Coventry City Council

Briefing note

To: Education and Children's Services Scrutiny Board **Date: 11 January 2018**

Subject: Quality Assurance Audit Activity

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 activity to date and provide a summary of case audit activity undertaken in Children's Services in this financial year.

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) Agree that Members from the Education and Children's Services Scrutiny Board (2) attend a Children's Services Audit Workshop, following SB2 on 14th February 2018.

3 Background/Information

3.1 The Quality Assurance and Continuous Improvement Framework was revised in December 2015 and last updated in October 2016. This 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 to improve the experience of users and carers. These aspirations and standards drive up expectations, improve learning, and strengthen outcomes and impact.

3.2 The Quality Assurance and Continuous Improvement Framework 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 2017/18 is part of the framework which is updated monthly.

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 January 2017 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 has developed a more robust programme of audit activity to inform continuous improvement in front line practice.

4 Monthly audit activity

4.1 Quality Assurance activity is mandatory for all managers across Children's Services.

4.2 Case audit activity, focussing on the impact and outcomes on children and observations of practice, are completed by managers at all levels, from the Director of Children Services to front line managers.

4.3 10% of audits are moderated by a Senior Manager to check for consistency and a standard approach.

4.4 Managers are engaged in developing action plans from audit findings.

4.5 Learning is collated and shared with staff at the Practice Improvement Forums for managers and front line practitioners.

4.6 A newly developed audit tool is now embedded onto Protocol for Social Care audits which means outcomes of audits are immediately available to managers and lead professionals.

4.7 Early Help audits are completed in word format and added to the child's file.

4.8 The audit tool used across Children Services is based on the Ofsted case tracking audit tool, which focus on outcomes based on the evidence and impact on children's lives.

4.9 Areas of audit activity identified by changes in our performance data also take place and inform the future Quality Assurance Framework schedule.

5 Training and good practice

5.1 Quality Assurance workshops were held in April and June 2017 for managers at all levels and were led by Neil Macdonald Strategic Lead, Quality Assurance and Palvinder Kudhail, Interim Strategic Lead, Improvement. Their purpose was to refresh managers' skills in undertaking audits and further Quality Assurance workshops will be held in January/February 2018.

5.2 Audit training was held in July and September 2017 and is ongoing for managers at all levels. Further audit training is scheduled for January, 2018. Training is facilitated by Steve Hart, Chair, Improvement Board and Palvinder Kudhail, Interim Strategic Lead, Improvement.

5.3 During 2017, audit training was rolled out for all Early Help managers. This has widened the area of quality assurance into Early Help whilst also increasing the pool of auditors currently completing audits on a monthly basis to cover all service areas across Children's Services.

5.4 Good practice audit exemplars are now available for managers to model their audits on.

5.5 Good practice guidance is available for practitioners on specific audit themes, such as Chronology Guidance.

6 Lead Member & Scrutiny Oversight

6.1 The Lead Member takes an active role in the work of Children's Services and regularly receives monthly audit highlight reports from Strategic Lead, Quality Assurance and Director of Children's Services. Quality Assurance audit activity reports are also taken to Education and Children's Services Scrutiny Board.

7 Senior Management Oversight

7.1 Senior Managers ensure quality assurance processes are consistently implemented and that learning informs practice change to safeguard and ensure an impact for children and young people.

8 Quality Assurance Reporting

8.1 Quality Assurance reports are produced and will inform decision and business planning for children's services, measure performance against our priorities and outcomes for children and young people.

8.1 Action plans are produced to monitor progress of audit recommendations and actions.

8.2 Each audit undertaken includes direct feedback and discussion between the auditor and the case holder, and where appropriate, the team manager. This provides an immediate opportunity to discuss good practice and improvement opportunities, and agree timescales for any actions required to bring cases up to standard.

8.3 Senior Managers undertake moderation of at least 10% of audits and provide feedback to the individual auditors where the moderators adjusts the overall judgement or identify any additional actions.

8.4 Where the auditor does not grade a case as at least 'meets good', Team Managers and Operational Leads ensure that appropriate corrective action has taken place within timescales set by the auditor to improve this specific case and outcomes for the child.

9. Findings from Audit Activity 2017

The results of audits from 2017/18 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 weakness in practice across the whole of Children's Services.

10 Audits undertaken in April and May 2017

In April, audit activity was limited to 4 audits due to the manager's quality assurance workshops taking place and the Ofsted Inspection in March 2017. These audits were identified as Annex H cases as a result of the Ofsted Inspection and were subject to a re-audit in April. The audits consisted of 2 cases of looked after children and 2 cases that were subject to child protection plans. The overall judgements by auditors and agreed by the moderators were that all 4 audits were judged 'does not meet good'.

