

NSPCC Consultancy Services

Safeguarding Review By the Bridge

Therapeutic Fostering Services

June 2011

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Review of By the Bridge Safeguarding Practice**

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1. INTRODUCTION

- 1.1. By the Bridge fostering organisation commissioned the National Society for the Prevention of Cruelty to Children (NSPCC) to undertake an independent review of their safeguarding practice relating to children and young people in their care. Practice was reviewed against By the Bridge policies and procedures (standards), and also Fostering Services National Minimum Standards (2011), Working Together to Safeguard Children (2010), and The Children Act 1989 Guidance and Regulations Volume 4 Fostering Services, as relevant. The purpose was three-fold: to ensure that By the Bridge professional practice is in compliance with the standards for safeguarding practice; identify areas of good practice; as well as areas which would benefit from improvement or further development. The review findings provide a baseline of data from which to measure future progress.
- 1.2. NSPCC undertook a previous safeguarding review in 2008 and the overall findings were positive, so it was agreed to focus on challenges for By the Bridge as it expands its business, and also areas which have been identified as benefitting from review. Full details of the aim and scope of the review are attached as appendix A. I have made recommendations only where I consider this will be helpful to assist future practice.
- 1.3. The term 'safeguarding' is used in this report to include primarily child protection, as well as broader situations where children might place themselves/others at risk, and 'children' includes all children and young people looked after in By the Bridge foster families.
- 1.4. The review fieldwork took place between February and April 2011 and includes 4 phases to ensure that I obtained a 'rounded' picture of safeguarding practice. Review phases as follows:
- Review of By the Bridge Child Protection reporting Procedure and Safeguarding Policy, and access to other relevant policies and written information.

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- Accessing a sample of 15 children's family files where there have been recent safeguarding concerns or complaints. I also looked at foster parents personnel files with whom these children reside/d.
 - Three focus groups with foster parents – contributions were received from 28 foster parents.
 - Interviews with 9 staff - 4 link workers, 4 managers, and 1 learning and development advisor.
- 1.5. Usually I would approach/speak with children to obtain their views and experience of how they are treated at By the Bridge. On this occasion, it was agreed that I would not in order to avoid duplication, as By the Bridge children recently took part in an independent review of standards relating to the quality of children's participation. This was undertaken by the Leading Improvements for Looked After Children (LILAC) team. I have a copy of the LILAC report which reflects the views expressed by the children who participated and I will refer to this where relevant in my report.
- 1.6. I wish to thank all By the Bridge staff, including administrative staff, for their co-operation, assistance, and support, without which, this review could not have been completed.

2. METHODOLOGY

- 2.1. **Choosing cases for the review:** I reviewed 15 children's individual family files across all four By the Bridge teams (Midlands, Kent, Essex, and North West) against standards identified in the case review instrument (attached as appendix B). The children's sample was selected from By the Bridge weekly Safeguarding Management and Consultation Records (minutes of meetings between December 2010 and January 2011). At these meetings relevant By the Bridge personnel discuss the individual circumstances of children who are the subject of safeguarding concerns, action is agreed, progress monitored, and follow up pursued where necessary. The scope of the review was to assess practice recording for the preceding 6 months (October 2010 to March 2011) to ensure

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that any learning relates to recent practice. However, in many instances I accessed information beyond this time frame to make sure that I fully understood each child and foster parent family in context. I categorised children's files by the presenting safeguarding concern or complaint - identified in table 1 below. The age of the children whose cases were reviewed ranged between three and seventeen years. Gender was represented by eight female and seven male children. Some individual cases involved sibling groups in placement, although siblings are not represented in the numbers reported.

Table 1: Files reviewed using the case review instrument which captures information regarding what information (documentation) is on file and also the quality of practice

Children's circumstances categorised by nature of presenting safeguarding concern or complaint	Number
Allegation relating to foster parent/s	3 (of these, one related to physical abuse, one involved a child witnessing domestic violence, and one involved inappropriate handling of a child's behaviour)
A child makes an allegation about past abuse	3 (of these, all related to allegations of sexual abuse by birth family)
A child is currently suffering harm or suspected to be suffering harm	3 (of these, one related to allegation about unknown adult sex offender, one involved risks during contact with birth family, and one was of an allegation of professional abuse by a teacher)
Child presenting an actual or potential risk to self or others	2 (of these one related to an unborn baby, and one involved risks to child by absconding behaviour)
A child at risk of harm due to an ongoing medical condition	1 (child with health difficulties that required vigilant and responsive care)
A child or member of their birth family make a complaint about foster parent	3 (of these two complaints were made by children, and one complaint was made by birth parent)
Total	15

