States of Jersey - Children's Service

Independent audit of the quality of front line practice and management

Phase four - care plans and planning for looked after children and young people

Context for the audit

The States of Jersey has invested in and embarked on an ambitious programme to improve the quality of children's social work in Jersey. This commenced with the implementation of rapid improvement plans and was augmented in April 2015 by the two year plan for sustained improvement, (SIP) the key outcome of which is to have good and outstanding social work services for children.

Change and progress in key areas of service delivery will be tested through independent audit and inspection. The Director of Children's Services (DCS) commissioned this independent audit to provide a baseline of front line practice and management. It took place between May and early July 2015.

Scope

The independent audit was conducted in four phases, each focusing on a key area(s) of service delivery within which it is essential that practice and management are robust.

Phase 1: the multi-agency safeguarding hub (MASH), covering responses to and decision-making in relation to contacts and referrals and child protection enquiries undertaken under article 42 whether these originated from the MASH or from social work teams. Phase 1 took place on 11 to 14 May 2015.

Phase 2: assessments and child in need planning. Phase 2 took place on 26 and 26 May 2015.

Phase 3: child protection plans. Phase 3 took place on 9,10 and 11 June 2015.

Phase 4: care plans for children and young people looked after and care leavers.

Key themes, underpinned audit activity in all four phases. The extent to which:-

- Work improves outcomes for children and young people.
- Practice is child centred, reflecting the focus to 'think child'.
- Dimensions of equality are effectively addressed.

Audit approach

A set of audit criteria were developed. These were derived from:

- The Jersey Children Law (2002).
- The Children Placement) (Jersey) Regulations 2005.
- The Children Act 1989 Guidance and Regulations, volume 2: Care Planning, Placement and Case Review (2010).
- Ofsted's inspection and evaluation schedule (2014).
- The department's mimimum standards document.

The criteria cover compliance with statutory regulation as well as what is considered to be 'good' practice. The criteria were agreed in advance of the audit with the DCS and were discussed with staff during the audit.

My approach was that of a 'critical friend' i.e. evaluative and developmental. Case audits were undertaken alongside managers and these discussions offered the opportunity for reflection on practice and management. Positive practice, alongside learning from cases, was highlighted where possible.

Cases were randomly selected by the auditor, from lists supplied by the children's service. These related to children and young people looked after as of 7 May 2015. They included children at different stages in their journey through care, whether by parental agreement or court order and in different placement settings. The sample reflected, where possible, a spread of gender, age and ethnicity.

The focus of the audit was on the quality of care plans and the most recent review of those plans, together with practice and case management over the last 6-9 months. The audit covered children supervised in the permanence, child in need and statutory teams.

The contribution of partner agencies was examined through contributions to review of looked after reviews and information contained in the children's services department case files.

Eight care plans and the associated planning were audited. Seven were of looked after children and young people, although key documents in relation to one of these could not be located and so this audit was not fully comprehensive. One was of a young adult who had left care:-

Cases referred back to senior managers

Senior managers were asked to conduct a learning review in relation to the quality of previous and current care planning in relation to one young person.

Key findings:-

In the light of the detailed verbal feedback already provided, this is a summary of the review's key findings, in relation to the 8 cases audited. Some of these findings are also reflective of the finding of Phases 1, 2 and 3:-

- All of the children and young people were appropriately looked after and attention was paid as to whether children should continue to be looked after.

- Outcomes are positive for four of the children, young people and young adults. Outcomes are mixed for two others and are not improving for the remaining two.

- The quality of care planning for children and young people looked after was variable, but the majority of work met minimum standards. Some aspects of some cases were good but aspects of others fell below minimum standards.

- Half of the children had experienced significant historical and more recent delays in removing them from situations in which they were being harmed.

- Recording systems make it very difficult to piece together the story of a child's 'journey through care'. This makes it harder for staff to quickly gain an understanding of the key issues or to help children understand the reasons they were looked after. The recording system does not support effective management and audit.

- Looked after children and young people have benefited from continuity of social workers who made regular visits to them. Several also benefited from direct work and/or additional therapeutic help.

- Looked after children have also benefited from living with stable and committed residential or foster carers who are helping to keep them safe.

- Half of the children experienced delays in being permanently placed. These were due to lengthy family proceedings and a lack of permanent foster care placements.

- None of the children and young people looked after had an up-to-date core assessment. Most were significantly out of date and key decisions were planned without re-assessment.

