

Children's Services



**One Children's Service – PROVIDING CHALLENGE AND
SUPPORT TO IMPROVE THE LIVED EXPERIENCE OF
CHILDREN AND FAMILIES**

Quality Assurance Practice and Performance Improvement Framework

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Introduction

Swindon is a Family Safeguarding authority. Family Safeguarding is a model of practice that was originally developed in Hertfordshire as a more effective and ethical way of meeting the needs of children and their families. It was developed to improve outcomes for children and their families in the context of rising numbers of children becoming the subject of child protection plans and entering council care. It was recognised that 'traditional' ways of working with families had led to too many children being separated from their families, with parents feeling that they had not had the help that would have supported them to care for their children and to live happily and safely together.

The ethos and approach of the Family Safeguarding model runs as a golden thread through all of our work with children, young people and families, from our early help services through our services to children in need and in need of protection to supporting young adults who have left our care.

Our vision and approach to practice

Our Vision	
To enable more children to live safely at home with their families	
Our Approach to Practice	
<ul style="list-style-type: none">• Collaborative: Practitioners and families are partners – we do things with people, not to them;• Strengths-based: All families have strengths, and we focus on using strengths to support change;• Purposeful: Our role is to meet child and family need and provide families with the right support, first time;• Rights-based: Families have a right to help and support for their children, and the autonomy to make choices. We use our authority to build on family resilience, rather than to issue instructions;• Empathetic: We listen carefully to families & offer a helping hand to create change for children;• Aspirational: We want the best for families and to help them to sustain change. When children and young people need to be in care, we work with them and their carers to ensure that they grow up healthy, happy, supported to maintain relationships that are important to them so that they can achieve the best that they can.	

Why do we need a Quality Assurance, Practice and Performance Framework?

As practitioners and managers, we should be constantly reviewing our performance and the quality of our services in order to deliver the best possible long-term outcomes for children, young people and their families. This means understanding not only the quality of our direct practice, but also using performance data to help us to compare ourselves with other similar authorities and our own previous performance.

Understanding performance data can help us to ensure that our involvement with families is proportionate as well as effective. Undertaking activities such as direct observations of practice, case

file audits, dip samples and similar help us to understand the overall quality of practice and the extent which this is improving outcomes for our children, young people and families.

The overall aim of our Quality Assurance, Practice and Performance Framework is to:

- Ensure that we are upholding the vision and values of Family Safeguarding in practice;
- Measure whether we are making a positive difference for families and to understand our effectiveness in keeping families safely together and safely returning children home from care where in their best long-term interests;
- Establish whether the right families are being helped, with the right resources, at the right time, so that we can use our resources efficiently;
- Seek the views of families on the help and support that they have received and to be responsive to what they tell us;
- Allow us to continuously improve what we offer to families and to strive for consistency and excellence in practice;
- To maintain the quality and practice standards that we use to hold each other to account;
- To be responsive to any changes or deterioration in the quality and effectiveness of practice and take action to address this and improve;
- To be able to share our learning about what works well;
- To know whether our workforce is satisfied that they are providing the help that families need and whether they are supported by their leaders to do this well.
- To aspire to provide consistently good and outstanding help and support to children and families.

Effective approaches to understanding the overall quality services for children and families enable leaders to have a clear line of sight to the quality of practice at the front line. This means that action can be taken at a strategic level when needed.

Responsibility for Quality Assurance

Everyone working within the system of children's services is making a contribution to meeting the needs of children and families, and therefore everyone has a part to play in quality assuring practice. It is activity that must be prioritised because we all need to know whether we are having the impact we aspire to as individuals, teams, services, organisations and partnerships. Specific examples of our responsibilities to ensure effective overall quality assurance of practice include:

- **Practitioners:** Being available to participate in casefile auditing alongside the auditor. To have taken some time before any auditing activity to reflect on the impact of their practice and time after to think about putting any learning into place;
- **Managers:** to prioritise the completion of casefile audits, dip sampling and other activities as set out within this framework. To provide feedback to practitioners in strengths-based ways that encourage learning and development;
- **Leaders and Senior Managers:** to lead by example by completing audit and other quality assurance activities and in using motivational interviewing techniques and other strengths-based approaches in their work across the organisation. To ensure that managers and others have the support and capacity they need to participate in effective quality assurance activities;
- **Reviewing Officers and Conference Chairs:** to ensure that they highlight good practice as well as address areas for improvement constructively and in strengths-based ways through the dispute resolution process. To ensure that plans for children and young people are

effective and are developed with children and their families. To ensure that children and families are enabled to participate positively in conferences and review meetings;

- **Principal Social Worker and Practice Leads:** to ensure that learning from quality assurance activities is summarised and then embedded in the service. To support and facilitate reflective discussions about good practice examples as well as situations where intervention is stuck or failing to have the necessary impact in order to secure continuous improvement in outcomes for our children, young people and families;
- **Business Intelligence:** to ensure that managers and leaders across the service have timely access to key information at team and service level and are supported to interpret and analyse the data provided.

All staff are responsible for the quality of their own practice and have a duty to contribute to their own and other's ongoing learning through the evaluation of practice. They are responsible for being open to quality assurance work and learning, and for raising areas of strength and concern about delivery in the service so that improvements can be delivered.

Staff with specific **strategic responsibility** for quality assurance include the Head of Service of Practice, Performance and Quality Assurance, Quality Assurance Manager, Principal Social Worker and Practice & Development Team and Practice & Improvement Leads. These roles each contribute to the improvement cycle by embedding the Quality Assurance, Practice and Performance Framework, providing team and service-wide analysis and recommendations from the data collected, and supporting the operational service to drive improvements through delivering training and resources specific to identified learning needs.

[Overview of contents of this quality assurance, practice and performance framework](#)

This document begins by exploring common themes in understanding the quality of our service and practice with children, young people and families:

- Listening to the views of children and families
- Listening to the views of practitioners and managers
- Summarising our approach to early help;
- Summarising our practice principles in early help and children's social care;
- Assessing the quality of practice through audit and other activities, including the audit and moderation process;
- How we use performance data to help us understand the impact we are having on outcomes for children, young people and families;
- How we bring the strands of information together in focused reflective and strengths-based forums in order to contribute to continuously improving our practice;
- Other ways in which we embed the learning from our quality assurance activities.

