 **DECEMBER 18 & JANUARY 19 audit findings. – Focus area on LOCALITY TEAMS**

**LEARNING BRIEF**

Welcome to our first set of changes in relation to the Audit Process. We recognised that in order to provide you with feedback plus highlight areas of Good Practice from the Audit process we needed to change the format of the Learning Brief. This is just one style we are trying, and in the coming months different formats will be experimented with. We welcome your feedback in terms of effectiveness, relevance and length.

Learning Briefs will be produced on a monthly basis, the aim will be to highlight what the Audits identified as Going Well or as a Worry. We want these to be used to help develop practice and therefore we will be seeking feedback as to how you and your team will be using these briefs and what if any outcomes has arose from this.

Another change we will be implementing is the move to a quarterly Deep Dive Audit Report which will reflect on the previous 3 months audit findings. We believe that a larger cohort of data will produce a better analysis of our strengths and areas to continue focus with. This will include recommendations, and feedback from teams in order that we have the opportunity to learn from each other.

**Feedback for Dec and Jan.**

The Findings are based on 26 Audits. This is a return of 87%! Thankyou everyone as this is a significant increase from previous months. – This is a reminder that Auditing is a Mandatory Process and your compliance is expected and required, the aim being to learn from each other, establish high standards and consistency for our children and families that we work with.

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| **POSITIVE FINDINGS** | **REMINDERS** |
| The IRO footprint and challenge is becoming more evident on the child’s record. This provides the child with a further layer of advocacy and QA . This will lead to timelier outcomes for Children In Care.    The Central Locality Team is demonstrating consistent child centred practice and decision making with real evidence of positive outcomes. There is a real sense of knowing and valuing the young people and language in files is largely respectful and child friendly.  One Professional commented that the standards within this team should be used as a benchmark for others.  Four Outstanding grades were awarded to one case. This was for quality and timeliness in a number of assessments, and a strong Team Manager footprint was present at key times, demonstrating solid and timely decision making and involvement with others.    Auditors felt that the principles and ethos of Sings of Safety was evident from case records in terms of working and communicating with families openly and honestly    7 audit categories had Outstanding grades. This is an increase where Outstanding practice has been identified.  One Parent gave the SW 10/10 stating they listened and provided them with time to say what they wanted to say.    One Professional stated the SW was respectful of everyone’s views. This is reflected in the improvement in collaboration with agencies. Where 1 case was graded ‘outstanding’, 14 graded ‘good’ and 11 ‘requires improvement’. None were graded Inadequate.    A Young Person scaled 9/10 in response to the question “have we helped to make things better”.    Professionals are feeling more involved in CIN meetings and therefore felt able to participate to plans more effectively.  Observations are indicating a high standard of practice and engagement with families. Most visits are prepared for prior to the event. | IRO challenges are to be encouraged as they are made to enhance standards and the child’s Looked After Experience. However they need to be responded to with remedial action promptly followed up.  Assessments must consider history and what, if any significance it has to today. Impact Chronologies will assist with this. - The CSWs are available to support practitioners with this work.  ACES (Adverse Childhood Experiences) needs to be integrated into assessments particularly when past trauma is known but the impact is not. CSW, Aimee Williams is the ‘Aces Ambassador’ so please contact her for further discussion and consultation on this.  The integration of risk factors needs to be more explicit in assessments. These continue to be inconsistent and often missing. 39% of cases were graded ‘inadequate’ for ‘identification and response to risk’.  Professional curiosity needs to be more evident in terms of exploration, challenge and analysis. Ask the question “I wonder what” …… “I am curious as to how”…….Expect the unexpected and believe the unbelievable.    Plans need to set out a clear trajectory of what, how and when. This will enable measurement of outcomes to be more easily identified and reviewed. Plus provide families with a clear framework of expectations and accountability. Jo Hillier and the S of S leads can support you with this.  Case notes need to reflect the work completed, conversations held and outcomes of these. Several audits referred to this being missing. It is important to remember that case notes are not just a requirement, they are the young person’s narrative and therefore require a degree of detail.  Children accommodated must have a care plan completed within 10 days of being looked after.  Minutes from Core Group and CiN Reviews must be shared promptly with parents and other professionals.  One young person scored the social worker 4/10 for explaining things. – Try different methods for communicating with children in order that opportunities for participation and understanding are maximised. |