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3. SUMMARY OF KEY FINDINGS

3.1. Strengths

- All practice was child centred, demonstrating a high degree of thoughtfulness and commitment alongside sensitivity to the experiences of each individual child.
- Assurance that there is overall compliance with By the Bridge standards and legislative frameworks.
- Overall, well structured and ordered case file recording alongside a good quality of recording by foster parents, link workers and managers, which supports safeguarding practice and demonstrates professional accountability.
- Good evidence of partnership working with foster parents, and a strong commitment to multi-agency working to optimise the best outcomes for children as far as By the Bridge can influence.
- Good examples which demonstrate action taken to ensure children are safeguarded and protected.
- Evidence that the potential vulnerabilities of specific children have been identified and addressed.
- Good management oversight and direction.
- Implementation of case auditing through the management line in order to quality assure local practice on an on-going basis.
- Feedback from foster parents and other staff that By the Bridge is a good organisation with which to work.

3.2. Areas for improvement/development

- Continued enhancement of recording/filing on the database and staff development to assist quality standardisation processes.
- Review and updating of By the Bridge's complaint policy/procedure and training for staff in this regard to support dealing with complaints effectively.
- Consideration of the need to develop an equality and diversity strategy that explicitly states that By the Bridge is an inclusive organisation that promotes equality and diversity in all of its work, and to assist the organisation in identifying priorities against which progress can be measured.

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- A need for managers to communicate on an on-going basis the message to all that while By the Bridge is an evolving growing organisation, commitment to By the Bridge's positive values and strengths remain at the heart of everything they are and do, and this will be taken into the future.

4. PREVIOUS NSPCC RECOMMENDATIONS (2008)

- 4.1. The NSPCC made 10 recommendations in the previous independent safeguarding review and nine were accepted by By the Bridge management team. The recommendation not accepted related to '*create protocols with placing authorities to address such matters as the prompt sharing of information*'. The reason this was not accepted is that any progress is restricted in view of the number of local authorities with whom By the Bridge provides services and their individual responses. That said, work has been undertaken to create links with relevant local authority designated officers (LADO's) and local authority children's safeguarding boards (LSCB's) and this was evidenced in the case sample reviewed.
- 4.2. Of the nine recommendations, six have been fulfilled, and progress made with the remaining three. Examples of some recommendations being met include: an assessment tool to facilitate the assessment of risk at the point of placement; a form fit for purpose that serves to confirm referral information to statutory authorities and notification to Ofsted; implementation of a quality assurance system to monitor and improve recording practice (the new database); roll out of a post approval workshop on safeguarding practice via all foster parent/link worker supervision groups; co-foster parent groups have been set up in three bases to offer support and is intended to help clarify expectations of co-foster parents.
- 4.3. Of the remaining three recommendations there has been ongoing development with varying degrees of progress. For example, a lot of energy has been put into children's participation with a children's participation forum being piloted via the Kent office and such groups are now established and running across all By the Bridge geographical bases. The drive to improve practice has been assisted by

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the LILAC assessment which identified areas of strength and proposed areas for development. It is also acknowledged that progress has been made in relation to By the Bridge managers establishing contacts with senior managers in placing authorities e.g. the business development manager has regular contact with placing authorities. While there has been some focus on some areas of diversity (e.g. training regarding children who have been trafficked or are seeking asylum, By the Bridge information available in different languages, and children are matched to the right foster parent family wherever possible), there is also recognition that 'diversity' covers a broad spectrum which requires continued development and focus. This is commented on later in this report.

5. BY THE BRIDGE SAFEGUARDING POLICY AND PROCEDURES

5.1. By the Bridge *Child Protection Reporting Procedure and Safeguarding Policy* was recently reviewed within their own organisation (September 2010).

Nonetheless, I reviewed it as part of NSPCC's wider safeguarding review and in my opinion this policy and procedure provides robust and sufficiently detailed instructions that make it clear to everyone what to do if they are concerned about a child. A clear and robust policy and procedure is essential to ensure that there is a speedy and effective response for dealing with such concerns.