- All of the looked after children and young people had a care plan that identified some of their needs, but these were not outcome focused or consistently ambitious. Plans did not identify strategies and actions. The care planning pro-forma requires urgent review.

- Risk assessment and reassessment is not systematically embedded in care planning and review.

- Case recording provides limited evidence of the quality of work undertaken with children and young people.

- Multi-agency participation in care planning reviews and meeting is mixed, and this contributes to delays in resolving issues of concern.

- Contact arrangement are routinely considered but practice in implementing these is variable and contact does not always cover the full range of important connections in a child's life. Where contact was not in a child's best interests, appropriate efforts were made to ensure that harm was minimised.

- All the children were reviewed regularly but not robustly as the level of scrutiny by independent reviewing officers was limited. Delays were not challenged. IROS did not monitor care planning in between reviews. Minutes of reviews were not circulated promptly. Recent movement and changes of independent reviewing officers has presented an additional challenge.

- Children and young people's participation in their reviews was variable.

- Team managers reviewed children in supervision, but this was sometimes too infrequent. Supervision was not sufficiently focused on ensuring that care plans are robustly implemented in a timely way.

- The department's care planning guidance is largely out-of-date and is not comprehensive. It requires urgent review to reflect latest research and good practice.

- The lack of available permanent foster care placements is an increasing concern and some children wait too long for a placement to become available. This is likely to deteriorate further as a consequence of recent action to more robustly protect children and young people.

- Looked after children and young people in Jersey would benefit from a more robust demonstration of ownership and active corporate parenting by the States of Jersey and its partners. Challenges, such as the difficulty in securing enough placements of sufficient range would be better overcome through a collective approach.

- Managers responded positively and non-defensively to the opportunity to explore cases in depth and consider wider questions in relation to thresholds and risk. They were able to develop individual case action plans in relation to those aspects of practice, management and recording that were below minimum standards.

Outcomes

- Outcomes are positive for four children. For example[REDACTED]) Another [REDACTED]

- Outcomes are mixed for two young people. For example, one child [REDACTED]A young adult [REDACTED]

- Outcomes are not improved for two young people, [REDACTED]. It is uncertain how far a period of being looked after, despite efforts, has resulted in sufficient risk reduction for a [REDACTED].

- It was very difficult to understand the child's the child's journey through care, where they had started, the progress they had or had not made and their feelings about and understanding of being looked after. This is, in part, due to poor and incomplete chronologies that do not indicate entry to care, placement moves or changes in family circumstances as well as a lack of clarity in care plans and reports. The basic information record does not include a list of all placements and their reasons for ending.

Child-centred practice

- Looked after children's cases were overseen by permanent and consistent social workers, often for periods of two or three years.

- Managers described workers as developing trusting, reliable and knowledgeable relationship with children and young people but this is not consistently reflected in reports and recording. Opportunities to discuss the purpose of work and the nature of the worker's relationship with a care leaver were missed. [REDACTED]

- Case recordings provided some evidence of the extent to which children's wishes and feelings were sought and understood. Social workers did not always respond to the worries and concerns that children conveyed to them in a timely and effective way. ([REDACTED]) An opportunity to undertake meaningful work in relation to separation was lost as the impact of a change of social worker was not explored. ([REDACTED]) More positively, an understanding of a child's experiences and their subsequent impact on the child demonstrated in one case. ([REDACTED]In another example, the social worker had persisted in making regular contact with a very vulnerable teenager. ([REDACTED])

- Children were offered direct work to help them understand why they are unable to live at home or to help them deal with birth family relationships. Specific life story work work was a feature of three cases but purpose, timescales and progress were not consistently recorded. ([REDACTED]) Direct work was sometimes delayed ([REDACTED]) and children continued to express distress during this time. ([REDACTED])

- None of the children and young people were offered an independent advocate.

Equality and diversity

- Needs arising from dimensions of equality were not taken sufficiently into account. The cultural, racial and class background of birth families and foster carers is not clearly explained in reports or care plans. This is consistent with findings from the previous three Phases.

Choice and stability of placements

- Three of the seven children and young people were in appropriate permanent placements that were meeting needs. ([REDACTED]) A review of whether the current placement remains the most appropriate is needed for one young person. ([REDACTED]).