In May, a total of 19 Children in Need audits were undertaken on cases held in Children's Disability Team, Family Placement Service, Referral and Assessment Service, North East Area, South Area, Looked after Children and in the CSE teams. The Auditors judged 1 (5%) case as 'meets good' whilst the remaining 18 (95%) cases were judged as 'does not meet good'. Areas of progress and requiring further improvement have been identified through the audits for learning and are outlined below.

10.1 Areas of progress

- Co-ordination between agencies is good in some cases, with all professionals working together to an agreed plan that supports the young person and family.

- Placements were judged to be either appropriate or meeting the young person's or child's needs with carers receiving appropriate support.

- The independent Reviewing Officer (IRO) continues to provide robust challenge and seeks to ensure there is no drift in one case. This scrutiny will ensure that the support provided is making good progress.

- The regular sharing of information between one family, their social worker and school resulted in the establishment of a good working relationship leading to improved outcomes for the children.

- Overall, there was some evidence that the social work involvement had improved outcomes for the child or young person and was keeping them safe from harm. Family members also benefitted and were fully supported and their needs met.

10.2 Areas requiring improvement

- Decision making was not timely or effective with little evidence provided to indicate decisions taken at professional meetings.
- Assessments were either incomplete, contained limited evidence or historical factors had not been included, and in some cases were not of a suitable standard that would enable the help required for the family.
- Plans were not always updated and could be smarter or progressed in a timely way and in some cases were either missing from files or recommendations had not always been acted on.
- Risk assessments were either missing, of poor quality, not up to date or not yet actioned.
- Children, young people and family members' were not always appropriately involved due to either lack of communication with professionals or limited information held on files.
- Information on diversity was lacking on most cases and the exploration of how this impacts on children and young people in terms of their lived experience.
- In a number of cases co-ordination between agencies needed to be better.
- Reviews were limited. There was either little or no evidence of sufficient scrutiny and robust challenge to ensure children were making good progress.

11 <u>Audits undertaken in June and July 2017</u>

In June, 20 child protection audits were undertaken on cases held in North East, North West, South and in the CSE team. The auditors judged 1 (5%) case as 'meets good' whilst the remaining 19 (95%) cases were judged as 'does not meet good'.

A dip sample of 47 cases was completed in June, looking specifically at return home interviews. These cases were not graded.

In July, 30 audits were undertaken on cases held in Childrens Disability Team, Referral and Assessment, North East, North West, South, Looked After Children, Children's Families First teams. The audits consisted of 17 cases that went to an Initial Child Protection Conference, 10 Early Help cases and 3 Child in Need cases. The auditors judged the children's cases as 1 (3.3%) 'exceeds good'; 7 (23.3%) 'meets good' whilst the remaining 22 (73.3%) were judged as 'does not meet good'.

6 managers undertook observations of Initial Child Protection Case Conference meetings. The results of the meetings were judged as 2 (33%) 'exceeds good', 2 (33%) 'meets good' and 2 (33%) 'does not meet good'.

A dip sample of 10 cases which went through the MASH was also completed in July, these cases were not graded.

Areas of progress and requiring further improvement have been identified through the audits and dip samples for learning and are outlined below.

11.1 Areas of Progress

- Partner agencies were actively involved in attending meetings and sharing information. There was evidence of good communication and where there was joint working, this appeared to be effective.

- Timescales for Initial Child Protection Case Conferences were met.
- Conference chair spent time with one family explaining how the conference would run.
- Use of Signs of Safety was good with one family taking ownership.
- Conference chair used closed access appropriately.
- The professionalism of one chair in managing an extremely challenging conference meant a complaint was avoided.
- The Chair encouraged a relaxed environment and listened carefully to other's views.

11.2 Areas requiring improvement

- Plans were not always updated and in most cases were out of date or not progressed in a timely way.
- Plans and assessments would benefit from smarter timescales.
- Further consideration of diversity in its widest form is required.
- Clearer information regarding the type of intervention which has taken place and how this has helped the child or young person.
- Assessments to include detailed information such as historical and parental factors.
- Chronologies were out of date and need to be updated.
- Significant issues regarding lack of information in reports.
- The practice of the Chair completing a genogram at the conference and missing family history increased the length of the conference.
- Some parents received the Child Protection Conference report the day prior to the conference meeting.
- Information shared in conference that the father was not aware of.
- Significant time spent on information sharing as opposed to evaluation/analysis of the risks.
- The language/terminology used by professionals could be simplified so that parents can understand it.
- There should be a practitioner with adequate and proportionate working knowledge of the case to be present at conference meetings.

12. Audits undertaken in September and October 2017

This section summarises the key findings arising out of the collation of children's services quality assurance activity undertaken during September and October 2017.

In September 15 managers completed 'looked after children' audits and 6 managers completed early help audits. The Looked After Children cases were randomly selected from the Looked After children and Neighbourhood teams. The early help cases were a mix of level 2 and level 3, all led by early help professionals in Coventry City Council teams.

In total, 21 cases were audited, 11 (52%) were judged as 'meets good', 10 (48%) were judged as 'does not meet good'. In these cases outcomes fell short of our expectations.