5.2. In particular I like the inclusion of a form which is signed by all By the Bridge staff, foster parents and contractors confirming that they have read, understand, and will comply with the reporting procedure in the event they become aware of any child protection matter or safeguarding concern. I found evidence of signed safeguarding forms on foster parent personnel files. Engagement of all individuals involved with children supports a position of active use of such a policy/procedure. The visual flowcharts provide a useful guide about what to do in different circumstances.

5.3. Separate to this report I have made minor suggestions for further enhancement, for example regarding updating some wording (formal definitions of abuse), and consideration being given to adding a code of conduct in the safeguarding policy.

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One example could be to explicitly state the expectation to value and respect children as individuals – a code of conduct would supplement the foster parent agreement that is already in place.

- 5.4. The By the Bridge *Essential Reporting Policy (2008)* and written guidance for staff and foster parents about what, why, and when to complete incident reports, also form part of safeguarding and safe caring strategies which make clear the expectations of foster parents, link workers, and managers.

6. RECORDING AND USE OF THE NEW ELECTRONIC DATABASE

- 6.1. Since mid-2010 By the Bridge staff (with the exception of By the Bridge North West) began using a new electronic database (known as CRM) to record all information about children and foster parents. It was agreed that I would access some children's family files/foster parent personnel files using the database to see how accessible information was, as well as hard copy files where appropriate. I accessed records relating to children (selected as part of the case sample) by team in the following way:

- Accessed electronic records only – Kent and Essex (7 cases)
- Accessed both hard copy and electronic records – Midlands (4 cases)
- Accessed hard copy records only – North West (4 cases)

NB: The North West service recently integrated with By the Bridge and will also use the database in due course.

- 6.2. The safeguarding manager initially showed me how to use the database and following this I accessed records independently. I found the database easy to use and logical in how file sections are structured and stored. I particularly found it helpful that there is a specific section to record safeguarding concerns/incidents which make it easier to retrieve such information expediently when required. Records on the database were clear and accessible e.g. family and professional information was complete, records brief and concise and the majority of cases were up to date. Where there were exceptions these mainly related to foster parent diaries (submitted monthly) not being sufficiently up to date. In one child's

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family file, there were few records about the child on the database – this involved a child who was placed with By the Bridge for a short time before implementation of the new database and who had since moved on. In this instance, I accessed hard copy records. Where gaps in information held on the database existed in nearly all instances the information could be found on hard copy files.

- 6.3. However, while relevant information on the database had been recorded (with the exception of the one commented on above), in 3 cases (of the 11 accessed via the database) some information was not filed in the correct place. For example, in one instance complaint information was found in the child's file but not in the foster parents file and should have been retrievable from the complaints section. In the remaining cases recording was found as an attachment to an email, but was not then filed in the correct folder. It is important that records are stored in the correct file section to assist quick retrieval when necessary and to ensure that management data collection is accurate for auditing purposes. I have made a recommendation in this regard.

Recommendation 1

By the Bridge managers need to ensure that link workers/administrators file all records in the correct folder on the database to support easy retrieval of information.

- 6.4. All files provided necessary information to show the child's story and children had a multi-agency plan in place. Reviews were up to date and appropriately demonstrated active involvement of children in plans and decisions about their lives (this was also a positive finding in the LILAC report 2011). In addition, for each child in a foster parent family By the Bridge ensured completion of a safe care plan, risk assessment, and a placement plan which supports good practice as expectations are explicit. Alongside, there was strong evidence in recording to show that link workers provide ongoing support and guidance to foster parents e.g. via regular home visits, and weekly telephone calls as a minimum.

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- 6.5. By the Bridge link workers and managers reported that while there had been some ‘teething problems’ in early use of the database (e.g. system going down), generally they found it easy to use and particularly beneficial in providing accessible information about children and families as needed e.g. *“information is readily available”*. Managers are clear that as an integrated database it has assisted the quality of information recorded and standardisation across sites, which is positive. Other benefits of the database include the ability to generate reports (e.g. about supervision) and that workflows are built in which assist the quality assurance manager in being able to gather statistical data and monitor progress on a rolling basis e.g. Ofsted notifications.
- 6.6. In addition to effective quality assurance processes operated centrally, all files have either been fully audited or are in the process of being audited locally and findings discussed with workers via supervision. The safeguarding manager discusses individual cases (where there are safeguarding concerns) with link workers/managers via the safeguarding forum and also accesses CRM to ensure the quality of practice and follow through. Alongside, the quality assurance manager visits all sites to spot audit child and family files on a regular basis. In interview, one link worker suggested the idea of link workers undertaking each other’s foster parent annual reviews in order to bring more objectivity to the process and support consistent and shared practices. Audit offers the opportunity to check what is being done and consider whether it could be done better. Self-assessment/auditing on the ground in many instances can be seen as a mechanism to empower staff in their commitment to on-going professional development while also assisting shared learning and standardisation where this is appropriate. It is positive to find that By the Bridge have robust systems in this regard.

