Coventry City Council

Briefing note

To: Education and Children's Services Scrutiny Board **Date: 6 April 2017**

Subject: Quality Assurance Framework

1 Purpose of the Note

1.1 To inform the Education and Children's Services Scrutiny Board (2) of the progress on Quality Assurance to date and provide details of the framework.

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 (**Appendix 1)** was revised in December 2015 and last updated in October 2016. The quality assurance and continuous improvement framework articulates how Coventry City Council Children's Services manages and measures quality. Improving the consistency in the quality of work improves outcomes for Coventry's children. This supports the development of a culture that expects and values high standards that improve the quality of service to users and carers. These aspirations and standards drive up expectations, improve learning and strengthen outcomes and impact.

3.2 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 2017 is part of the framework which is updated monthly. **(Appendix 2)**

3.3 The framework continues to evolve as changes as a result of information learnt from the assurance activity is embedded. It is informed by learning from the audits, single agency learning reviews and serious case reviews overseen by Coventry Safeguarding Children Board.

3.4 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.

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

4 Improvement

4.1 As indicated in the September 2016 briefing 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 from 2016/17 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 these audits were:

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 always reflective.

4.4 Whilst audits have identified the deficits in practice it has allowed senior managers to begin in collaboration with the Principal Social Worker to develop action plans which will facilitate learning through: action learning sets, the Performance Improvement Forums, formal training, reflective supervision, and informal/formal workshops. This will 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 Performance Indicators and audit – the connection

5.1 Performance Indicators 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, in addition to regular monthly audits 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. Inspection 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 will then be produced, detailing the findings, both in terms of areas for improvement and existing strengths. There will also be a set of recommendations attached to the report. Reports will then be sent to relevant Strategic Lead's and the Principal Social Worker. Strategic Lead's produce action plans which address the areas for improvement, within their service area. Action plans will then be sent to the Strategic Lead for Quality Assurance to monitor their progress, through quarterly quality assurance meetings. This does not, however, replace individual performance clinics in each service area, which are normally held fortnightly. This approach will be rigorously applied to all audits going forward.

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 Child Protection (CP) Chairs and Independent Reviewing Officer's (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

7.1 Training in auditing for impact and outcomes, has now been undertaken by 4 cohorts of managers/IRO's. During December, this training has continued ensuring the development of Service Managers, IROs and first line managers to undertake audits in the new audit model. This will increase the pool of current auditors and offer additional capacity to carry out monthly audits. As well as training auditors, four quality assurance workshops were also held and attended by service managers, team managers, senior practitioners and focused on the impacts & outcomes on children's case recordings. 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.

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

7.3 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.

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

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

7.6 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 external audits - Overview

8.1 An external audit team has been commissioned to undertake a rapid programme of audits across the system to provide assurance that risk is being 'held' in the right part of the system and that management oversight and 'grip' is sufficient. The audit programme has assessed the quality of recent (last 6 months) front line practice across all areas of the child's journey. The audits also included an assessment of the findings in the recent Ofsted monitoring inspection as follows:

- Timeliness of the response to, management, and reduction of risk
- Robustness of the interventions and plans
- Challenge from IRO and CP Chairs when risk is identified
- Quality of management oversight and supervision.

8.2 It is intended that this work will be completed in two stages. Stage one has taken place during January and February 2017 and stage two in approximately six months' time (post inspection) so that we can evidence the progress and improvements made.

8.3 The selection of cases covers the child's journey using the Ofsted methodology. The cases also include a sample of cases that have already been subject to the monthly audit programme in the last 6 months to evaluate if practice and outcomes have improved. Audits have mostly been undertaken remotely based on the case recording on Protocol, using the agreed audit tool. The list of cases has been shared with them. Managers have received verbal feedback during the course of the programme that commenced in January 2017.

8.4 Approximately 150 cases have been audited to date. The emerging findings are as follows:

Children in need of help and protection – strengths

- Evidence of good information sharing between agencies in the MASH, timely decisions, analysis of risks using the signs of safety model and sound management oversight
- Initial contacts from anonymous source appear to be escalated to referrals evidencing learning from SCR reviews
- Some good recordings of evidence of the child's journey and the social worker understanding of impact
- Some evidence that decisions in S47 cases were clear and focussed to achieve change
- Evidence of communication with children which had an impact on intervention (though children were not always seen alone)
- In RAS assessments were allocated with no delay

- Good coordination between the social worker, parent/carers, health, third sector and schools where information was shared so there could be a consistent approach to meeting the child's needs
- Use of Signs of Safety methodology in CP cases
- Young people's wishes and feelings were considered as part of the CP reviews and Core Group Meetings
- Some exemplars of good practice identified
- Most assessments were completed promptly and were comprehensive, using the Signs of Safety format, which assisted analysis and agreeing focused plans where necessary
- Warm handovers between the previous social worker and the new early help practitioner is good practice and focuses on the families experiences

Children in need of help and protection – development

- Variable threshold application at the front door - over reliance on the Level 3 practitioners to respond to new concerns arising on a case already opened to their service
- The quality of the information shared by some professionals at the point of initial contact is variable from adequate information sharing between the referrer and SW to very poor and sparse
- Drift and delay in strategy discussions taking place in some cases, an inconsistent quality
- Assessments in domestic abuse cases can be overly optimistic and rely on parents' reassurance that the relationships were over
- History of families are not being thoroughly and consistently considered as part of initial triage
- Supervision is not always regular and inconsistent use of Signs of Safety
- Over optimism about parents ability to change and expectations not clear
- Lack of challenge and drift in CiN cases
- Some delays in progressing to an LPM or ICPC
- Lack of exploration of the impact of diversity
- Assessments not updated
- Chronologies not always up to date and not used to inform plans and decision making
- Case summaries don't always include relevant information about the journey of the child
- Signs of safety not embedded across all services

Children looked after and achieving permanence – strengths

- Some good evidence of direct work being undertaken with children and young people
- Good engagement with parents (including absent parents)
- Children seen regularly and alone by social worker and IRO
- Some good examples of supervision using signs of safety
- PEPs and pathways plans updated in a timely way
- Evidence of the IRO footprint more visible
- Personal Advisors work effectively with Housing

Children looked after and achieving permanence – development

- Delays in transferring cases to Route 21 and unnecessary hand off to another change of social worker
- Decision making and recording too variable, descriptive, often repeating what the social worker has said
- Case summaries do not reflect the child's history, particularly in leaving care
- Evidence in drift and delays in achieving emotional and legal security/permanency
- Assessments not updated when circumstances change
- Chronologies not updated and do not contain the right information
- Delays in undertaking life story work
- The quality of plans is too variable, some plans lacked detail, not SMART
- In some Section 20 arrangements it was not always explicit as to what was expected of the parents in terms of what they needed to change/improve
- Timeliness in relation to completion of assessments was variable
- The level of coordination and information sharing between Personal Advisors and Probation was inconsistent
- Some young people remained vulnerable in the community and were putting themselves and others at risk due to their criminal behaviour
- Supervision is not regular and is not done using signs of safety methodology

8.5 There will be 2 final reports covering children in need of help and protection and children looked after and achieving permanence.. An action plan will be formulated based on the recommendations.

It is evident that practice is improving from a low base. Only through audit and by identifying the issues in practice will it be possible to drive up standards, improve practice and make a difference to children's lives.

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