# **CHESHIRE EAST COUNCIL**

## **REPORT TO: Children And Families Senior Management Team**

Date of Meeting:	22.12.10
Report of:	Glynis Williams and Kate Rose
Subject/Title:	Quality Assurance social care audits

#### 1.0 Purpose of Report

To update SMT on the first cycle of the Quality Assurance Social Care Audits and highlight key areas of concern.

#### 2.0 Background

The Quality Assurance Frame work audit paper came to ELT in July 2010 from the Interim Principal Safeguarding Manager.

The first cycle was intentioned to introduce the tools, familiarise the managers with the auditing role and establish some early findings both in relation to the process and quality of social care's practice in keeping children safe.

The audits were carried out in pairs by Group Managers and Independent Safeguarding Chairs (ISC's). The Safeguarding Unit oversaw and administrated these audits, providing training, support and guidance. This cycle's theme was Child Protection.

#### 3.0 For discussion

Findings:

There were 29 audits requested and 26 were completed and returned by the auditing team. The 3 that were not returned have been followed up but the delay has meant that it was not possible to include them in the analysis within this report. This anomaly was not representative of the process as a whole, and there has been excellent engagement from the auditors involved with most attending the training offered, familiarising themselves with the audit tool and contributing to the process. The absent reports are a reflection of specific circumstances.

In reviewing the findings it is important to recognise there are clear limitations. The methodology needs to develop much further, both in terms of the process, including statistical significance of the audit sample; what the audits are telling us about the standards we set ourselves, the quality of the work social care are providing and the difference it is making in keeping children and young people in Cheshire East safe.

These tentative results need to be viewed within that context and not assumed as a definitive reflection of the current position of practice across the service as a whole.

The initial findings identified 8 key areas : (the figure represents where evidence was on file)

- Core groups that were held regularly and judged of good quality -60%
- Involvement of parents in core groups -50%
- Evidence of gate keeping and decision making on file (although this was covered in the tool it was not answered in all cases and therefore a meaningful figure can not be ascertained)
- Care Plan judged to be of good quality -60%
- Child seen at point of core assessments -60%
- Complaints info made available for families -48%
- Evidence of involvement of parents and child at initial assessments -48%
- Supervision notes evident on Paris -70%

#### Analysis:

As stated previously, any analysis needs to be viewed with great caution as the process and tools are in their early stages of development. Of equal significance, there is no historical benchmark that allows any judgement as to whether this is an improvement against standards or what the expectation of achievement should be. It is also important to note that there may be an issue of the evidence not being located consistently in the same place within records, rather than it not having been done. This may mean that evidence has been missed by the auditors

The raw data suggests that there are improvements that can be made in all areas but in only two areas was compliance with expectations below 50%. It may be of significance that these were both areas that related to the involvement and information for families in the process. It is possible that this should be the focus of more concentrated work if it is representative of a current gap in service delivery. The advocacy contract has recently been awarded to Barnardos and the service has been widened to facilitate all service users (children) to access advocacy not just our Cared for population

There is evidence that the quality of the work is judged good in 60% of cases audited in the areas considered and it my be useful to develop exemplars of good work for staff based on the audits, to help drive up standards, if this has not already been done.

There are some 'quick wins' that can be made to improve performance in some areas that are possibly a reflection of staff 'forgetting' the requirements e.g. complaints information being made available, evidencing that a child has been seen. This can be through sending out reminders or implementing processes that ensure it occurs each time.

Lesson's from the process:

There are number of areas that can be developed further as the auditing cycle progresses in relation to improving the process itself:

- The tools need refinement to ensure that they: capture what is required, that this reflects agreed standards of practice and also allows for more descriptive evaluation of the judgements made.
- The tools need to be established within a performance framework that brings together the quantitative and the qualitative data such that they inform each other and the themes and priorities for improvement. It also needs to bring together all the areas of audit currently planned or underway both across services and within service areas e.g. supervision files
- The Auditor's feed back very clearly indicated that using ICS presented huge challenges in trying to locate some of the simplest of documents. Local variations on where to store certain documents within ICS was prevalent and the variations on use of paper files varied greatly.
- There needs to be a way of capturing the wider organisational issues that impact on cases such as managing vacancies and changes in social workers and team managers, in order to provide a context for the findings.

### 4.0 Recommendation/Actions

- That SMT accept the findings within the report
- There is agreement to continue with the Quality Assurance Social Care Audits -cycle two, reporting next to SMT in February 2011. The next theme is Cared for Children post 16
- Report the outcome from the Audits to the LSCB QA&PM sub group
- Feedback to Group Managers and ISCs (Auditors) with the overview of findings and disseminate to Social work staff
- That a steering group is established, led by the Safeguarding Unit to refine and develop the audit tool, develop a framework for auditing across children's social care, which incorporates SCR findings, inspection criteria and locally determined practice priorities and bring this draft report back to SMT at a later date
- Make cycle improvements benchmarking against existing areas highlighted in this report and creating new ones.

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