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7. QUALITY OF PRACTICE BY PRESENTING SAFEGUARDING CONCERN OR COMPLAINT

7.1. **Allegation relating to foster parent/s:** Three cases were reviewed of children who had made allegations about a foster parent. Of these, in two instances information came to light via information shared with respite foster parents and in the remaining case a child raised concerns with their local authority social worker.

- All children to whom the concerns relate are no longer in placement.
- One child was moved out of placement as a direct result of the allegation of inappropriate handling of behaviour. In this instance, there were issues about the immediacy of the child being moved and the proportionality of this action to the presenting concern when the matter was considered in its entirety e.g. the level of risk and the impact upon the child of being moved in an unplanned manner. By the Bridge appropriately raised this with the local authority questioning if the right action had been taken and also for the purpose of capturing learning for future practice. It is recognised that ultimately decisions about children's future rest with the placing authority. Support has been offered to the foster parents in this situation, including Foster Talk (allegation service). Prior to the child's move the link worker also asked the out of hours service to contact the foster parents in order to offer ongoing support, and this was provided.
- One child had already moved out of the foster family home when the concern was raised, and there were already plans for the other child to move.
- In two cases there were other children in placement and their local authority was informed of the allegation, in order that they could make their own assessment considering the children's best interests in full knowledge of events. For example, in one case there was a shared view across agencies (including discussion with Ofsted) that it was in the children's best interests to remain in placement, which they did with supportive measures in place.
- In both situations where concerns were disclosed to respite foster parents there was a delay (e.g. two days) before they reported the incident to their link workers. While it is acknowledged that individuals may feel uneasy passing on concerns in respect of colleagues, this needs to be done without delay in

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accordance with By the Bridge reporting procedures which states “*allegations must be reported immediately*”.

- Of the three cases, two had relevant incident reports on file, although there was a delay with both (of 3 days and nearly two weeks) – outside the procedural requirement of being completed and submitted within one working day. The remaining case did not have an incident report on file, although the information was clear in an email and also in the completed Ofsted notification form.

Recommendation 2

By the Bridge safeguarding manager should remind foster parents that as soon as they become aware of any child protection matter/safeguarding concern (including those relating to other foster parents) they are required to notify the organisation *immediately* and complete/submit an incident report within *one working day* in line with policy and procedures.

- Strategy discussions took place in all cases to which By the Bridge contributed in some way.
- As required, the local safeguarding designated officer (LADO) was informed of allegations in a timely way in all three cases.
- Situations evidenced By the Bridge’s strong commitment to multi-agency working – showing good communication with foster parents, placing authorities, and other professionals as necessary.
- By the Bridge demonstrated strong evidence of good child focussed practice. In my opinion considerations regarding all children in placement were measured and reasonable and not knee jerk reactions to being presented with challenging issues.
- In all three cases the foster parents were re-presented to fostering panel and measures agreed proportionate to each situation e.g. in one case training and support was explored, alongside ongoing monitoring of the quality of fostering provided by the family.

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- There was good evidence of management oversight and direction in all three cases reviewed, which included By the Bridge's team managers and the safeguarding manager.

7.2. A child makes an allegation about past abuse:

Three cases reviewed related to children who disclosed historical sexual abuse in respect of their birth family, with some children displaying sexually harmful behaviour towards other children and also placing themselves at increased risk of harm.

