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INTERNAL AUDIT FINAL REPORT

PEOPLE DEPARTMENT

QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

Issued to:	**Director of Children, Education and Families** **Head of Service, Quality Improvement**
Cc (Final only)	**Assistant Director, Strategy, Performance and Corporate Transformation** **Head of Finance, Children, Education and Families**
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QUALITY ASSURANCE FRAMEWORK – CHILDREN'S

INTRODUCTION

1. This report sets out the results of our audit of the Quality Assurance Framework of Children's Social Care. The audit was carried out as part of the work specified in the six-monthly Internal Audit Plan for 2022-23, agreed by the Audit and Risk Management Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.
2. The function of the Quality Improvement service is to:-
    - deliver a comprehensive quality assurance programme 'system of control', identifying strengths and areas for development across the services which make up the Department
    - ensure compliance with legislation such as the Children and Families Act 2014 and the Ofsted ILACS (Inspecting Local Authority Children's Services) framework element of 'knowing about the quality and impact of social work practice in your local authority'
    - ensure that lessons learned from workstreams, including Practice Assurance Stocktakes and Practice Reviews, are embedded in service delivery.
3. This function supports the Making Bromley Even Better ambition for 'children and young people to grow up, thrive and have the best life chances in families who flourish and are happy to call Bromley home'.
4. The objective of the audit was to review the effectiveness of the arrangements in place to assure quality of practice and a safe service.
5. We would like to thank all staff contacted during this review for their help and co-operation.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 5th August 2022. During our fieldwork, we reviewed and tested the following key risks:-

- Effective oversight of Quality Assurance workstreams (Governance) is not maintained. Roles and responsibilities are not clearly defined or undertaken by staff with sufficient skills, leadership and practice knowledge. The service is unable to demonstrate how it assesses, monitors and, where required, improves the quality and safety of service
- If Quality Assurance work is insufficiently robust, poor quality practice may not be identified and inadequate services may be delivered to residents
- If recommendations/best practice to improve outcomes for service users are not disseminated, embedded and followed up, practice improvements may not be sustained.

AUDIT OPINION

7. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable Assurance	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**2**	**1**

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SUMMARY OF FINDINGS

8. At the time of the fieldwork, the Quality Assurance Framework was undergoing a refresh. This was a result of the Quality Improvement service having identified areas which were not fully working as desired. Amendments made include elevating the minimum tier of staff undertaking Performance Reviews from Team Leader to Group Manager.

9. Our testing was against the Framework in place at the time of the fieldwork. In October, we had sight of the refreshed Framework which was approved in September 2022. At the time of reporting, launch was imminent. The Framework contains provision for 'review in six months (March 2023) by the Group Manager to the Performance Improvement Board and annually thereafter', to ensure that it remains live. We have considered the contents of the new Framework when making our recommendations.

10. The Performance Improvement Board is an established Group, with attendees including the Director of Children, Education and Families and the Chief Executive. It is empowered to oversee and determine action for continuous improvement, innovation and consistency of high-quality practice and service delivery. During the last year, both a new Independent Chair and Quality Assurance Group Manager have been appointed.

11. Our fieldwork highlighted a number of key strengths. We found that the Quality Assurance Framework and Timetable incorporate both internal and externally commissioned workstreams. There is a robust reporting mechanism to the Performance Improvement Board encompassing further independent challenge by the Chair. These layers of scrutiny provide Senior Management with clear sight of strengths and areas of good practice, together with areas for development.

12. Thematic findings are disseminated, in detail, to staff through the 'Getting to Excellence' training seminars which take place approximately every six weeks. We noted that both the trajectory to Excellence and the links between the Practice Standards and the Quality Assurance Framework to monitor services for quality and effectiveness, were reinforced via this medium.

13. The majority of templates used for the Quality Improvement process invite the reviewer to comment on strengths or excellent practice identified, and these have been well used. We also noted that overarching reports include commentary on strengths identified.