[2. Evaluating the extent to which our involvement is making a difference: Listening to the views of children and families](#)

The Family Safeguarding practice model places great importance on working alongside families, children and young people, empowering and enabling them to address the difficult situations they are facing.

"Users' views on services and self-reported impacts is needed to establish if children and families feel valued and empowered, and whether the support they receive meets their needs, respects their rights and makes a difference

to their lives. While it is increasingly common for CSCS to collect feedback from their users, the focus is usually on views about the service rather than on perceptions about the difference that services have made to their lives.”¹

Some of the most important information to be gathered and analysed when undertaking quality assurance activity is what families themselves say about the impact on them of the service they have received, and Family Safeguarding authorities need to ensure that there are opportunities to capture the views of children, parents, and families throughout the period of involvement with them.

Those evaluating practice should be seeking the views of the family about:

- The quality of relationships with those working with them. Do they feel involved and empowered? Do they trust workers to be open and honest? Do they feel they can be open and honest about what their needs are? Have they been treated fairly?
- Whether they have had the reason for involvement clearly explained to them;
- What they think about the assessment of their family’s needs – how much of it do they agree with? What did they disagree with?
- Whether they think the team working with them have worked together effectively
- What/who they found most/least helpful and why?
- Whether they feel clear about their rights, including the right to choose whether to accept help;
- Whether they would want to share their experience to help other parents who are struggling.

There are a number of ways in which we incorporate the views of children and families into our quality assurance, practice and performance framework. These include:

- Feedback from complaints and compliments;
- Participation by our children in care through the Children in Care Council [Raise Your Voice];
- Hearing from our foster carers through the Corporate Parenting Board;
- Seeking views directly from children and families with whom we are working.

When we complete individual case file audits, practice weeks and some thematic audits, we will always seek the views of the children, where of sufficient age and understanding, and parents and carers about the services we are providing. Appendix 1 is a brief guided questionnaire for practitioners who are seeking the views of children and families as part of audit activities.

These questionnaires will be completed by the Participation and/or Quality Assurance service. This is to help parents, carers, children and young people to speak openly about their views.

3. Views of the workforce

It is also important that we understand the views of those working with children, young people, parents and carers on their perceptions of the impact that they are having.

In relation to individual file audits and practice weeks, the audit should compare the views of the parents, carers, children and young people on progress being made with those of the practitioner.

¹ How do we know if children’s social care services make a difference? Development of an outcomes framework

July 2019 Ivana La Valle, Di Hart and Lisa Holmes with Vânia S. Pinto

More generally, it is important for the service as a whole to have an understanding of the overall confidence of the workforce in key areas. Practitioners need to feel confident in their skills, abilities and knowledge if they are to offer the most effective support to the families with whom they are working. They need to have access to good quality supervision and management oversight, and they need to have the capacity and tools available to them in order to practice effectively.

This understanding is obtained through a variety of approaches, including through:

- Staff surveys;
- Practitioner focus groups;
- Activities undertaken by the Principal Social Worker;
- Analysis of other relevant information including, for example, through exit and stay interviews.

4. Our approach to early help

Our Early Help Strategy seeks to address inequalities of health, wealth and opportunity in Swindon through co-ordinating, brokering and commissioning the right help and support *at the right time* to local communities. We are committed to using local data and intelligence to help identify current and emerging themes, and jointly plan on how best to address the need. Our Early Help offer promotes the independence and self-reliance of children, young people and their families by providing supportive relationships and connections within local communities to help people or families continue to survive and thrive.

We aim to deliver good quality, evidence-based and timely interventions which improve outcomes for children and young people and build their and their family's resilience. Reports are commissioned using the same annual programme focusing on the different areas of Early Help practice, e.g. youth work, parenting and work with fathers.

Swindon's Early Help offer is governed by standards and the 'Right Help at the Right Time' threshold document. The Early Help audit tool measures against this Practice Guidance, identifying areas of strengths and areas for further development. There is a clear focus on evidencing impact of intervention on improving children's outcomes.

Co-ordinators and Operational Managers carry out a monthly schedule of audits. Audits are collaborative with the worker and follow a format parallel to the social work audits to test quality of practice. Monthly audits are identified by the Strategic Lead for Early Help and are selected from children's records that have been open for a minimum of 2 months.

5. Practice principles in early help and children's social care

Swindon is a Family Safeguarding authority and as such, needs to evaluate the quality of practice against the values and ethos of the Family Safeguarding model, which apply across all levels of service and intervention, from early help through to children in care and young people leaving care. These are set out in the table in Section 1 above.

5.1 Practice principles common to all levels of help and support

Seeking the views of children, young people and their family about the support they received, as described in Section 2, and understanding the views of practitioners, as described in section 3 above, are vital factors in assessing the overall quality of the services that we provide. In evaluating the quality of practice with all children, young people and their families, a number of **common themes** need to be considered and evaluated, including:

- **The reasons for involvement with the family.** This should include evidence of a clear rationale for the threshold decisions and actions at the point of the most recent referral, but also that the service currently being provided reflects an appropriate application of the law and thresholds for intervention. The judgment of the auditor should answer the question about whether initial responses and subsequent actions are proportionate according to the needs identified in the family. Where families are being supported by our targeted early help service, is there a clear plan to enable to support to step down to community early help support? Is there evidence of actual or likely significant harm (for Sec 47 processes), or of significant impairment of the child's health or development without the provision of services (Sec 17 10.b)? For children and young people in care, is there an evaluation of whether a child or young person should remain in care or can be returned safely to their family with the right support, regardless of how long they have been in care?
- **Consent in place.** Auditors should be looking for evidence that parental consent was sought prior to sharing information, making enquiries, or taking action, save for exceptional circumstances i.e. because the parent cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would compromise a child's or young person's immediate safety or jeopardise an ongoing police investigation. Where the disposal of consent is used is it proportionate and evidenced.
- **Including broader relationships important to the child –** Children have relationships that are important to them outside of their immediate family. Engaging extended family and others who have positive relationships with children from the earliest point is vital for the on-going strength and resilience of the child's family circumstances. Where a child may not be able to remain within their immediate family, there may be opportunities for them to remain in their extended family network, rather than coming into care. Where a child is in care, maintaining important relationships with immediate and extended family supports the maintenance of life-long links for the child. Family circumstances change over time, meaning that the potential for children to safely return home from care should always be considered.
- **Cultural competence:** Our practice with children, young people and their families must demonstrate cultural competence. This is more than superficial statements about a child's religious and/or cultural background. It is about understanding the past and current relationships and experiences of the child and their family, their beliefs and values, the impact of any discrimination that they have or are experiencing.
- **Considering the child's wishes –** often referred to as the child's voice, or wishes and feelings, but this should explicitly include evidence of what the child wants to happen in response to the needs of their family (if they are able to understand this), and what protection they need, as well as what help they think their family needs, including when initiating CP processes (CA 1989 Sec 14), or when considering whether care is the right plan for the child.
- **The role of other services in helping the child and family:** Children, young people and their families will need to access support and services provided by other agencies including schools, early years' settings, colleges, health services, voluntary agencies and so on. Auditors should consider the extent to which this partnership working is meeting the needs of the child, young person or family.
- **Case summary and chronology –** is there an up-to-date summary of the needs identified for this family and what is being done to help them? What has worked? What child and parent needs have yet to be met? Is there a chronology that helps understand the family's history and key events? This should be the family's chronology and not a service history.

- **Supervision and management oversight:** Is this taking place at the level of frequency needed as indicated by the needs of the family? Is supervision reflective and multi-disciplinary where appropriate? Does supervision help to ensure that the plan for the child is progressing? Does the process identify where progress is being made, and where different approaches may be needed, using MI approaches? Is the lived experience of the child informing planning? Is management decision making clear? Are reasons for decisions and, where appropriate, do decisions relate to statutory thresholds?

5.2 Additional practice principles for children in need and children in need of protection

Assessment/Workbook – for children in need and in need of protection, relevant professionals for each family's situation are involved in completing the assessment of the family's needs and recording their relevant information and analysis in the Workbook. One of the key aims in introducing the Workbook within the Family Safeguarding model was to free workers up from their computers so that they could spend more time with families. Instead of recording everything that ever happens with a family or other professionals in case notes, more meaningful recording should be captured with a focus on analysis, family strengths, and impact on the child of the needs identified in the family.

Auditors should be looking for evidence that the Workbook:

- has clear reason for involvement, what the aims are of the work are, and the desired outcomes for the child;
- evidences that the worker is following the Family Programme, is being purposeful, and deploys a motivational approach e.g. Cycle of Change;
- includes expertise from the relevant members of the multi-agency team;
- includes the family's strengths;
- evidences progress, change, or any failure to engage the family (and a plan to address this);
- analyses impact of work on the child's welfare and protection and proposes next steps;
- uses language that is empathic and empowering for the family.

Direct work/Family Programme – the Workbook should contain information about the direct work completed with the family, using all 8 modules of the Family Programme. Auditors need to evaluate the quality of practice evident in the work undertaken, but also its impact on outcomes for the family. They should be looking for evidence of:

- Relationships that facilitate honest and open discussions about what the family needs and their motivation to make and changes needed.
- Understanding of the family history, family values and culture, and how these impact on current family life and relationships. This should include exploration of the impact on the family of their financial circumstances and whether anything more can be done to help those experiencing the impact of poverty.
- Exploring the impact of parental needs (including abuse in relationships, poor mental health, alcohol and drug use) on the child or unborn baby.
- Direct work with children that explores what day-to-day life is like for them; what they like about their family; whether they feel loved and cared about; what they would like to be different; what they want to stay the same; who they can talk to if they're unhappy.
- Observations about how the family communicate with each other, including warmth, demonstrating love and care; any evidence of abuse and/or controlling behaviour including in the parents' relationship.
- What help has been offered; whether it was accepted; and whether the family feel helped.

- Progress on achieving the outcomes sought and follow up work required.

Analysis – the sum of all the evidence gathered and whether that has identified needs in the family; and whether the family are motivated for things to change and accept help. Are any changes made sustainable? Are there children in need of services in the family? Is there evidence of actual or likely significant harm attributable to the care by the parents? What needs to happen before a child can return home from care?

Decision-making – what should happen now based on the outcome of the assessment and plan? Does help and support need to be offered or continue in order to meet the child's needs? If so, who should provide it and for how long? Should involvement with the family end? What help can be provided that would allow the child to return home?

5.3 Additional practice principles for children and young people in care

Children and young people in care are a diverse group; some will have been in care for only short periods of time, with plans to return home, move on to relatives or progress through to adoption, while others may have been in our care for significant lengths of time.

Understanding the quality of relationships for children and young people in care is arguably even more important than for those who are living within their families. The quality and consistency of relationships with foster carers, residential staff, their social worker, reviewing officer are all important and are, rightly, often the main focus when we set out to understand the overall quality of our services to children in care. Our children in care will also have important, if sometimes difficult, relationships with parents, siblings and extended family and it is these relationships that will often form the core of lifelong links once children leave care.

A key social work task is to help and support children and young people to navigate relationships with their parents and extended families. Good and outstanding practice is where social workers are including assessments and understanding of these family relationships in planning for the child and young person, routinely revisiting what the child or young person's views are, and the extent to which family members are making changes or could be supported to make changes that would enable a child or young person to return safely to their care.

Having high aspirations for children, young people and their families is a key principle of the Family Safeguarding model. This is also of particular importance for our children and young people in care. We need to ensure that we are stretching their ambitions, that their carers are doing the same, and that there is the support in place needed to enable them to achieve their full potential. This includes understanding and supporting their emotional and mental health needs, given the higher prevalence of difficulties in this area for children in care. This means taking a proactive approach to building emotional and mental health resilience.