- All three cases (with one instance where there was an exception) demonstrated that on occasions when it came to the attention of foster parents that a child in their care had suffered harm or is suspected of suffering harm in the past (and/or that due to related behaviour a child may be presenting an actual or potential risk to others) they verbally and directly reported it to By the Bridge immediately. The one exception involved an incident while on holiday and the foster parent reported it when the family returned home. This foster parent's usual practice was to report concerns immediately, but nonetheless the link worker reminded the carer of the need to report incidents even during holidays and this was accepted by the foster parent.
- With two exceptions, incident reports were completed and submitted in accordance with By the Bridge reporting procedure. One exception has already been commented upon and the other related to another foster parent who was then prompted by the link worker and this was then submitted.
- By the Bridge staff followed policy and procedures in all three cases.
- One case led to an extensive child protection investigation by the local authority and police and By the Bridge contributed and cooperated fully. This enquiry also related to the protection of other children not known to By the Bridge. In this situation there was strong evidence of effective communication and information sharing between agencies.
- One case showed good evidence of By the Bridge following up progress with the local authority on a weekly basis. The local authority and police decided not to progress a child protection enquiry. It was believed that the abuse

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concerns were already known and the child had recently been spoken to and did not wish to pursue allegations and felt happy and safe in placement. It was agreed that the foster parent would vigilantly monitor any further attempts to disclose by the child.

- In the remaining case child protection enquiries were pursued, the child interviewed, and an individual was arrested but denied allegations. The local authority and police considered there was insufficient evidence to take further. By the Bridge queried why a strategy meeting had not taken place and also challenged the local authority for not keeping them informed despite By the Bridge staff persistently chasing up progress.
- By the Bridge staff showed a strong commitment to good multi-agency practice.
- Professional accountability was demonstrated by the link workers and there was evidence of clear management oversight.
- By the Bridge recording and safeguarding practice was to a high standard in work with these children and staff and foster parents did their utmost to ensure that the focus remained on the children involved.

7.3. A child is currently suffering harm or suspected to be suffering harm:

Three cases were reviewed involving recent concerns about risk to children outside their foster family home. Of these, one related to an incident of an adult exhibiting sexually offending behaviour in the community, one was of concern about professional abuse by a teacher, and the remaining situation concerned risks to children during contact with birth family.

- Compliance with legislation and having a child centred approach was strong in all three cases.
- In two cases By the Bridge foster parents, link workers and the safeguarding manager demonstrated exemplary safeguarding practice. For example, in one case the foster parent immediately reported concerns to By the Bridge, the police and local authority social worker and followed this up with completion and submission of a By the Bridge incident report which was recorded to a high standard. The foster parents listened to, offered support, and acted on

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what the child disclosed demonstrating good child centred practice. Another example, involved By the Bridge positively influencing the direction of a child protection enquiry relating to professional abuse which fully took account of wider risks to other children. This enquiry widened to include concerns associated with poor safeguarding practice by a school and resulted in appropriate referral to the Independent Safeguarding Authority in relation to both the individual teacher and the school. There is evidence to show that the action taken was significantly influenced by representations made by By the Bridge.

- In the remaining case, safeguarding practice was good. The foster parent communicated concerns to the link worker in accordance with procedure. By the Bridge reported concerns to the local authority social worker and influenced the agreed action which was followed through to ensure the protection of children. However, there were other incidents relating to sibling behaviour in placement which had been reported to the link worker, but one such incident which occurred out of hours should have been reported to the out of hours service. This has been discussed with the foster parents to inform future practice.
- Safeguarding records contained all relevant information and management accountability was good with evidence of endorsement of plans, decisions, and actions.
- There was commitment to diversity in all aspects of work. For example, this is well evidenced in foster parent diaries and schedule 7 submissions which demonstrated that the individual needs of children and their identity was appropriately considered and responded to.

7.4. Child presenting an actual or potential risk to self or others:

Two children's family files were reviewed involving a child about whom there were concerns about potential risks to her unborn baby, and the other related to risks to a child during periods of absconding from the foster family home.

- In both cases intervention was planned, purposeful, and timely and there was good evidence of a child centred approach to work.

