information and analytical assessments available for consideration by Court at the earliest stage. This will reduce the need for independent social workers and other expert witness's reports being required by court. At the first hearing, the allocated Judge will give direction and by Day 12 a Case Management Hearing will be convened when all assessments will have been completed and any gaps in evidence identified. At Week 20 (or earlier) an Issues Resolution Hearing will be held and a date for a Final Hearing set.

The expectation is that IRMs are kept up to date with this legal process and liaise with CAFCASS Guardians appropriately. In Halton, IRMs are routinely sent information from the legal team. The need for IROs and Guardians to develop productive working relationships both during care proceedings and when seeking to resolve a dispute on behalf of a child is also commented on in the recent IRO Ofsted Survey which is referred to later on in this report.

As the numbers of children in care continue to rise there will be implications for the SGU in terms of caseloads. Currently the SGU undertakes foster carer reviews and independent Child In Need reviews (CIN). If the CIC population continues to rise at this rate the SGU will need to consider how the other responsibilities are undertaken.

3.3 Children and young people's wishes and feelings

The IRMs are committed to ensuring that the needs of children and their wishes and feelings are heard and influence their care plan and the reviewing process. All the IRMs consider carefully the age and understanding of the child they are appointed to review and will make decisions about meeting the young person prior to the statutory review. Whilst it is not appropriate in all instances, some of the young people do not want to meet with the IRM but the offer is made regardless. The IRM will also be available for the young person prior to the start of the meeting.

The IRMs ensure that the review is child focused and every opportunity is given to the young person to attend. The notes produced from the reviews are written for the child and this is accompanied by a card or a personal letter.

The participation officer worked with a small group of young people to develop a tracker card for their reviews which they are able to complete and keep track of how the recommendations made at the meeting are being progressed. This is a recent addition and more will be known about the success of these in the next reporting quarters.

There are consultation forms for young people to complete prior to their review meetings, these do need to be revised and be made available for young people of different ages.

Further work will be undertaken regarding ways to engage the young people with the reviewing process exploring new ways to capture views and increase participation. A consultation is planned with the Children in Care Council to gather views about the development of a Web Site for Children in Care. Such a site would enable the young people to contact their IRM directly and securely online. Young people would be encouraged to set the agenda for their review, leave feedback and also be directed to links to other relevant services and online resources.

A Business Card for IRMs has been produced to enable IRMs to pass their contact details to young people and their carers when at CIC Reviews.

3.4 Timely reviews

Throughout the last reporting year, one CIC review was out of timescale and this was as a result of a late notification to the SGU that a child had been received into care. When looking at how this has happened and to implement ways to ensure it does not happen again the Safeguarding Unit have produced a 'guide' to the review process including timescales for all Social Workers and Managers in Children's Services.

The SGU has received several late notifications from the Social Work teams of children coming into care. Fortunately, with exception of the one referred to , it was possible to arrange the initial review within the timescale but this is not ideal and gave little time for these to be arranged or for the Independent Reviewing Manager to see the children and the key people being invited to attend.

3.5 Consistency of IRM for Children in Care

Children and Young People are allocated a named IRM at the time they enter care. This IRM reviews the plan and monitors Children's Social Care's implementation of agreed actions throughout the child or young person's time in care. This enables the child or young person to get to know their reviewing manager and the role that they play both in the review meeting and between reviews. Increasingly, it is noted that the response to the question who they would talk to about concerns and worries includes IRMs among carers, teachers and family members. At a time when Children's Social Care are again experiencing a high turnover of staff and the need to employ agency workers, the IRM represents to young people a thread of continuity and reference while in care.

3.6 Agency Decision Maker

IRMs now join the meeting held by the Agency Decision Maker to consider a child's plan for adoption. This has the advantage of the IRM being able to input a long term perspective on the planning and assessments that have informed the plan for adoption. The IRM is also able to update the ADM on any subsequent changes to the plan or obstacles to its implementation.

3.7 IRO Survey

Ofsted have recently commissioned a survey 'Independent Reviewing Officers: taking up the challenge?' which looked at the effectiveness of IROs in discharging their duties and responsibilities to children in care. This report is available via this link:
http://www.ofsted.gov.uk/resources/independent-reviewing-officerstakingchallenge

- When dispute resolution processes are used there was limited evidence of outcomes of disagreements being used to inform organisational learning.
  In Halton IRMs are able to resolve most issues by discussing these with senior managers and coming to a satisfactory conclusion for the child or young person. When this has not been the case the Escalation Policy is used to formally record and resolve the dispute.