5.4 Additional considerations for young people and young adults leaving care:

As for children in care, young people and adults leaving care are a diverse group. Our planning and support needs to reflect their individual circumstances. As with children and young people in care, understanding the range and quality of relationships is extremely important. Young people and adults leaving care will also have important, if sometimes difficult relationships with parents, siblings, extended family. It is these relationships that will often become the most significant as young people move into adulthood.

It is therefore a key task of working with young people leaving care and care experienced young adults to understand the importance of these relationships and to support them to navigate the

complexities involved. Often being in care will have disrupted these relationships, particularly where, for example, placements have been at distance from family and friendship groups.

Care experienced adults often describe one of the hardest things about transitioning into adulthood as loneliness. Planning for them through the pathway planning process must therefore include all those who are significant, including those where relationships are complex, unless there are clear reasons for not doing so.

We must be ambitious for our young people leaving care and our care experienced young adults. Having high aspirations for those we work with is a key principle of the Family Safeguarding model. This is also of particular importance for young people leaving care and our care experienced young adults. We need to ensure that we are stretching their ambitions, and that there is the support in place needed to enable them to achieve their full potential. This includes understanding and supporting their emotional and mental health needs, given the higher prevalence of difficulties in this area for care experienced young people and adults.

5.5 The role of child protection conferences, core groups and reviews for children in care:

Child in Need Reviews, Child Protection Conferences and Reviews, Child in Care Reviews, and Core Group meetings are opportunities to bring the wider team together that are working with the family to share their analysis and make decisions about the progress of the plan. Like Family Safeguarding supervision, a way of quality assuring them and evaluating practice in these meetings is for someone to observe them and pay particular attention to the family's contribution in the meeting and the relationships that professionals have with them. Features of positive conference and review meetings include:

- Whether there is evidence of effective, respectful, and empathic relationships;
- Whether the status of the parents as experts in relation to their family recognised and valued;
- Whether the view of parents and children/young people are given sufficient weight;
- The extent to which parents and children/young people are being encouraged and supported to collaborate on the content of the plan;
- Do professionals use language that will be understandable for the family?

Observers of meetings such as these will want to comment on whether the plan is meeting the objective of supporting the family to stay safely together (or for the child to return home from care, where safe to do so), and that the law and statutory guidance is being applied proportionately for the needs identified, and to ensure that children are protected from significant harm.

Records of these meetings should show evidence of family engagement and collaboration, as outlined above. They should confirm that the relevant people were involved in reviewing the work with the family and demonstrate evidence that the right services are in place to meet the family's needs and reduce harm to the children.

6. Assessing the quality of practice

There are a number of ways in which we assess the quality of practice, including audits, observations of practice, practice weeks, peer reviews and other external reviews.

6.1 Audits

6.1.1 Monthly case-file audits

These are completed by team managers, conference chairs, reviewing officers, service managers, heads of service and directors. They are completed alongside the social worker, using the audit template found at Appendix 2. Feedback from parents/carers and children and young people is collected separately, using the guided questionnaire which can be found at Appendix 1.

All those expected to complete an audit will be notified of the case file number by the QA service in line with the process as set out in Appendix 3.

Audits should be completed with reference to the principles of Family Safeguarding practice as laid out in sections 1-5 above and the pillars of practice in Appendix 4.

The QA Team will undertake moderation exercises as appropriate to ensure consistency of assessment of the quality of practice, and in order to identify themes for learning and reflective practice.

The expectation is that auditors across the service undertake one case file audit per month.

6.1.2 Head of Service, Service manager and team manager dip-sampling

Head's of Service, Service and team managers are to complete a random dip sample of 5 case files within their team or service area or at least one practice observation per month.

Dip samples are focused on a theme set by the QA team. Themes might include the quality of chronologies or case summaries, or of assessments or plans for children.

This work is evaluated within the Team Performance Clinic, from where it is collated by the QA team to support our self-assessment of the quality of our practice against the pillars of practice at Appendix 4.

6.1.3 Thematic audits

These are undertaken at regular intervals and are usually completed by the QA Team. They evaluate specific areas of practice, as set out in the annual audit plan. The annual audit plan is regularly reviewed by the QA team, the senior leadership team and the Practice and Performance Board.

Additional themed audits may be completed in response to lines of enquiry emerging from other audit activity, from performance data, or as a result of decisions by the senior leadership team or at the Practice and Performance Board.

6.1.4 Ad-hoc audits

These are usually undertaken by the QA team as directed by any specific areas of concern and/or in response to indications of changes in practice, such as threshold decision making as indicated by performance data. Examples might include an increase or decrease in numbers of child protection enquiries, social work assessments, re-referral rates and so on.

6.1.5 Multi-Agency audits

Effective decision making at the front door requires good multi-agency decision making. The MASH governance board should have arrangements in place to support multi-agency auditing, the outcome of which is reported to the Board.

Auditing and dip-sampling should identify themes including, for example:

- Patterns in relation to contacts where outcomes are most likely to be that children do not reach thresholds;
- Common themes in respect of consent;
- Timeliness of decision making;
- Quality of feedback to referrers;
- Attendance at strategy meetings and evidence of decision making in line with statutory guidance;
- Outcomes for strategy discussions and child protection enquiries in order to support better application of threshold decision making in future;
- Any areas of disagreement by partners in respect of decision-making.

More broadly, the Swindon Safeguarding Children Partnership facilitates multi-agency audits to ensure effective partnership working.

The multi-agency audit programme is agreed through the local safeguarding children partnership. Family Safeguarding is a multi-agency and multi-disciplinary approach and therefore quality assurance activity should include all the partner agencies evaluating their effectiveness in meeting the needs of the family together.

Multi-agency audits provide an opportunity to evaluate how well agencies are working together and what the impact is on families. Evidence gathered from this activity, as well as providing important information about effectiveness of the local partnership arrangements, can be used to inform planning and self-assessment for inspection by Ofsted, CQC HMIC, and HMIP as preparation for Joint Targeted Area Inspections.

6.1.6 Audit tools and assessing the quality of practice

The Swindon Audit tool can be found at Appendix 2 to this framework. The tool guides auditors through the areas of practice that need to be considered when undertaking a full audit, as opposed to a dip sample.