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- There was evidence of effective communication and information sharing.
- There was evidence of good safeguarding practice, which demonstrated By the Bridge's compliance with standards, relevant legislation and statutory guidance. For example, when a child went missing the foster parent immediately reported this to By the Bridge out of hours service who then informed the local authority emergency duty team and the Police. There were particular concerns about this child being vulnerable to sexual exploitation/harm and this was responded to sensitively, including the Police taking the matter seriously. While a strategy meeting was not convened full interagency discussion occurred and plans made which resulted in the child being moved to another foster family out of the area to ensure the child's safety.
- In the situation where there were concerns about a young person's unborn baby, By the Bridge appropriately challenged the local authority for inconsistency in meeting statutory requirements for visiting the young person who was pregnant and the case not having an allocated social worker. When safeguarding concerns arose a local authority duty social worker did visit to undertake a pre-birth assessment and the young person later moved to a mother and baby unit, which was appropriate.
- There was strong management oversight, which included involvement of the safeguarding manager and registered manager in both cases.

7.5. A child at risk of harm due to an ongoing medical condition:

This child was discussed at the Safeguarding Forum and I included it in the review case sample as an example of the board nature of concerns discussed at such meetings.

- There were no safeguarding concerns about this child as a result of the care received from foster parents or from other parties. However, in view of this child's serious medical condition it was necessary to discuss fully to ensure that the child received the best possible care within the foster family and also from health professionals in order for health to improve.

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- The foster parents have been responsive to this child's needs and vigilant regarding ongoing care and attention. For example, the foster parent appropriately took the child to the doctor's when symptoms presented and the child was then referred to hospital. The foster parent immediately reported this to By the Bridge out of hours service and the local authority and link worker were informed. The illness report form was completed and submitted as necessary.
- There were also a number of serious incident reports on this child's file completed by the foster parent, which again showed compliance with By the Bridge policy and procedure.
- There was good evidence of partnership working with all relevant individuals, with strong evidence of child focussed recording and practice. I understand that the child's health is now making good progress which is great news.

7.6. A child or member of their birth family make a complaint about a foster parent:

By the Bridge are aware of a need to develop their practice regarding complaints/representations, and as such it was agreed that I would review a small sample of situations whereby complaints/concerns have been made. Alongside, I accessed By the Bridge's complaint policy. Three complaints were selected. Of these, two involved complaints from children and one was made by a child's birth parent – all related to the care/treatment received by foster parents while children were in their care.

- One complaint was made by a birth parent after a placement disrupted and the child was moved to another foster family. The outcome of this complaint was that it was unfounded, which seems reasonable in the circumstances. Initial investigation of the matter showed that the matter was reported by the foster parent at the time and there was a completed incident report which provided a full account of the presenting situation and how the foster parent responded. The complainant did not request to move to the second stage of the complaint process and the complaint concluded.

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- Aspects of the other two complaints were found to be cause for concern and resulted in the need for the foster parents to be reassessed and return to panel.
- In one foster family the matter which gave rise to the complaint was addressed with the foster parent and the unwanted behaviour ceased. There has been a reduction in the number of children that can be placed with the foster family alongside other supportive measures. The foster parent has since resigned from By the Bridge.
- With regard to the other complaint further assessment has identified questions about the quality of care provided and decisions are yet to be made about the outcome of the complaint.
- In all three complaints full liaison appropriately occurred with the children's placing local authority.
- In my opinion, the complaints have been responded to by By the Bridge with due care and consideration to foster parents, balanced with ensuring that the needs and care of children remain the primary focus.
- The LILAC assessment report (2011) is clear that By the Bridge meets the standard for complaints and advocacy. For example, findings report that 85 per cent (from a sample of 47) '*children confirmed they had been either told or seen information about how to complain*', and 86 per cent (from a sample of 50) foster parents said '*information on how to complain was displayed or available in their home*'. I have seen information which By the Bridge provides to children in their care about complaints information which makes it clear what they can do if they are not happy with the way they are treated and want to make a complaint. This is good practice.
- In addition to the proposal in the LILAC report to '*create a new complaints policy or procedure aimed at children*', I would like to recommend that By the Bridge Complaints and Feedback Policy is reviewed and updated to ensure it meets statutory requirements and best practice. For example, regarding the timescales for dealing with complaints at various stages, the role of advocacy, the need for independence at stage 3 of the complaint process, reference to the Local Government Ombudsman, and a clear procedure showing clarity

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about the role of those involved in dealing with the complaint (*Getting the Best from Complaints* regulations, DfES (now DfE), 2006).

Recommendation 3

The managing director should ensure that By the Bridge's Complaints and Feedback Policy and Procedure is reviewed and updated to ensure it meets statutory requirements and reflects best practice.

