Herefordshire Council

MEETING:	**HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE**
DATE:	**2 MAY 2013**
TITLE OF REPORT:	**AUDIT PROGRAMME FOLLOWING OFSTED INSPECTION**
REPORT BY:	**Head of Safeguarding & Review**

1. Classification

1.1 Open

2. Key Decision

2.1 This is not a key decision

3. Wards Affected

3.1 County-wide

4. Purpose

4.1 To advise the Committee on the outcome of the audit programme undertaken in response to the Ofsted Inspection Report into Children's Safeguarding Services in Herefordshire.

5. Recommendation(s)

5.1 That members note the findings of the audit programme and the actions being taken in response to the resulting recommendations.

6. Key Points Summary

6.1 The findings of the audit reflect the conclusions of the Ofsted inspection in respect of interagency thresholds for service, case work, recording, management decisions and oversight, and the outcomes for children. The findings also reflect Ofsted's areas for improvement including the quality and regularity of supervision, quality assurance and the timeliness and quality of assessments.

6.2 There are a number of recommendations for improvement for inclusion in an action plan arising from the audit programme.

7. Alternative Options

7.1 There are no alternative options as a requirement by Ofsted.

8. Reasons for Recommendations

8.1 The recommendations are a direct result of the findings of the audit programme

9. Introduction and Background

9.1 The audit was commissioned by Herefordshire County Council and undertaken by Outcomes UK in response to a requirement in the report of an inspection of local arrangements for the protection of children conducted by Ofsted and published on 19 October 2012 to "audit all cases closed in the last three months and risk assess all current cases within children's social care services (and) ensure that this led to appropriate action to protect children effectively".

9.2 A total of 1,440 cases were audited, including 91 by Herefordshire social workers with support from the audit team.

9.3 The audit work was undertaken by a team of 9 auditors over a period of 8 weeks from early November 2012.

9.4 Cases were audited against two pro-formas developed by Outcomes UK in consultation with, and approval from, managers from the department. One was comprehensive and designed to be used for closed cases, and the other was to risk assess the current cases (Appendix A). Judgements were made using the Ofsted Grade Descriptors for the inspections of local authority arrangements for child protection services, i.e. Outstanding, Good, Adequate and Inadequate. In addition, to assist staff and managers in responding to cases deemed to be inadequate, a subset of descriptors was developed by the Lead auditor which specified the nature and immediacy the deficiencies identified. (Appendix B)

10. Key Considerations

10.1 The below themes have been identified as significantly recurring issues that HCC should attend to.

Recording Practices

10.2 Auditors identified a number of common failures within a range of case records. This suggests either that staff were unaware of the required procedures for record keeping, or there was a culture within the service that tolerated noncompliance with them.

Eligibility for service

10.3 There would appear to be a culture in the service that suggests that cases that do not include child protection concerns do not fall within eligibility criteria. This can mean that some children in need do not receive an appropriate level of or, subsequently, services to meet their needs.

Lack of analysis or enquiry

10.4 There is insufficient analysis of information contained in case records before decisions about contacts, referrals and further action are taken. It would appear that social workers and managers are relying on the recording system to do this rather than questioning, amending and updating information.

Supervision skills

10.5 From the audits completed we concluded that supervision appears not to happen regularly or in line with local policy or recognised good practice supervision guidance.

Interagency working

10.6 There is a lack of clarity about interagency working practices and the way the lead agency (usually Children's Services) coordinates activity and ensures a coherent approach to the work with the child and family overall.

Casework practise and management oversight

10.7 While 22 per cent of cases were judged to be of good quality or better and there was evidence of a more rigorous approach by managers to ensuring that specific approaches should be undertaken in individual cases in the last few months, overall the quality of social work intervention was extremely variable.

Recommendations for Improvement

10.8 The following proposals complement and in some instances add to the understanding of the key areas identified in the Ofsted inspection, September 2012.

10.8.1 A quality assurance system will assist in embedding a service improvement culture aimed providing better outcomes for children through improved management oversight and clearer and more consistent recording practices.