- Inspectors did see examples of IROs engaging with children and meeting them in between reviews, although excessive workloads in some authorities affected their capacity to meet with children more often. When IROs were able to meet up with children, their wishes and feelings were more likely to be fully taken into account. In Halton the IRM's see children and young people in between reviews when this is appropriate and as part of the Children in Care Council and other events that are hosted throughout the year specifically for the child in care population.

- Ofsted found that where IROs caseloads where higher than recommended in statutory guidance this seriously reduced their capacity to undertake their role effectively. These difficulties were exacerbated in most areas by a variety of additional responsibilities for IROs. In Halton the caseloads are within the recommended guidance but IRMs do have additional responsibilities.

- Inspectors found that senior managers valued the quality assurance role of the IRO and nearly all said they would welcome more consistent and stronger challenge from IROs. Improvements were needed however to ensure that IROs are sufficiently supported and challenged by leaders to undertake their role in driving effective improvement in services for children in care. In Halton the IRM's are well regarded and included in operational leadership meetings, performance review days, strategic placement planning, partnership board meetings and as part of regular file auditing days. These are all intended to develop practice and good outcomes for children in care.

A number of recommendations have been made for local authorities to act upon and for the purposes of this report the following points are a brief summary of these requirements:

- IROs should have the required skills, training, knowledge and time to undertake all elements of their role effectively, ensuring that children's wishes and feelings properly influence the plans for their future.

- Management oversight of IROs is sufficiently robust which should include formal and rigorous challenge where there is delay in making permanent plans for children's future.

- An annual report is produced by the IRO service in line with statutory guidance setting out the quality of corporate parenting and care for children in care. The recommendation is that it is publicly accessible and include information on IRO caseloads.

- Seek regular feedback from children, young people and families, carers, professionals about the difference the IRO has made to the lives of children in care. This information should be collated by the local authority and used to improve service. In Halton IRMs have many examples of how they have made a difference and carer's and children have acknowledged this in a number of ways. This can be for the direct support they have offered to children, training they have delivered or discussing issues with CAFCASS Guardians that have had a direct impact on the children in care. In addition to this, the safeguarding unit produce regular reports that highlight any themes and issues that they have picked up from children, families and carers.

- Prioritise and implement strategies that enable the most vulnerable children in care, such as children with complex communication needs and children living away from their home local authority to participate fully in the care planning and review process. In Halton, all children receiving Short Break care regardless of them not having more than the 75 nights a year are classed as 'children in care' and are independently reviewed to ensure the quality of care

planning is good and appropriate to meet individual children's needs. Children and young people who are in placement out of borough are generally independently reviewed every three months as these can be the most isolated children who have limited contact with birth families.

3.8 Timely completion of notes

The SGU has struggled to ensure that the CIC records are completed and sent out in a timely way. There have been a number of reasons identified for this during a review of the process as follows;

1. As with other neighbouring authorities the IRMs are expected to write up the majority of their own records of the CIC review.

   In order to try and reduce the backlog of notes for the IRMs have some additional administrative support and whilst this has helped it has coincided with an increase of young people coming into care.

2. The IRM's were expected to sign a form for every review document advising that the addresses of family members and professionals were correct. When an IRM is out of the office for a few days admin would not send the notes out until the form was signed this contributed to the delay in some notes going out.

   As the information could be obtained from the electronic system it was agreed to remove the signature required.

3.9 Summary of key themes and Issues

In addition to monitoring the timelines of the implementation of Care Plans between reviews, IRMs continue to raise issues of concern at an appropriate managerial level. In the last year, the need for timely Child in Care health assessments has been drawn to attention and in individual cases the Child in Care nurse has been engaged to expedite outstanding assessments. IRMs also met with Health colleagues to address the matter and some improvements have been noted.

IRMs have recently identified outstanding Life Work for children in long term care. This has been drawn to the attention of the managers concerned and as a result life work allocated to support workers to complete.