Recommendation 4

The managing director should ensure that relevant By the Bridge staff receive training/support in using the updated Complaints and Feedback policy and procedure in order that complaints/compliments/representations are responded to effectively.

- It is important to do our best to get it right to ensure that children's voices are heard and necessary improvements in service delivery made. Advice from children on how best deal with complaints is that procedures should be "*quick and easy*", those hearing complaints should "*listen and take action*", and organisations should "*always sort it out*" (*Commission for Social Care Inspection, 2005*).

8. FOCUS GROUPS WITH FOSTER PARENTS

- 8.1. Three focus groups were held with foster parents, two in the Midlands and one in Kent with approximately 28 foster parents contributing. Foster parents I met joined By the Bridge between six months and nine years ago, with some having prior experience of fostering for other organisations. Nearly all had current children in placement and many had experience of a number of children previously placed. Some had children sibling groups in their care. I prepared questions aimed at capturing how foster parents ensure that safeguarding and the welfare of children is the first priority in their work.
- 8.2. I was impressed by the level of professionalism, expertise and honesty shown by the foster parents. They expressed great empathy and understanding for the children in their care, while at the same time expressing clearly the challenges that the foster parent role presents, requiring "*immense personal and family*

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sacrifices” to provide quality care for children who have in the majority of instances experienced abusive and disruptive backgrounds and are living with the consequences. There was a view that *“nothing can prepare you for the reality of fostering, even though By the Bridge do their best to prepare you”*. Interestingly, two thirds expressed feelings of not being treated as professionals by others outside By the Bridge, but confirmed that By the Bridge do try to remedy this and challenge others when necessary. They also reported a significant variance in the quality of local authority social work practice in relation to the children in foster families.

8.3. By the Bridge strengths were expressed as:

- *“Clear what the expectations are of foster parents when there are safeguarding concerns/incidents”*.
- *“The standard of training provided is really good”*, with one foster parent saying *“training is phenomenal”*.
- *“Support from link workers who are always there to support and offer advice – you couldn’t expect much more”*.
- *“Group supervision is really good and support from each other is valued – as other foster parents appreciate what it is really like to be a foster parent”*.
- *“Good that By the Bridge pay for membership of foster parents membership to Foster Talk”*.
- *Responding to the diverse individual needs of children e.g. foster parents developing expertise and knowledge in responding to the cultural needs of children seeking asylum”*.

8.4. Foster parents perception of what By the Bridge could do better:

- *“Less paperwork – there is too much to do “*.
- *“Anxiety that with the growth of By the Bridge and changes being made that the personal touch and family ethos may be lost and this is what attracted us to the organisation in the first place”*.

Information to the contrary was reported to me by managers and there may be a need for further communication to foster parents that the values and ethos

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will be maintained and this is a priority for By the Bridge, so I have made a recommendation. I make further comment at 9.2. of this report.

Recommendation 5

The managing director/managers should ensure that the message is reiterated, to all foster parents and staff that *commitment to the positive values and strengths of By the Bridge remain at the heart of everything By the Bridge is about and does, and this will be taken into the future as the organisation grows and evolves.*

- *“Some concern that as a business By the Bridge may at times be reluctant to challenge poor practice or bad decisions by local authorities that affect children for fear that future commissions may be lost”.*

I found no evidence to support this view in the children’s family files accessed or in interviews with link workers/managers. In fact some foster parents also provided examples of By the Bridge raising issues with local authority staff. There may of course be occasions of differing professional views between By the Bridge and foster parents about individual children’s interests. It is important that in each circumstance By the Bridge is clear with foster parents what, when, and how matters will or will not be raised with local authorities and the reason for this.

9. INTERVIEWS WITH LINK WORKERS AND MANAGERS

- 9.1. Four link workers (across three bases), four managers (including the managing director, safeguarding manager, quality assurance manager and one team manager), and one learning and development advisor contributed to this review. All had a wealth of experience, knowledge, and skills relating to children, particularly looked after children.
- 9.2. Commitment was expressed about the quality of, and need for balanced decision making in safeguarding practice in order to get the best for children. Attempts are made to get the balance as right as possible when challenging others about safeguarding practice and sustaining positive partnership working with others, who ultimately make decisions about children. The needs of children are always placed first by By the Bridge – and managers recognise the importance of

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organisational values, strengths, and ethos needing to be sustained as the organisation moves forward – this was not underestimated by managers. Managers provided a range of examples to demonstrate the great lengths they go to in order to ensure that the culture is communicated, protected and valued e.g. environments designed to promote common values of warmth, value and worth to everyone who is part of By the Bridge as well as those who come into contact with the organisation. Even so, a significant minority of foster parents felt this may be threatened so I have made a recommendation in an attempt to further strengthen communication in this regard.

