Coventry City Council

Briefing note

To: Education and Children's Services Scrutiny Board **Date: 15 September 2016**

Subject: Quality Assurance Audits

1 Purpose of the Note

1.1 To inform the Education and Children's Services Scrutiny Board (2) of the progress on Quality Assurance and Auditing over the last six months.

2 Recommendations

2.1 It is recommended that the Education and Children's Services Scrutiny Board:

1) Consider the information presented and note the progress made to date.

2) Identify any recommendations to the appropriate Cabinet Member.

3 Background/Information

3.1 The Quality Assurance and Continuous Improvement Framework was revised in December 2015. It focuses specifically on casework services for children provided by children's social care and early help services with an emphasis on quality assurance that underpins continuous improvement. The framework has been used to support improved outcomes. Assuring quality of practice is essential to the provision of a good service to the children and young people of Coventry. A revised Audit schedule for 2016 is part of the framework which is updated monthly.

3.2 Since November 2015 there has been a renewed and relentless focus on improving the quality of practice through the audit and review cycle, which is linked to developing practice through the use of supervision, team meetings, practice improvement forums and manager briefings.

3.3 The service have developed a more robust programme of audits to inform continuous practice

4 Improvement.

4.1 Audits have been undertaken by a number of different sources, including, Practice Improvement Partners and the LSCB. The outcomes of each audit have led to the construction of action plans, focused on using the findings of audits to drive up the quality of practice.

4.2 The results of audits have reinforced findings across a range of different services along the child's journey. This has allowed for some triangulation and definitive conclusions in relation to both the strengths and weaknesses in practice across the whole of Children's Services.

4.3 The headlines from the audits are:

1. Children are seen, and they are listened to.
2. Social Workers are committed and motivated.
3. There are some examples of good practice.
4. Early help workers are proactive and tenacious when intervening with families.
5. There are early signs that practice is becoming less reactive.

6. Conferences are beginning, through Signs of Safety to consider a more collaborative approach.
7. Care planning continues to cause concern, with drift and lack of contingency planning.
8. Neglect and "start again" syndrome is highly visible on a high proportion of cases including those held in early help.
9. Focus is on assessment, rather than on intervention, impact and outcomes.
10. Looked after Children, have too many moves.
11. Life Story work continues to be inconsistent.
12. Placement sufficiency has a negative impact on the ability of the service to identify appropriate placements for those young people ready for independence.
13. Whilst children are being seen, it is sometimes unclear about the purpose of the visit or nature of the intervention.
14. Recording is still inconsistent
15. Use of chronologies is not routine or properly understood.
16. Supervision is task focused and not reflective.

4.4 Whilst audits have identified the deficits in practice it has allowed senior managers to begin in collaboration with training courses and the Principal Social Worker to develop action plans which will facilitate clear processes, learning through: action learning sets, the Performance Improvement Forums, formal training, reflective supervision, informal/formal workshops. This will begin to have an impact on the quality of practice; repeat audits in certain areas will then evidence improvement. The on-going monthly audits should show an increase in the number of those cases where practice is considered good, as opposed to "not yet good enough".

4.5 The inconsistent quality of the actual audits, as opposed to the practice has meant work has also had to be undertaken to help managers develop skills in auditing to be able to conduct an audit with the impact on the child firmly at the centre as opposed to a task centred management audit. Mentoring and support has begun to develop "audit champions" who are confident and able to audit with the impact on the child being the primary focus.

5 Indicators and audit – the connection

5.1 Indications are numerical and as such relate to quantity and timeliness whilst the analysis of data around indicators identifies the trajectory against benchmark and target, this does not in itself give a narrative about quality. The trend of an indicator, however, is often the first sign that there may be problems relating to the quality of practice. It is therefore, critical to analyse and interrogate indicators, in order to hypothesise about practice and then test the hypothesis through the audit process. In relation to audits undertaken in Coventry, other than the regular monthly ones, it has been the indicators which have led to move to a detailed exploration of certain areas of practice, through the audit process. Through examination of data, the following audits were identified as necessary:

1. Re referrals (% was raising)
2. Placement Stability (% of children with 3 or more placements increasing)
3. Use of Police Powers (numbers appeared high in comparison with statistical neighbours)
4. Thresholds (LSCB audit, following high number of families receiving one visit and NFA)
5. Care Planning (LSCB audit, concern that care plans do not reflect outcomes for children rather they detail actions for parents)
6. Early Help (re-referral audit identified potential issues with step-up and step-down)
7. Ofsted preparation audit.

5.2 All of the above have now been completed. Continuing interrogation of data will help to evidence where practice is improving and conversely where there might continue to be problems. Indicators, alone however, are not an accurate barometer of the quality of practice more an early warning sign or confirmation of improvement.