In October 9 managers completed audits on Section 47 (Child Protection) cases with a focus on domestic abuse, and 9 managers completed audits on child in need and child protection cases with a focus on neglect. 14 managers completed early help audits. All cases were randomly selected from these cohorts.

In total, 32 cases were audited and judgements were made using the 3 point score of 'exceeds good', 'meets good' and 'does not meet good'. 12 (37.5%) were judged overall as 'meets good' and 20 (67.5%) were judged as 'does not meet good'. No cases were judged 'exceeds good'.

12.1 Areas of progress

- In the majority of cases risks were correctly identified, responded to and reduced in a timely way and safeguards put in place to keep children safe. Significant progress had been made by the professionals and parents to improve the outcomes for the children.

- There was good evidence of the involvement of children, young people, and family members being appropriately involved in the assessment, planning and intervention process. In cases where children were too young to express their views, representation was sought from either a guardian or advocate.

- Joint working with professionals and partner agencies was considered good with professionals sharing information ensuring the safety of the child was the main focus.

- Looked after reviews had been regular and Independent Reviewing Officer's robust in scrutinising the care planning process to ensure the support for the child or young person was making good progress.

- There was good evidence of the involvement of children, young people, and family members being appropriately involved in assessments and Team Around the Family (TAF) meetings.

- In a number of cases, consideration had been given to issues of diversity and the likely impact on the child. Information was provided in assessments and reflected in their care plans. In one case, the worker worked jointly with professionals to understand the family's cultural background and in doing so, was able to help the family sensitively understand the assessment and the help provided by the service.

12.2 Areas requiring improvement

- In most cases, assessments were either incomplete, out of date or did not include an up to date chronology and therefore did not reflecting the child's whole story. Without an up to date chronology there is not a complete picture that tells the young person's or child's story and without an up to date assessment, it is unclear how the intervention has supported the child or young person and what progress has been made.

- Decision making has not been timely or effective and in some cases contain limited evidence of management oversight. Not only does this make it difficult to assess the level of reflective decision making but can also lead to drift and delay. In one case the decisions made for the child have not protected them from further abuse.

- The majority of care plans did not contain SMART timescales. This means there is no way of measuring whether the plan has been effective or not.

- The identified risks to the child or young person were unclear and in one case, there has not been any clear analysis or critical thinking in identifying the risk. Therefore, it is unclear how the intervention has supported the child or young person and what progress has been made.

- There was limited evidence of involving either the mother, father or young person in the care planning process.

- In a number of cases there was limited evidence to suggest that any consideration has been given with regards to diversity and its impact. Without considering and exploring the child's diversity, opportunities will be missed to provide the full support needed by the child.

- Review of care plans have not been regular, scrutinised or challenged robustly.

13 Audits undertaken in November 2017 and Audit Schedule

In November, 12 supervision case files audits were undertaken and a 174 dip samples of contacts coming into the MASH. These have now been completed and draft reports are being taken to the Children' Services Leadership Team Meeting on the 8th of January.

The table below outlines the audit schedule until the 31st of March, 2018.

Month	Audit Activity
December 2017	1. Local Authority Designated Officer (allegations against professionals) – case file audit. 2. Looked After Children in long-term foster care – case file audit. 3. Early Help – observations of practice by managers.
January 2018	1. Early Help cases – case file audit. 2. Children with disabilities – case file audit. 3. Child in Need review – observation by Operational Leads. 4. Looked After Children review – observation by Strategic Leads & Director of Children's Services.
February 2018	1. Adoption – case file audit. 2. Private fostering – case file audit. 3. Care Leavers – case file audit.
March 2018	1. Children in need – re-audit of case files. 2. Early Help - re-audit of case files. 3. Young carers – case file audit.

14 Conclusion

The themes from audit activity have been identified both in relation to areas of progress and those requiring improvement. Where audits have identified deficits in practice and a number are repeat themes it has allowed senior managers in collaboration with the Operational Leads, Team Managers and Principal Social Worker to develop action plans which will facilitate learning. This learning will take place through: action learning sets, discussions at the Practice Improvement Forums, manager's briefings, 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. This is particularly important where there are repeat themes and the need to evidence that practice learning has had an impact through re-auditing to demonstrate outcomes are improving for children. Audit themes and activity including re-auditing are linked to the Coventry Children's Services Improvement Plan - Getting to Good.

Continuing interrogation of data will also help to evidence where practice is improving and conversely where there might continue to be challenges. Indicators alone, however, are not an accurate barometer of the quality of practice more an early warning sign or confirmation of improvement.

Once audits have been completed, reports are produced detailing the findings, both in terms of areas for improvement and existing strengths. Recommendations are also attached to the report. Reports are sent to Director of Children's Services, Strategic Lead's and the Principal Social Worker. Front and middle managers take part in developing action plans which address the areas for improvement within their service area. Action plans are monitored through 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.

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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