Managers and others who are completing audits can sometimes be anxious about assessing the level of practice. The Swindon Practice Pillars are there to help with this and can be found at appendix 4. Managers should also read Sections 1-5 of this framework in order to understand the ethos of the Family Safeguarding practice model and our approach to evaluating the quality of practice in Swindon.

In terms of assessing the grade for individual elements of the work and the overall grade, the extent to which we have improved outcomes for children and young people in a timely way through practice that is in line with the principles of our Family Safeguarding model is key. Minor gaps in recording and similar omissions should not be sufficient to reduce the assessment of the overall quality of intervention.

Significant gaps in recording, in supervision and/or management oversight and/or of procedures not being followed, or delays in the progression of the work are likely to lead to a reduction in the evaluation of the quality of the work being undertaken.

The act of carrying out an audit alongside a practitioner is an opportunity to model best practice. Audits should be framed in strengths-based ways. This does not mean that deficits should be overlooked, but that auditors should find ways of describing how practice would be even better if...

Training is available on how to audit a case file and evaluate practice. A proportion of completed audits are moderated by the quality assurance team, and feedback will be provided where the moderation results in a different evaluation of practice, and why.

6.1.7 Child of concern process – where an audit identifies inadequate practice

Should the overall practice relating to a child, young person and their family be assessed as being inadequate through a file audit, the child of concern process must be followed.

Actions for improvement identified through the audit must be followed, and a short re-audit of the file will take place 6 weeks following the original audit to ensure that these have been complied with.

6.2 Practice Observations

Team and service managers are expected to complete either one practice observation or 5 dip sample per month.

Practice observations include observing a visit to a child or a family, a child protection conference or review meeting. Evidence of a reflective discussion following the observation is required. Any additional training or development needs should be identified. This is to be included within the supervision file.

Learning and/or areas of strength should be presented at team and/or service meetings as appropriate by the practitioner concerned.

6.3 Practice weeks

Practice Week takes place twice per year, where service leaders spend time with frontline practitioners, observing their practice and finding out first-hand what is happening for the families they work with and includes:

- Observing Core Group meetings and Child Protection Conferences.
- Observing Child Looked After Reviews and Pathway Planning Meetings.
- Observing how we work with our multi agency partners.
- Observing office and home visits with families.
- Undertaking audits alongside Social Workers.
- Visits to the workplace and talking with practitioners and managers.

A summary report of the findings of Practice Week is presented to the Practice and Performance Assurance Board. This provides opportunity to celebrate best practice identified, and continue to develop areas of practice where further work and scrutiny is required.

Peer and other reviews

Swindon is part of the South West regional sector-led improvement programme. This enables us to participate in peer reviews, which will typically focus on an area of or element of service activity or outcomes for children and families.

We are also able to request that the Local Government Association undertakes a peer review, and these follow a similar format to those undertaken through the sector-led improvement programme.

Decisions around participating in sector-led or LGA peer reviews are made by the children's services senior leadership team.

Over time, as our confidence and capacity to undertake quality assurance activities continues to develop, we may introduce a model of internal peer reviews, where one part of our service area reviews another.

External independent reviews can also be commissioned at the discretion of the senior management team.

6.4 Other activities related to ensuring the quality of practice

There are a range of other checks and balances in our systems that help to ensure that our practice is effective at both an individual child/young person/family level and more generally. These include:

Dispute Resolution by the IROs in relation to our cared for children. This has a number of levels, but it is expected that any concerns about the quality of practice are resolved at the lowest level. Following each Cared for Child's Review, a QA process monitors practice issues and standards. This information is shared in a monthly report to the Performance Board and summary information is included in the Annual IRO Report. A similar process is in place in relation to children who are the subject of Child Protection Plans.

It is important that we capture common themes from both conference chairs and reviewing officers, so that these can be addressed as part of our continuous improvement process.

Learning from Practice Reviews both locally and nationally. Audits may be commissioned to review local practice in light of Practice and Rapid Review findings. During the audit process, we look for evidence that learning and improvement has been embedded. Practice Briefings are developed by the Safeguarding Partnership and reflective learning takes place. Regular Learning from Local Child Safeguarding Reviews and Rapid Reviews is delivered through Social Work Managers Meeting, with a closing the loop process to ensure the learning is disseminated to the teams and frontline practitioners.

Complaints , we will review complaints and identify the learning from these as part of our ongoing assessment of practice and priorities for practice. We will ensure that children and young people know how to complain and ensure we capture their voices and views to inform our learning and improvement priorities.

Notifications to Ofsted

When required and when a serious incident occurs, we will review the practice that has occurred identifying both strengths, any missed opportunities and identify key learning themes for practice. These will inform our practice improvement priorities and staff development.

7. Analysis of key performance data

Audit activity, practice weeks and similar all help us to establish the quality of practice with individual children, young people and their families.

Active use and analysis of key performance data is also essential if we are to be confident that our service as a whole is operating in ways that are likely to result in the best long-term outcomes for children, young people and their families.

As a minimum at **team** level, team managers need to use available dashboards to ensure that visits and statutory requirements to children and young people are being undertaken in a timely way. As

confidence and experience grows, team managers should become more inquisitive about what other data measures may be telling them about their team, compared with other teams in the same service area. This in turn can then lead them to ask questions about how their team is performing, which in turn can form the basis of reflective discussions.

For example, data broken down to team level may show that there are differences in the rates of initial child protection conferences, of children and young people who have been closed to the service being re-referred and so on. Such differences may point to emerging differences in the application of thresholds, or to changing patterns of need among the children and young people open to a particular team.

This information is brought to the monthly Practice and Performance Clinics as described in Section 8 below.

Similarly, at a more strategic level, active use of performance data can help senior managers identify where practice and/or decision making may be changing. This should then lead to further actions being taken to investigate further, such as dip-sampling or ad-hoc audit activity being undertaken by the QA team.

Analysis of data can also help us to have confidence that our work with children, young people and families is delivering good and sustainable outcomes, when triangulated with other available information including feedback from families, children, young people and partners, and audits of the quality of practice.