- A significant challenge is a lack of available local permanent foster carers, especially for children with attachment issues. This has led to and is leading to delays in achieving permanence for three children. ([REDACTED]) It is likely to become an even more pressing issue in the light of robust recent action to remove children for whom periods of child protection registration has been unsuccessful.

- Good efforts have been made to place children safely and securely with connected persons. I was satisfied that this option had been fully explored for those children in long term foster care.

- Good multi-agency co-operation to secure permanent and good quality housing for a young adult who has left care were successful. [REDACTED])

- I saw sound use of resources to provide additional therapeutic support that is contributing to placement stability. For example, [REDACTED]) A ‘therapeutic team’ has been created around another child living [REDACTED].

- A key reason for improving outcomes was the quality of care children received in placement. It was surprising that that foster carers were largely invisible in care planning documentation with very little reference to the nature of the fostering household and its composition. Carers' views of children's development did not feature across key documents such as statutory visits and reviews or in case notes.

- The impact of a [REDACTED] on a foster home was not discussed in care planning and reviews. Children of foster carers did not feature in plans or discussions. [REDACTED])

Up-to-date-assessments and chronologies

- Previous phases identified that many children and young people did not have up-to-date assessments. This was also the case in this sample. None of the seven children and young people still looked after had an up-to-date core assessment. In one case a core assessment was not commissioned before relative were encouraged to apply for a residence order. [REDACTED]) In others, assessments had not been completed for children that had been looked after for some time. (e.g. since 2006) A core assessment in respect of a very challenging young person had not been repeated since 2011. ([REDACTED]).

- The overall poor quality of chronologies is concerning and has a negative impact for workers taking on cases, for managers in supervision work and for auditors. In one instance, it took about 50 minutes to establish an overview of the child's care experience.

The quality of care plans

- All the seven children and young people had a care plan that had been completed within the last 12 months. Plans were not consistently updated after statutory reviews or when circumstances changed.

- The care plan pro-forma does not support the creation of a comprehensive and robust plan. I was informed that it has been in use since at least 2004. There are a number of key gaps; there is no section that requires staff to identify and respond to the risks that children face or pose to others. There is no reference to desired changes and outcomes. The format does not include a section dealing with what services will be provided to meet needs, what specific actions will be taken or require the role of carers and other professionals to be outlined.

- Notwithstanding the limitations posed for social workers by the care plan pro-forma, the quality of care plans requires improvement to reach a good standard and evidence shared ambitions and aspirations for children and young people. A number of features were found across care plans. Not all were found in each case. These were:-
    - The use of overly complex and 'professional language'.
    - A lack of understanding of what an 'outcome' is and how it differs from needs and actions to meet unmet needs.
    - A lack of reference as to why the current placement was chosen and how far it met needs.
    - Needs were not sufficiently specific and detailed, including those relating to ethnicity and diversity.
    - Where needs were identified, actions to meet needs were either absent or were vague, lacked precision and associated timescales.
    - Little reference to risks and strategies to reduce these.
    - Little reference to the role of other practitioners, the focus for their involvement and the hoped for changes resulting from this.
    - Contingency plans were not focused on the particular circumstances of individual children and young people.

- It was positive that care plans were signed by some parents but their views were not recorded. Case records do not clearly include a field to record that parents have been given a copy of the plan.

The quality of placement plans

- The BAAF pro-forma for placement plans is in use for foster care, but I was informed that there is no placement plan for children placed with parents or in residential care.

- I reviewed placement plans for two of the three children who had become looked after or changed placement in the last 6-9 months. The detail with which they were completed was variable. Language included 'jargon' and the information that carers need about children's health and development was not clear or specific enough. More though needs to be given as to how these plans can support carers to provide high quality support.

- I was not able to locate a current placement plan for [REDACTED].

Statutory visits

- Almost all children were seen in time with statutory requirements and these visits were consistently recorded for all children and young people. They were often visited more frequently, ([REDACTED]) including [REDACTED]) Most children were seen alone or babies were seen awake. The first statutory visit was delayed for a child recently looked after. ([REDACTED]).

- The recording of statutory visits is an area for improvement. None of the recordings were clearly good, and in two instances they were inadequate. Visits were not clearly connected to progressing the care plan or actions agreed in reviews. Key features were:-
    - A lack of stated purpose. (e.g. [REDACTED])
    - The progress that was or was not being made was not sufficiently clear. (e.g. [REDACTED])
    - A lack of detail and specificity in describing the visit.
    - Children's views, including in their own words, were not consistently recorded. Work with one child was an exception to this. ([REDACTED]).
    - A lack of reference to the quality of care the placement provided and enquiry into challenges experienced by carers. Foster carers' own children and their relationship to the looked after child were rarely mentioned.