6 Closing the audit loop – improving practice

6.1 Once audits have been completed, and this includes the regular monthly audits, a report is produced, detailing the findings, both in terms of areas for improvement and existing strengths. There is also a set of recommendations attached to the report. Reports are then sent to relevant Heads of Service and the Principle Social Worker. Heads of Service produce action plans which address the areas for improvement, within their service area. Action plans are sent to the Head of Safeguarding to monitor their progress, through quarterly quality assurance meetings. This does not, however, replace individual performance clinics in each service area, which are held more regularly.

6.2 A number of mechanisms have been introduced to enable learning from audits to be disseminated to staff. These include, the practice improvement forum, learning sets, formal and informal training, training through LSCB, learning reviews, workforce development and through reflective supervision.

6.3 The regular monthly audits show a steady improvement in practice with the identification of an increasing number of good cases which can be used for appreciative enquiry. Dip sampling in individual service areas, will also evidence whether learning is becoming embedded.

6.4 The safeguarding team, (CP Chairs and IRO's) also have a quality assurance and scrutiny role. They are beginning to demonstrate more robust challenge in relation to perceived poor practice and they are expected to identify areas of concerns which may warrant further attention, input and development. The process for management alerts when concerns are identified has been reinforced and is now in line with the IRO management handbook.

7 Moving forward and next steps

1. Training in audit process, from the view of the outcome / impact on the child, has now been undertaken by 3 cohorts of managers/IRO. This will enable the actual quality of the audit to become more child centred, and therefore learning will also become more child focused. This should lead to practice becoming more about outcomes and impact which will begin as a natural consequence to improve practice.

2. A planned Ofsted preparation audit was undertaken mid-June by those trained in the new audit format.

3. The quality assurance framework includes a programme of audits. This will be added to as appropriate through the use of performance data and practice outcomes.

4. A programme of learning will be developed and delivered through regular mandatory practice improvement forums.

5. Audit outcomes will be used to identify and commission training.

6. Trend analysis will be completed over the next 3 months, to measure any differences in the outcomes of audits – ie. The number of good, and not yet good. If training / learning / supervision is having an impact on practice the number of cases audited as good, should gradually increase.

8 Update July 2016 - Overview.

8.1 The new audit tool has been introduced which replaces the existing audit judgements of; inadequate, requires improvement, good and outstanding with: not yet meets good, meets good and exceeds good. The focus of the new audit tool is about the impact of social work intervention on the child and whether this is evidenced throughout the file and in discussion with the allocated social worker. The process of audit then becomes less about a management review and more about understanding the child's experience and being able to evidence that intervention has had a positive impact/outcome for the child.

8.2 Training in relation to the new audit tool has been provided. This is, however, in its infancy and it has become clear that staff find the new audit tool difficult with the focus continuing to be about what has/has not been done rather than being able to assess the impact on the child. It will take some further training and practice for this more child centred approach to embed.

8.3 There have been a number of audits conducted through the LSCB which have been multi agency these have been very successful and helped to bring agencies together to compare views and look at a shared understanding of what good looks like.

8.4 A further selection of audits have been conducted. These audits have usually been commissioned due to questions raised by the performance data and have been specific to areas where the data has suggested that something is not quite right and requires further examination.

9 Summary of Audit Activity: January to June 2016.

9.1 Monthly case file audits; completed by heads of service, service managers and team managers. These have been moderated by the head of safeguarding. Total number of case file audits from January to May 2016 is 81 in addition 10 were specific to the voice of the child only. An Ofsted preparation audit was undertaken with 25 case file audits. There were also a total, over the same timeframe, 36 case file audits undertaken within in children and families first.

- Children with 3 or more placement moves.
- Missing Children. (LSCB)
- Children made Subject of Police Powers.
- Quality of Practice review.
- Re Entry into Care.
- Section 47.
- Private Fostering.
- Early Help.
- Re referrals.
- Thresholds for Referral (LSCB)
- Care Plans (LSCB).
- Children with Disability child protection.

9.2 Each of these audits have a set of recommendations based on audit findings which have been sent to relevant heads of service to develop action plans to address the issues. These action plans are held by Quality Assurance who will monitor progress against the action plans through continuous audit and feedback. This should focus on areas of strength as well as weakness. These action plans should be scrutinized through a quarterly performance meeting.

9.3 The audits undertaken through the Quality and Effectiveness sub group of the LSCB have generated a multi-agency action plan. Due to the themes from each of the 3 LSCB audits being interlinked and having commonality, the action plan is a combined one taking the learning from each of the 3 audits. This action plan will be monitored through the QE sub group. Any relevant training will be raised through the LSCB training sub group.

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