Indicators that have a particular role in helping us to understand the overall effectiveness of our service are set out in the following table, together with the data source where available:

Measure	What the data may be showing	Existing national dataset?
Re-referral rates to Early Help	The impact and sustainability of change for the family of work undertaken in Early Help	Annex A with adjustment
Step ups and step downs between Early Help and Social Work	Whether children have been effectively protected and supported within the system at the right level	Annex A
Referrals & Assessments that lead to no further action	A high % <u>may</u> indicate that the needs identified at referral did not meet threshold of CIN or CP and therefore be an indicator of appropriate referrals to social work	Annex A/CIN Census
Recording of consent in audited cases	Level of compliance on need for consent to be sought before making enquiries & taking action and throughout involvement. Is any dispensing of consent proportionate and evident.	Local monitoring needed
Re-referral rate	May measure effectiveness of earlier interventions. High re-referral rate may indicate failure to achieve outcomes in a sustained way.	Annex A/CIN Census
Rate of sec 47 enquiries and strategy discussions	Higher rates than comparators and/or previous performance may indicate that children are unnecessarily becoming the subject of CP processes	Annex A/CIN Census
% of children with S47 enquiries that do not lead to a CP plan	Higher rates than comparators may indicate that children are unnecessarily becoming the subject of CP processes	Annex A/CIN Census

Measure	What the data may be showing	Existing national dataset?
% of strategy discussions where all 3 statutory partners involved in discussions and decision	Level of compliance on need for statutory partners to be involved in strategy discussions/decisions	Local monitoring needed
Number/percentage Workbooks opened in relevant teams	Whether all families open to FS teams are being worked with using FS Workbook	Local monitoring needed
Rate of CP plans	Where the Family Safeguarding model is embedded, fewer children should need the support of CP Plans than in non-Family Safeguarding authorities. Any variation may reflect effectiveness of work with family	Annex A/CIN Census
Rate of entry into care as a result of abuse and neglect in the family	Post FS implementation there should be a reduced rate of children entering care due to abuse/neglect. Any variation may reflect effectiveness of work with family	Annex A/SSD903
Outcomes of pre-proceedings processes	If work with the family in pre-proceedings process is effective, fewer should result in the need for court application	Local monitoring needed
Reduced applications to family court for care orders	FS adopters should expect to see reduction in care order applications	Local monitoring needed
Outcomes at conclusion of family court proceedings	Whether the court agreed with the evidence presented by the LA and approved the care plan (or not)	Local monitoring needed
Increased cost avoidance due to reduction in use of children's care placements	Reduced placement spend should follow from reduced need for care as more children remain in family	Local monitoring needed
Number/rate of children who leave care to live with family	Increase in number/rate of children leaving care to return to family could be an indicator of successful reunification, but this needs child level analysis of the circumstances	Annex A/SSD903 with local qualitative analysis
Number of changes of allocated Social Worker for children in last 2 years	Frequent changes may reduce likelihood of effective working relationships	Local monitoring needed
% Practitioner turnover and vacancy levels including use of locums	Possible indicators of job satisfaction depending on reasons for leaving	Local monitoring needed, including employers of adult specialist roles
Rate of practitioner sickness absence	Possible indicator of workforce emotional wellbeing dependent on reason for absence	Local monitoring needed, including employers of adult specialist roles
Outcomes of staff survey	Level of job satisfaction; whether staff feel supported by their line manager and senior leaders; what they think of council's priorities	Local monitoring needed
% Satisfied with workforce learning and development offer	Whether staff feel supported to do their job well, including having learning needs met	Local monitoring needed

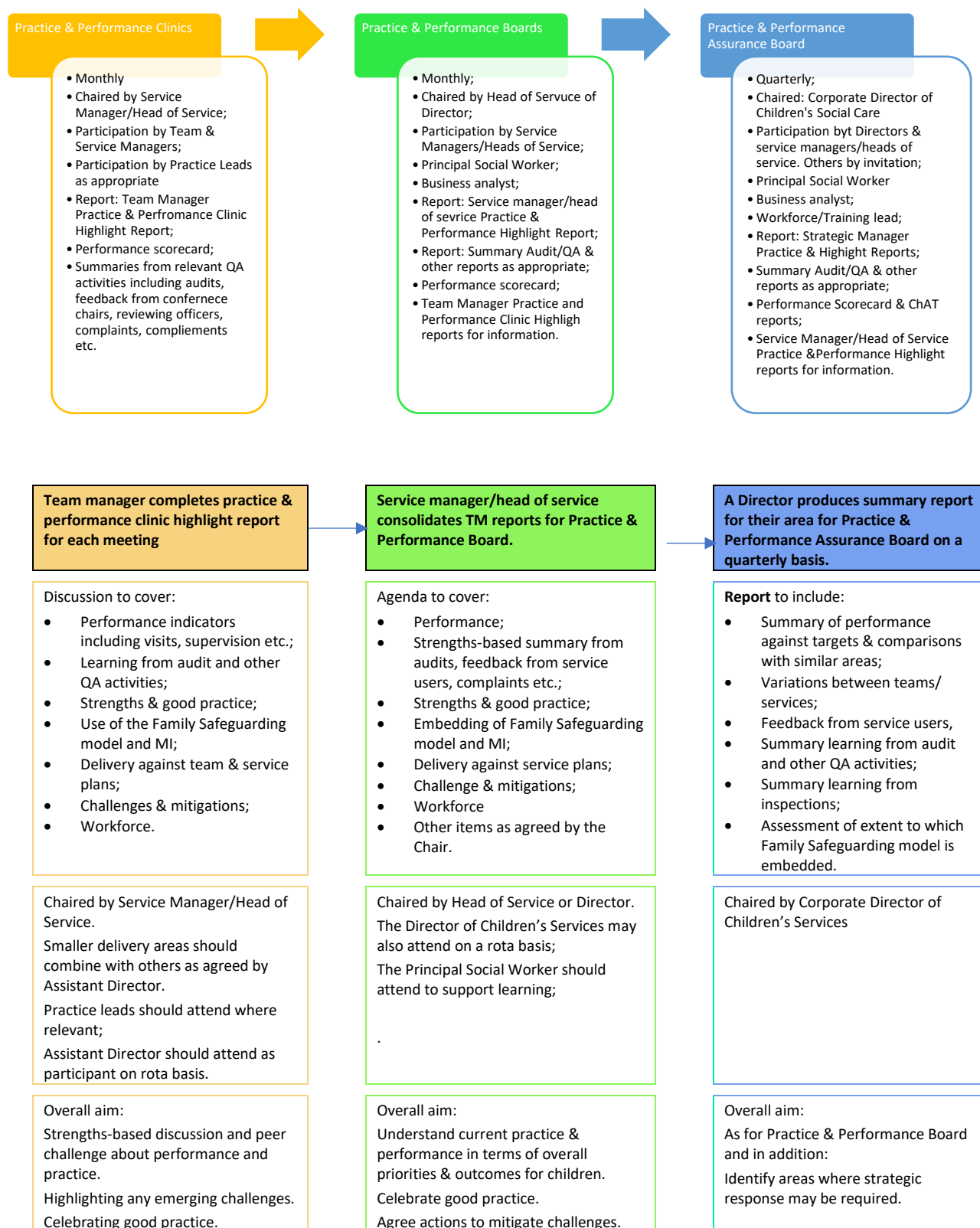
The above is not an exhaustive list, and managers and leaders will need access to the full range of performance data in order to fully understand the overall effectiveness of services, alongside the qualitative measures of practice quality discussed above.