- Not all teams use the same pro-forma to record statutory visits.

Risk assessment and management

- Six children and young people child appeared to be safe in their current placement. (children [REDACTED]) I was told about extensive efforts to keep [REDACTED], vulnerable to sexual exploitation and self destructive behaviour, safe. However, there was no multi-agency risk management plan or multi-agency involvement in care planning and current risks must be reassessed. ([REDACTED])

- The extent and quality of risk assessment/management was variable. Risk assessments and risk management plans are not an integral part of all care planning. For example, the action to be taken to respond to self harm. ([REDACTED]) Care planning documents require revision to ensure that prompts in relation to risk and threat posed to and by children are embedded in them.

- Risk assessments in relation to the threats posed by parents were completed for [REDACTED] children. These had been started at critical points such as the transition to care and appropriately addressed key risk. They included management plans to keep children and, in [REDACTED], workers safe ([REDACTED]). The risk management plans were not reviewed when circumstances and potentially risk levels changed both positively and negatively.

- The risks that could be posed by changing the legal status of one child had not been robustly examined. ([REDACTED])

- A lack of careful risk assessment also had the potential to lead to over reaction, for example in relation to the dangers arising from children having accidental contact with wider family members. ([REDACTED])

[REDACTED]

Contact with birth families and connected persons

- Contact with birth parents and siblings was regularly recorded in care plans and reviews. The challenges arising from contact or the impact of changes in levels of contact were not consistently considered. In one case, [REDACTED]. In some plans better attention was given to contact with parents than with siblings, while in others, it was the reverse. References to wider family and connected persons were infrequent.

- An example was seen of positive, child-focused work to ensure that contact with a birth parent only took place when it was safe. The purpose of contact was very clear and work to minimise the child's potential distress was effective. ([REDACTED])

- A small number of children in foster care had very little contact with birth parents and the reasons for this were not recorded on care plans or in statutory reviews. It must be assumed that these parents did not receive a copy of care plans.

- Sensitive recording of supervised contact was a feature of one case. Detailed descriptions of the interaction between parent and child together with a brief analysis of what had been observed was clearly recorded. ([REDACTED])

Care planning

- Clear, up-to-date multi-agency guidance on the purpose and conduct of care planning meetings is very limited. This contributes to the variability of practice reviewed in this audit.

- Delays in progressing aspects of care plans was also a feature of some cases.

- Practice in relation to holding care planning meetings at an appropriate frequency was variable. Meetings might be held on the same day as a statutory review, which limited their key purpose.

- More benefit could be gained from care planning meetings and their effectiveness was limited. In general, meetings did not clearly focus on the care plan or the actions arising from the last statutory review. In one example, [REDACTED]) key actions were not progressed in the child's timescale. In another, ([REDACTED]) the meeting dealt only with the most pressing issue and did not consider other risks. The record of the meeting was not sufficiently differentiated from the content of a statutory visit in another instance. ([REDACTED])

- Multi-agency attendance at care planning reviews was variable and information about the impact of work was not consistently forthcoming from key agencies, including where children were receiving therapeutic help. Partner agency resources and support were not used to their full effect in work with a vulnerable young person. ([REDACTED])

- The review of health assessment and personal education plans was not a feature of this audit, so I am unable to comment on their quality and the effectiveness of their contribution to improving outcomes.

- The pathway plan for [REDACTED] formerly in care was three years out-of-date. [REDACTED]

Permanency planning

- Two children are in an appropriate permanent foster care placement. (children [REDACTED]) One child, [REDACTED].

- Other children experienced delay in achieving permanence due to three main reasons; failure to act sooner, lengthy family proceedings and a lack of permanent foster care placements. ([REDACTED])

- Some children's difficulties were exacerbated by a failure to take authoritative action soon enough. Children experienced several episodes of child in need work and child protection registration before they were removed. These delays were both historical and more recent. (e.g. [REDACTED])

- Delays occurring during the court process included those due to the time taken to obtain expert witness reports, parental illness, and a lack of available court dates. [REDACTED], with a care plan for adoption, [REDACTED]. Very positively, the child's move to an adoptive placement was then well-planned, swift and matching appeared thorough. ([REDACTED])

- There is scope to pay more careful attention to transitions occurring during the journey to permanence. For example, it did not appear that a social worker who had known a child for some time had prepared the child for their moving on ([REDACTED] and the extent of preparation with foster carers about to take on a permanent placement appeared unclear. ([REDACTED])

- The lack of provision for special guardianship orders meant that the possibility of securing a stronger level of permanency for two children was not an option.