10.8.2 Current guidance on record keeping should be reviewed to ensure it complements the Frameworki structure and to provide clarity for staff about recording practice and file structures, and ease of access for service users when required. It should include the requirement to maintain up to date chronologies and transfer summaries where appropriate. Its application should be monitored via the QA and audit processes described above.

10.8.3 All case records should be accessible, accurate and up to date, in particular case plans, and running records should be complete and timely.

10.8.4 Interagency eligibility criteria should reviewed (preferably using the LSCB processes) to ensure that they are clearly understood by all partners and implemented by practitioners. Their application should be monitored by the LSCB and through the LA's QA system.

10.8.5 The council should explore the possibility of developing a joint protocol for responding to reports of domestic violence with West Mercia Police. This could be developed in collaboration with neighbouring local authorities.

10.8.6 The quality, timeliness and recording of assessments should be considered and appropriate training provided to staff and first line mangers. There are a number of easily accessible methodologies which can be used to analyse risk, e.g. Signs of Safety, London Safeguarding Board Risk Analysis tool, Positively Safe, The Victorian Risk Assessment Framework (State of Victoria Australia) among others.

10.8.7 Multi-agency collaboration on individual cases should include clear roles for each professional and organisation and clearly specify the lead agency with responsibility for coordinating each agency's contribution.

10.8.8 CAFs should not be used as a substitute for child protection or children in need plans.

10.8.9 Individual case supervision decisions should be routinely and regularly included on the relevant record at a frequency and level of detailed defined by local procedures.

10.8.10 The application of supervision requirements should be rigorously monitored.

Response to the Report

10.9 The Report has identified similar issues and themes to those within the Ofsted Report and the findings are an accurate representation of the standard of casework within the department. All

of the recommendations have been fully accepted are being addressed via the existing Improvement Plan with progress already having been made in a number of areas.

10.10 The Audit has been hugely demanding but has assisted in:

- Identifying under performance with specific cases;
- Identifying issues in LAC services;
- Reinforcing key messages from the Inspection;
- Confirming under performance within sections of the department;
- Reinforcing the worth of systematic case auditing;
- Improving auditing skills within the department;
- Engaging staff in critical analysis and problem solving.

Progress

10.10 Seven briefing sessions for all members of staff plus sessions for partner agencies via the HSCB have been held. These have focusing on key messages and learning from the audit and are assisting in planning and reinforcing the improvement agenda. Further analysis of the audits will be undertaken to refine our knowledge.

10.11 The internal Quality Assurance System has been upgraded and commenced on 1st April. The system will include:

- Regular case auditing by Team and Service Managers, Heads of Service, ADs and DCS;
- RAG ratings of all CPCs and LAC Reviews;
- Thematic Audits;
- Feedback from parents and children;
- Peer Case Audits;
- Independent Dip Sample Audits of cases;
- Staff Surveys;
- Peer Service Reviews;
- Regular reports to Management Teams within the Council and to HSCB.

11. Community Impact

11.1 Contribution to Herefordshire Safeguarding and Protecting Children Improvement Plan.

12. Equality and Human Rights

12.1 These have been taken into account in constructing the audit process and tools.

13. Financial Implications

13.1 Payments made to Outcomes UK.

14. Legal Implications

14.1 Required by Ofsted and no other legal implications identified.

15. Risk Management

15.1 The audit has assisted in identifying the risks in relation to practice which have been linked into the HSCB and Departmental Risk Registers and are being mitigated through the implementation of the Safeguarding and Protecting Children Improvement Plan. Failure to adequately meet these will place children at risk and negatively impact upon the Council's reputation.

16. Consultees

16.1 Herefordshire Safeguarding and Protecting Children Improvement Board, Herefordshire Safeguarding Children Board.

17. Appendices

17.1 Audit Pro Forma – Herefordshire Audit Tool document attached separately

17.2 Sub-set of descriptors for Cases Judged to be Inadequate

18. Background Papers

18.1 Herefordshire Audit Tool

18.2 Ofsted Evaluation Schedule and Grade Descriptors