The important thing here is to bring together all the different strands about how we know about the quality of the support that we are providing to children, young people and their families, which is set out in the next section.

8. Reporting arrangements, governance and scrutiny

This section sets out the practical arrangements for practice and performance reporting in Swindon, as summarised in the following chart:

Summary: Practice & Performance reporting, discussion, support & challenge



Exemplar terms of reference for the above boards can be found at Appendix 8.

Knowing ourselves & improving outcomes and performance

The aim of the above approach is to support strengths-based discussions at all levels within the organisation, that enable an open approach to discussions about performance and measures we can take together to improve outcomes for children, young people and their families.

The reports required of managers are highlight reports and should not be burdensome; managers should know or be using the information being requested in fulfilling their management and leadership responsibilities. The reports should be summaries and no longer than 3 sides of A4 when completed. Being concise in relation to this reporting framework is an area where managers are likely to need help and support. The templates can be found at Appendices 5-7.

The **practice and performance clinics** should consider individual team performance including strengths and areas for developments. These meetings provide a forum for discussions around some detailed aspects of performance including visiting to children, foster carers, frequency of supervision and so on, as well as a review of learning from the auditing and other QA processes/information. This is about sharing good practice, identifying any changing patterns in demand and considering how we know that we are making a difference for children, young people and their families.

These meetings are chaired by the Service Manager/Head of Service. The chair should model strengths-based and solution focused approaches to understanding performance and steps to take to continuously improve outcomes for children, young people and families. They should be looking for reassurance that the Family Safeguarding model of practice is embedded and tools such as MI are being used appropriately.

Practice leads should attend as appropriate. The PSW may attend on an occasional basis. The relevant Director should attend meetings in their area on a rota basis, as a participant. The aim here is for the Assistant Director to be able to contribute to the discussion, and model open analytical reflection of what the information shared in the meeting means in terms of quality and outcomes for children and young people. It also provides a further means of supporting visibility of senior leaders across children's services, and for senior leaders to maintain a line of sight to frontline practice.

In some parts of the service, it may be appropriate for these clinics to join across team/service areas. It will, however, be important for there to be sufficient time to enable full discussion of all areas.

Practice and Performance Boards are chaired by a Head of Service or Director. These should consider the information provided by Service Managers/Heads of Service in their consolidating practice and performance highlight reports. The Director should use this information to support an analytical discussion about what information from audit and other QA activity, feedback from service users/practitioners/stakeholders and performance indicators is telling us about overall outcomes for children and young people.

Performance indicators should not be looked at in isolation; we should be looking at baskets of indicators and combining this with other information to assess out overall impact. Thinking about front door and assessment performance, for example, we should not only be interested in the proportion of social work assessments completed in timescale, but the rate of these completed per 10,000 and the proportion that end in no further action.

Where we are completing a high rate per 10,000 compared with similar authorities and we have a relatively high rate ending in no further action, it means that we are probably doing too many assessments. This is likely to impact on quality, may impact on timeliness, and represents an over intervention into the lives of families. This last point is important in terms of securing long-term outcomes since research tells us that families tend to be less willing to engage in support services after a social work assessment or child protection enquiry.

Because these boards look at performance across wide ranges of activity, they provide an opportunity to identify and explore reasons behind different performance and practice in different teams. This allows sharing of good practice as well as helping to develop our knowledge about the needs and characteristics of the diverse communities we serve.

Other agenda items may be added to these meetings, provided they relate to improving practice and performance and, ultimately, outcomes for children.

The Director of Children's Social Care should attend these meetings as a participant on a rota basis, again to promote and model analytical discussion, ensure visibility and line of sight to front line practice.

The **Practice and Performance Assurance Board** is the principal forum for collating practice and performance information together for the service as a whole. It will consider summary reports from the Assistant Directors, pulling together the themes from the highlight reports. It will also consider the latest performance information, information collated from audit and other QA activities and service user/stakeholder views to analyse the extent to which the Swindon's children's services are delivering against our priority outcomes.

This will require consideration of performance information against statistical neighbour and England performance as relevant, as well as against local targets.

The Board will be chaired by the Corporate Director of Children's Social Care, who will be responsible for setting the agenda and leading the discussion. The meeting will be attended by Assistant Directors and Service Managers/Heads of Service. The meeting may choose to focus on particular aspects of service delivery on a rotation basis, and will want to consider a variety of other information relevant to understanding the overall performance of the service as a whole, and our impact on outcomes for children and young people. It may decide to invite others to support such discussions.