Recording

- Recording are not yet consistently clear, purposeful and succinct. Actions and tasks are not specific enough. Without this, some records read as superficial and do not evidence the quality of work that has taken place.

- Child-centred recording, that, in the words of one manager, gets 'right to the heart of the issues', was the exception, rather than the rule. There should have been a greater focus key aspects of the current care plan and more evidence that difficult issues were tackled during visits e.g[REDACTED]

- Key documents and case notes made very little reference to foster carers, the quality of care they provided or the challenges they faced. In a few examples the composition of the fostering household was not made clear.

Care plan monitoring

- Looked after reviews were generally timely. Delays in holding reviews were explained. A small number of children would have benefited from more frequent reviews of their plans.

- Most review reports met minimum standards. Within this, some were detailed and progress or otherwise was evidenced. (e.g. [REDACTED]) Other reports were more descriptive and did not evaluate the impact of actions or changes in circumstances. In others the quality of information was patchy e.g. a strong focus on some aspects such as reducing delay but silent in relation to others such as risks arising from alcohol misuse or changes in parental circumstances. Social workers consulted with colleagues in partner agencies but the detail of this were not systematically recorded in review reports.

- Multi-agency involvement in reviews was variable and did not always fit with the level of support from other agencies that might have been required. The [REDACTED] was generally in attendance but it was not consistently explained why key agencies such as schools and CAMHS did not attend.

- I appreciate the importance of considering the child's views about whom they would like to attend their review, but in three instances ([REDACTED]) a lack of multi-agency involvement in reviews and care planning meetings was a significant disadvantage and impeded planning. For example, even though there were very concerning issues relating to behaviour at school, no educational professionals attended and it was not clear if they had been invited. ([REDACTED])

- The extent to which children of an appropriate age and understanding were present and participated in their reviews was variable. Positive examples of active participation were seen. ([REDACTED]) In one example, with an IRO new to the child, the child participated well, but changes to contact arrangements and anxieties about progress in achieving permanence were inappropriately discussed. In other instances it was not clear why children did not participate.

- Insufficient numbers of staff together with recent turnover of staff has resulted in a lack of continuity for looked after children and young people in the chairing of their reviews and this did not facilitate their participation.

- Changes in personnel and high workloads go some way to explain why I could find little evidence that IROs monitor care planning between reviews. In one case ([REDACTED]) it was positive that the IRO requested a copy of an updated risk assessment to be sent to them.

- Risks and harms to which children are subject were not a feature of discussions at statutory reviews.

- There was a lack of evidence of robust independent challenge from IROs e.g. delays in completing actions from previous reviews, to PEPS and health assessments, in arranging effective educational placements and undertaking direct work. In one [REDACTED]

- Independence and challenge might be assisted if the required headings for the IRO's report were reviewed. For example, there is no field covering risks to and from the child or young person or if safeguarding issues had emerged. Headings in relation to achievements of looked after children and their participation in leisure activities would also be helpful.

- The underpinning reasons for decisions reached were not made explicit and actions did not routinely have timescales attached to them.

- Circulation of statutory review minutes was not timely. The record of reviews held in May and June in respect of four children had not been received. ([REDACTED]) These delays did not assist social workers in progressing care plans and I was unable to audit three of the four sets of minutes.

- I saw an example of positive practice in a social worker following up inaccurate information in the minutes of a statutory review meeting. ([REDACTED])

- The review of a pathway plan with a young adult formerly in care was insufficiently comprehensive. [REDACTED])

Management oversight and supervision

- Managers had signed care or pathway plans in all cases.

- Some of the cases identified a lack of robust management 'grip' and oversight. All the children had been discussed in supervision once or twice over a twelve month period. This was not frequent enough for several of them, given the level of activity and challenge in the work and the fact that children were at critical points and transitions. I was also told that although supervision had been held, there are backlogs in completing notes and uploading these to children's files.