Improved links have been made to a number of CAFCASS Guardians and this has strengthened the voice of the child in the care planning and review process. An example of this was when an IRM contacted a Guardian for their view on a care plan and assessment completed by the Local Authority as the IRM did not agree with the Local Authority plan of adoption and supported the plan of a Special Guardianship Order to a family member. The Guardian and IRM jointly challenged this view and the Local Authority revised the care plan presented to Court for this child. The outcome of this challenge was that this child will live as part of his extended family. His identity needs and sense of belonging will be met within the family placement with his paternal aunt and her children and he will continue to have direct contact with his birth parents who he is very attached to and are very significant to him

PEPs - The quality of Personal Education Plans for Halton's Children in Care varies widely across the service. IRMs have experienced examples of excellent plans that identify necessary support required for academic achievement and in addition focus on uses for the Pupil Premium funding which can provide an opportunity for children to widen their skills and experience by learning a musical instrument or attend dance or sports clubs. Other PEPs are prepared hurriedly and can lack detail and depth. In such cases issues are raised with Halton's Lead for Vulnerable Groups and Safeguarding who receives copies of all completed PEPs and provides training and guidance to Social Workers.

A recent report produced by the National Children's Bureau (NCB) and the Nuffield Foundation raised concerns that IRMs are not always able to provide the high-quality service that children growing up in the care system need. The reasons for this are difficult to unpick but this research suggests that heavy caseloads and a working culture that does not properly value IRMs' contribution are important factors. IRMs in Halton do feel that Practice and Principal Managers value their view and the quality assurance role they undertake. However, there are occasions when IRMs are not presented with the information required to make a clear decision in respect of the proposed Care Plan. In one case, a Final Care Plan was presented at court despite the IRM indicating that they could not agree it due to a lack of detail in respect of the proposed plans for the child's contact with his mother. The Social Worker and Children's Guardian advised the court of the IRM's position which resulted in the judge adjourning the case and stating strongly that she was not prepared to consider a Care Plan that an IRM was unclear about and had not agreed. This view is welcomed by IRMs in Halton as it vindicates the long established practice in Halton of IRMs reviewing care plans prior to them being filed in court.

4.0 Part Three – Additional Work Undertaken by the Conference and Reviewing Managers

4.1 Foster carer reviews

This process is currently under review and it is proposed that there be a mini panel created to complete this task with the SGU represented on the panel and the IRMs completing the three yearly face to face review.

The process has been fraught with the same difficulties for many years, which are that social workers reports are often delayed and the supervising social workers complete their reports in absences of having sight of the social workers reports. Despite this being raised every quarter no improvements have been noted.

It is hoped that the new process will offer more independence in the process.

Halton has a range of experienced and newly approved foster carers who do a vital job as part of the 'team around the child'. New carers are offered a high level of support from the fostering service and also can be mentored and linked to more experienced carers for additional support. A number of foster carers who have had

children placed with them on a long term basis have recently progressed Special Guardianship Orders for the children they care for recognising that this gives them the 'parental responsibility' to make key decisions in the child's best interests. From the child or young person's view this is always welcomed as it 'normalises' their lives and reduces the need for social care involvement.

4.2 Life Appreciation Days

These are meetings held with a child's prospective adopters and all those who have worked with and supported the child up to the time of an introduction to their new family. The child's IRM facilitates the meeting by reflecting on the child's journey to enable and encourage all present to share their memories and experiences of the child. Six Life Appreciation Days were held.

Feedback from Life Appreciation days is universally very positive. Prospective adopters consistently report on the value of receiving information not contained in written material and of the value of hearing first hand from significant people in their child's life. Prospective adopters frequently comment that they learnt information that informed the way in which the helped their child settle with them. Other agencies attending comment on the value of understanding the part they have played in contributing to a positive outcome for the child concerned.

4.3 Disruption Meetings

These are meetings held following the breakdown of an adoption or long term foster placement to learn lessons for future practice and the future care of the child.

No meetings were held in the period reported. There have been three long term placement breakdowns for which disruption meetings will be arranged.

4.4 Regulation 33 Visits

These are a statuary requirement under OFSTED regulations carried out monthly by an independent person on an unannounced basis.

Six Reg 33 visits are undertaken a year alternating between Inglefield and Edinburgh Road. Visits focus on interviews with staff and time spent with the young people in residence. Staff from both establishments consistently report positively on the level of training and supervision they receive and the manner in which they engage in preparing detailed care plans for each individual child.

4.5 **LADO-a separate annual report is submitted to the LSCB**

The number and nature of the referrals to LADO vary greatly from month to month. The two main sectors where referrals are received from relate to education and other Local Authority children in Care placed in Halton, most of these referrals are as a result of allegations regarding physical assault, and most conclude as unsubstantiated.