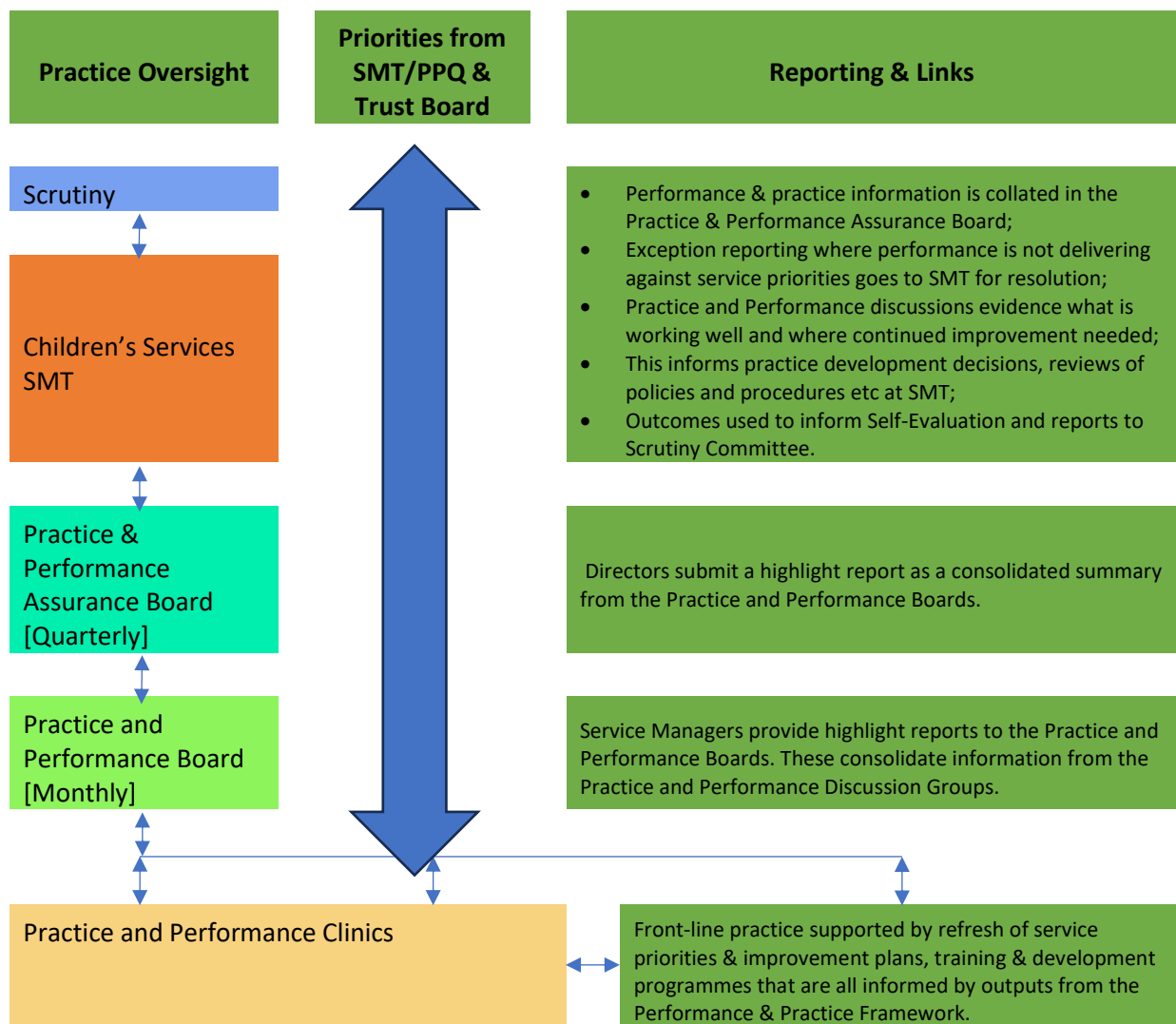
Alongside performance dashboards, the ChAT tool should be available for this meeting in order to support discussion around performance relative to similar areas and England averages.

By collating information in this way, the Board helps to determine strategic priorities and performance targets for the service as a whole.

This board should also consider implications for staffing, recruitment activities, learning and development as well as any financial implications arising from changing needs within communities and/or indications of changing patterns of demand.

Overall governance arrangements

The table below illustrates the overall governance relationships between the practice and performance clinics, performance boards and senior leadership/Member oversight:



9. Closing the loop: Learning and reflective practice

The sequence of practice and performance clinics and boards outlined in Section 8 above provide a clear framework for learning opportunities to be identified as well as assessing the impact of such activities to date at all levels in the organisation. The model ensures that there is a clear and accurate ongoing self-assessment of the overall quality of practice and outcomes being achieved for children and young people. The discussions in these forums also feed directly into the learning and development cycle.

There are a number of other ways that learning from audit, practice observations, feedback from chairs and reviewing officers, parents, children and young people can inform practice and performance across the organisation. These include:

- **The auditing and practice observation process itself:** Feedback from practitioners is clear: they find the opportunity to discuss a case file or a piece of observed practice as being highly valuable. Looking in detail in a reflective way at the work with a child, young person or family provides the opportunity to model best practice, decision making and evaluation of impact. This is part of the reason why completing audit activity is a core part of the role, and not an add on.
- **Reflective case and learning discussions facilitated by Practice Leads:** An important part of the role of the practice lead is to facilitate reflective practice discussions that help to embed best practice. These can be focused on common themes being identified within audit activity, or a discussion around next steps in work with a family, child or young person where progress has become stalled;
- **Reflective discussions led by PSW/QA team?**
- **Regular analysis of performance data:** Team and Service Managers scrutinise the latest performance data, taking operational action and giving direction as required.

Appendices

- Appendix 1: Guided questionnaire for consultation with children, young people and families as part of the case file audit process.
- Appendix 2: The Swindon case file audit tool.
- Appendix 3: The case file audit flowchart.
- Appendix 4: The Swindon Pillars of Practice.
- Appendix 5: Template team manager practice and performance clinic highlight report.
- Appendix 6: Template service manager/head of service report for practice and performance board.
- Appendix 7: Template assistant director report for practice and performance assurance board.
- Appendix 8: Exemplar terms of reference for the practice and performance clinics and boards.