- A recent strengthening of authoritative management at all levels had led to court proceedings for one child for whom protection planning had been ineffective over a number of years. ([REDACTED])

- Supervision recordings did not show that analysis and challenge had taken place. Key questions in relation to whether children were safe, the quality of care they were receiving, the delays their plans were subject to or the impact of work did not form the core of reflective activity.

- Supervisors did not make sufficient use of care plans and statutory review outcomes to identify priorities. Where appropriate actions were agreed they were not always implemented and supervision of the case was too infrequent to pick up this omission. (e.g. [REDACTED])

- I was struck by the level of distress that children experienced and the anxiety that was created for staff when a permanent placement was not forthcoming. Managers acknowledged that the exploration of the emotional impact of the work on staff is an area for development.

- There is scope for managers to intervene more directly and authoritatively when care planning is 'stuck' or delayed.

Recommendations

The sustained improvement programme is overseeing a number of actions. These recommendations are intended to underpin or supplement these and target the most important priorities for change:-

To ensure that looked after children on Jersey are safeguarded and their life chances promoted

1. Review current arrangements for corporate parenting to ensure that the resources and contributions of elected members, government departments and all partner agencies are used to provide the best possible care for Jersey's looked after children and care leavers.

To ensure that care planning is robust:-

1. Urgently review current care planning guidance and the care plan pro-forma to reflect research, best practice and incorporate risk assessment and re-assessment.

2. All children have a care plan that comprehensively identifies why children are looked after, why the current placement has been chosen, their needs, the risk they might be subject to, the roles of carers and other professionals. Ensure that SMART actions are in place to implement the plan.

3. All care leavers have a comprehensive up-to-date pathway plan that supports their transition to independence.

4. All visits to looked after children and young people have a clear purpose that is related to implementation of the care plan, include observations of and discussions about the quality of care children receive and that the records of statutory visits reflect these discussions.

To ensure that multi-agency reviews of children and young people looked after and care leavers are effective:-

1. All young adults who have left care receive regular reviews of their pathway plans that fully consider all aspects of their life.

2. All statutory reviews consider the full range of required issues, including delays in achieving plans and permanence and that risks are reviewed. The reasons underpinning decisions are recorded and actions and tasks are SMART.

3. Review multi-agency attendance at care planning meetings and reviews so that planning benefits from partners' active participation.

4. Support, including from independent advocates, is provided to help children and young people to express their views about the help they receive and to participate at an appropriate level in their reviews.

To provide effective management oversight of children and young people who are looked after

1. Ensure that there are a sufficient number of permanent and skilled IROs and that they effectively scrutinise and monitor the implementation of care plans.

2. Ensure that all IROs receive regular supervision that provides critical reflection about the quality of chairing, decision-making, independence and challenge in the role.

3. Ensure that social workers for looked after children receive reflective case supervision that focuses on the extent to which the care plan is being achieved, challenges delay and is at a frequency appropriate to the complexity of the case.

To ensure that managers and senior managers across all agencies have an accurate understanding of the quality of front-line practice:-

1. The Children's Services Directorate: to further develop and embed the routine dip sampling and auditing of the work undertaken to ensure that looked after children planning is robust and purposeful.

2. The Children's Services Directorate: to explore with partner agencies the contribution that partners can make to improve the quality of care planning through systematic audits of their contribution, including the quality of health assessments, PEPs and work undertaken by CAMHS.

3. The Independent Safeguarding Service: To develop an audit process in relation to the quality of chairing of looked after reviews that includes routine dip sampling and periodic observation of reviews.

To ensure that all children who need a local permanent placement can be placed in a timely way

1. Review best practice and accelerate current plans to increase the supply of on-island permanent placements, including the use of resources across government and partner agencies to support this.

The following recommendations from Phases 1, 2 and 3 are also relevant to the findings of Phase 4 of the independent audit:-

To ensure that key staff across all agencies have a shared understanding of outcome - based work:-

To improve the lives of children and young people, ensure that staff across all agencies understand the basic features of outcome - based practice and that they consistently consider, review and record the impact of their work on improving outcomes for children.

To ensure that children are at the centre of practice and management:-

Develop a programme of learning and development that enables front-line staff to develop skills in direct work and risk assessment and to consistently use those skills.

The following recommendation is made that is also relevant to Phases 1, 2 and 3 of the independent audit:-

To respond effectively to children's different needs and experiences

All planning and practice is sensitive to, and responds appropriately to, dimensions of equality such as gender, disability, ethnicity, faith and belief, sexual orientation and culture.

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