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| WHAT ARE WE WORRIED ABOUT?  16 Cases, 39%, were graded Inadequate for identification and response to Risk. This is an ongoing theme and potentially leaves children/ young people at risk of harm.  There was a 3 month delay in producing a Care plan for a Looked After child. This had a significant impact on the child’s understanding and expectations of what was happening next.  Decision making and management oversight continues to remain inconsistent. 31%, (8 cases) were graded ‘good’, 46%, (12 cases) were graded ‘requires improvement’, 19%, (5 cases) were graded ‘inadequate’, whist 4% of the cohort, (1 case) was graded as ‘outstanding’.    Visiting frequency is not consistently applied. This impacts on drift, planning and intervention.  Assessments inconsistency in reflecting on history, involving partners and extended family is impacting on the quality and accuracy of the assessment. 9 assessments (34%) were graded as ‘good’, 12, (46%), were graded as ‘requires improvement’, 4, (16%) were graded as ‘inadequate’, and 1 (3%) was graded as outstanding. This disparity means the analysis of risk is often skewed and can lead to over-optimism.  Some professional feedback raised concerns around our practice citing the organsiaion was chaotic and it felt “a battle to get concerns acknowledged”. Other comments were made such as “deficits in mothers parenting were overlooked. No sense of the childs voice”. Poor communication and sending out of minutes.    One parent feedback said they were “not kept in the loop, not involved in decision making”. Involvement was scaled at 1 and they said “different Social workers have different views and now not clear on what needs to be seen”. |

**NEXT STEPS**

With these findings in mind please remember to follow up any audit action within supervision and record it clearly in terms of what is needed and the timescale for this. This will be followed up as part of the tracking process in the Quarterly report.

We would like managers and their teams to consider the issue of consistency and how this can be better achieved. 1 case was graded with 14 ‘inadequate’ and 2 ‘requires improvement’, compared to another which was graded with 13 ‘goods’ and 1 ‘requires improvement’, and finally 1 case had 4 ‘outstanding’s’, 7 ‘goods’ and 2 ‘requires improvement’ grades. We would like your feedback on this issue in order that we can work together to look at practice, systems, supports, training and tools.

On the final page of this brief are some links to Tri.X updates and new documents which we hope will be of assistance in your practice. A number of new documents and Practice Tips are being created and we will keep you updated of these.

We welcome your feedback on any messages within this brief, our aim is to encourage a more participative approach to auditing and learning where we can learn from each other.

Thankyou.



Linda & Aimee.



 **LINKS TO LEARNING**

Thefollowing Links will help practitioners to reflect upon the Audit Findings and how to develop practice.

**ACES** - <https://trello.com/b/1lIACXrr/adverse-childhood-experiences-resource-library>

**SIGNS OF SAFETY MATRIX OF HARM**

https://www.proceduresonline.com/southglos/cs/user\_controlled\_lcms\_area/uploaded\_files/harm%20matrix%20with%20questions.docx

**ASSESSMENT TOOLKIT -** <https://www.proceduresonline.com/southglos/cs/user_controlled_lcms_area/uploaded_files/PRACTICE%20TOOLKIT%20FOR%20ASSESSMENTS%20-%20JAN%202019.docx>

**NEGLECT TOOLKIT WITH TOOLS**

<http://sites.southglos.gov.uk/safeguarding/wp-content/uploads/sites/221/2015/05/Neglect-Toolkit-201>

**CORE STANDARDS**

<https://www.proceduresonline.com/southglos/cs/user_controlled_lcms_area/uploaded_files/Core%20Standards.pdf>

**SUPERVISION BRIEFING**

https://www.proceduresonline.com/southglos/cs/user\_controlled\_lcms\_area/uploaded\_files/190122%20Briefing%20Supervision%20Policy%20for%20SLT%20v7.docx

**NEW - Strategy Discussion Guidance for Chairs -** <https://www.proceduresonline.com/southglos/cs/user_controlled_lcms_area/uploaded_files/Strategy%20discussion%20script.docx>

**NEW - Draft Shaken Baby Guidance -** <https://www.proceduresonline.com/southglos/cs/user_controlled_lcms_area/uploaded_files/shaken%20baby%20syndrome.docx>

**NEW - Safeguarding Young People with a Disability** - <http://sites.southglos.gov.uk/safeguarding/wp-content/uploads/sites/221/2015/05/Final-Safeguarding-Children-Young-People-and-Young-Adults-with-a-Disability-Guidance.pdf>

**NEW - Guidance on the Issue of Consent -** <https://www.proceduresonline.com/southglos/cs/user_controlled_lcms_area/uploaded_files/Consent%20Guidance.docx>

**NEW - Transition Planning -** <https://www.rip.org.uk/~ftp_user/Transitional_safeguarding_adolescence_to_adulthood_Strategic_Briefing_2018_rip//files/assets/basic-html/index.html#1>