- 9.3. By the Bridge was identified as a good place to work and the combination of staff with fostering backgrounds/experience alongside staff with recent local authority experience (particularly with child protection knowledge and experience) is seen as a real positive, as each can learn and compliment the other. Supervision was reported to be received regularly with managers and other staff appropriately seeing this as a priority. Although I did not test this by accessing staff supervision records as part of this review.
- 9.4. There was recognition that as a growing organisation there was a need for further standardisation and development of policies and procedures to support good practice. For example, there is some confusion about the complaint process and I have already made recommendations about this. In addition, while progress has been made in relation to equality and diversity within the workforce and in relation to meeting the needs of children who are placed with families, there may be a need to refocus in this area. Development of an equality and diversity strategy that assists the organisation in setting priorities and monitoring progress may be beneficial and I have made such a recommendation. The strategy could include areas such as: reaching and helping a more diverse range of children; accessibility; recruitment and retention processes; learning and development; and measuring performance.

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Recommendation 6

By the Bridge management team should consider the benefits of developing an equality and diversity strategy, for the purpose of assisting the organisation in identifying diversity priorities against which progress can be measured.

10. RECOMMENDATIONS

- 10.1. By the Bridge managers need to ensure that link workers/administrators file all records in the correct folder on the database to support easy retrieval of information.
- 10.2. By the Bridge safeguarding manager should remind foster parents that as soon as they become aware of any child protection matter/safeguarding concern (including those relating to other foster parents) they are required to notify the organisation *immediately* and complete/submit an incident report within *one working day* in line with policy and procedures.
- 10.3. The managing director ensures that By the Bridge's Feedback Policy and Procedure is reviewed and updated to ensure it meets statutory requirements and reflects best practice.
- 10.4. The managing director should ensure that relevant By the Bridge staff receive training/support in using the updated Complaints and Feedback Policy and Procedure in order that complaints/compliments/representations are responded to effectively.
- 10.5. The managing director/managers should ensure that the clear message is reiterated, to all foster parents and staff that *commitment to the positive values and strengths of By the Bridge remain at the heart of everything By the Bridge is about and does, and this will be taken into the future as the organisation grows and evolves.*

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10.6. By the Bridge management team should consider the benefits of developing an equality and diversity strategy, for the purpose of assisting the organisation in identifying diversity priorities against which progress can be measured.

Wendy Noctor

NSPCC Senior Consultant

17 June 2011

APPENDIX A

AIM AND SCOPE

Aim of the safeguarding review:

- To undertake a review of By the Bridge's safeguarding policy and procedures to ensure they are fit for purpose
- To examine the extent to which staff/managers (across all four teams) respond appropriately to concerns that children have been abused or placed themselves/others at risk
- To assess the extent to which staff/managers are using the new database to support quick and reliable access to information to support good safeguarding practice
- To assess the extent to which children are enabled to raise concerns/complaints and examine how these are responded to
- To assess the extent to which progress has been made in respect of the review recommendations (made in 2008).

Methodology/scope:

- Reviewing/accessing By the Bridge's safeguarding policy and procedures and reference to other relevant external procedures and guidance documents
- Examining minutes of management meetings (previous two/three months) focussing on consultation/guidance slots where safeguarding concerns in relation to children are discussed (to include concerns taken by out of hours staff). The case sample (at least three cases from each of the four teams) will be selected to reflect a range of safeguarding concerns (selected from the minutes of safeguarding meetings). Related records will be accessed using both hard copy and database records.
NB: Safeguarding matters often comprise: historical allegations, sexually harmful behaviour, physical assaults by/of other children, risky behaviour, some complaints about foster parents
- Examination of a sample of records pertaining to complaints made by children while in the care of By the Bridge. Where possible, to speak with young people to obtain their views about how concerns raised by them are responded to, and/or explore with them if they feel able to and know what to do in the event they wish to make a complaint/raise a concern
- Discussion with a small sample of staff/managers/foster parents involved with the selected case sample