Children in care from other local authorities placed in Halton can present as a significant challenge for the LADO. The CIC who tend to make most of the allegations have been placed by London boroughs. There have been a number of occasions when the child has not been seen or spoken to by the placing authority after making the allegation for up to a week. This is clearly unacceptable for a number of reasons. In addition to this the placing authorities have allowed the providers to take responsibility for attending the police and medicals with the children. LADO has spoken to the independent providers and the managers from the placing authority about this and advised this practice is not acceptable.
The SGU will be amending the policy and procedures regarding the LADO process to reflect Working Together 2013 and changes in legislation. The new procedures will provide more clarity about which cases meet the LADO Threshold and at what point a strategy meeting should be convened.

Within this reporting period the identified outcomes have been amended to unsubstantiated, substantiated, false and malicious. Previously allegations were classed as unfounded also.

SGU has also amended the reporting information to fall in line with the expectations from the DFE and to also provide the LADO with a better opportunity to review trends and vulnerable groups. Whether a child is a child in care or has a disability is now also recorded.

4.6 **Child Sexual Exploitation**

In January 2013 the Lead conference and reviewing manager took responsibility to co-ordinate and chair an operational group; to share information on cases were CSE was identified as a risk or where there was evidence that a child was being Sexually Exploited. Whilst the initial agreement was made for a period of three months the Lead Conference and reviewing manager will continue to chair until a permanent chair is identified.

The Aim of the CSE operational group is to gather and share information in order to identify perpetrators of CSE and identify areas within the community were young people are vulnerable in order to tackle the issues and reduce the risks of the young people in Halton being sexually exploited. The Operational group receives referrals from all agencies regarding children they are working with were they are managing or concerned about CSE. The operational group consider the information and check their own organisations for involvement which is fed back to the case holder to assist them in their case planning which takes place at a different meeting.

For example; a young person is referred to the operational group. All professionals check their records to identify if the young person is known either directly or by association with another young person. They share this information with the lead professional so that they can develop an appropriate plan to keep the child safe. The operational group considers the areas were the young person hangs out and whether agencies such as police and Addaction should visit the location more frequently to ensure that the young people are safe.

8 Operational groups have taken place and whilst initially only a few referrals were received this has changed over the months. The operational group is beginning to identify areas in the local community were Young people gather and has agreed agencies intervention be targeted in these areas in order to reduce risks.

5.0 Looking forward

5.1 Child Protection

A significant area for improvement is the timely completion and circulation of notes following all Safeguarding meetings. This has been an on-going issue for a significant period of time, as identified in 2011 by OfSTED, with periods of improvement not sustained.

The child protection plans developed at child protection conference identify the outcomes to be achieved for young people but they need to be more child focused and the voice of the child, their wishes and feelings need to be included in them in a format that supports families understanding of the concerns and their understanding of what and why things need to change. This will be achieved by developing participation groups with young people and parents to look at how the SGU can change the format and language in the plans to support this.

The SGU must get better at seeking the views of children and families in all aspects of its work and this will be reflected in the team plan and will include an annual survey of all stakeholders regarding the services provided by the unit.

Continued Improvements should be made in GP attendance and contribution to child protection planning.

The impact of the loss of the designated police officer attendance at CP conferences needs to be monitored and a request has been made for consistency of practice in provision of written reports from the police.

The SGU needs to be proactive in improving partner agencies understanding in the importance of their information at CIC reviews and CP conferences via briefings and training sessions.

The low numbers of children on child protection plans against the increasing numbers of children coming into care needs to be urgently considered in more detail It has been proposed by the SGU that Early intervention services undertake an audit of all cases that have been open to them for 12 month plus to ensure that they are at the appropriate level of intervention.

5.2 Children in Care

The unit continues to be committed to investigating and developing new ways of encouraging the participation of children and young people in the review process. The newly launched use of Tracker Forms will be monitored and their design modified depending on feedback. The Unit intends to work with the Participation Worker and Children in Care Council to review the style and content of all consultation forms associated with the review process. In addition, it is intended to develop a website dedicated for the use of children in care. It is intended that this will allow the unit to receive more immediate feedback about the services that are provided and the issues that are of concern for children and young people.

The unit intends to develop a business plan that will clearly identify the issues that will be addressed for Children in Care. The Children in Care Council will be consulted and provided with the opportunity to inform this plan.
A number of recent cases have highlighted the importance of working closely with Guardians in the scrutiny of care plans and the timely completion of actions. In the year ahead IRMS intend to develop closer working relationships with CAFCAS Guardians to more effectively guard the interests of children during proceedings.

.