14. Our audit review has, however, identified the following areas which we would like to bring to management's attention:

- Return rates of the Practice Reviews were low for some cycles, with one service sampled seeing a return of 64% 'in time' and a second service seeing a return of just 15%. For Practice Reviews which had been graded overall as 'Requires Improvement' or 'Inadequate', there was not a clear line of sight to ensure that the Practice Review Improvement Meeting (PRIM) had taken place or that actions recorded had been followed up through the supervision process.

  We acknowledge that the Quality Improvement service had identified both of these areas as gaps and have strengthened the process as part of the September 2022 Framework refresh.

- The main data repository, for documentation which cannot be held in the Social Care Management System, is a restricted access section of the 'Shared' drive. The file management system is ad hoc in nature, both in terms of file structure (high level and sub structure), and the actual documentation held. We could not establish a full audit trail for the workstreams from this data source. It is, however, acknowledged that further material is held in personal E mail boxes.

- Whilst not every section of the Practice Review forms will be relevant for each case sampled, evidence as to whether each section had been considered for inclusion/exclusion was inconsistent, with no formal process in place.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

15. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and timescales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

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DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

1. Quality Assurance Framework – Considerations for six month review

Finding

During our testing of the Practice Review process, we found that:-

- Return rates of the Practice Reviews were low for some cycles, with one service sampled seeing a return of 64% 'in time' and a second service seeing a return of just 15%.
- For Practice Reviews which had been graded overall as 'Requires Improvement' or 'Inadequate', there was not a clear line of sight to ensure that the Practice Review Improvement Meeting had taken place or that actions recorded had been followed up through the supervision process. This includes those that had been regraded during the moderation process.

We acknowledge that the Quality Improvement service had identified both of these areas as gaps and have strengthened the process as part of the September 2022 refresh.

As part of the refreshed process, 25 Practice Reviews are to be carried out for each service/theme reviewed, this being the number of staff in the revised tiers of Management undertaking the reviews.

We reviewed the Quality Assurance Frameworks for a selection of local authorities as available in the public domain. We observed that one Framework stated 'Members have oversight of QA Activity' and they provided a 'Practice Assurance Stocktake Report' on 7th February 2022 to their Safeguarding Sub (Community & Children's Services) Committee. Whilst we acknowledge that this is not a statutory requirement and service areas report separately to the Children, Education and Families Committee, we recommend consideration is given to an annual Quality Assurance Information Briefing.

Risk

Insufficient return of Practice Reviews, lack of a robust follow through process for actions for 'Requires Improvement' or 'Inadequate, and an insufficient initial sample size leaves the Quality Improvement process at risk of :-

(i) lack of critical mass on which to base an opinion as to the quality of service provided (ii) inability to demonstrate that recommendations/desired improvements have been followed through to conclusion and embedded.	
Recommendation We recommend that as part of the initial six month review of the September 2022 Quality Assurance Framework Refresh, consideration is given to: - (i) Mechanisms for ensuring that Practice Reviews are being completed within time to provide a sufficient base on which to provide an opinion as to the quality of work across the service. (ii) Mechanisms for ensuring that actions and recommendations resulting from 'Requires Improvement' or 'Inadequate' gradings, together with those emanating from overarching Practice Assurance Stocktakes and Practice Review reports, are followed through until closure. (iii) Whether a static sample size of 25 provides a sufficient cohort on which to base an opinion as to the quality of service. (iv) Providing an annual Quality Assurance Information Briefing to the Children, Education and Families Policy Development and Scrutiny Committee. (v) Whilst there is clear evidence of the Quality Assurance Timetable's oversight at both Director and Assistant Director level and it forms part of verbal discussions at the Performance Improvement Board, it is recommended, for good practice, that the document itself forms part of the Board's standing agenda items.	**Rating** Priority 2

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DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
The recommendations are agreed and viable. We have adjusted to ensure a greater compliance with returns of Practice Reviews to timescale as set out in actions below. We are in our Ofsted inspection window and have presently increased our audit coverage to reflect inspection preparations and the cycle will then be reviewed post-inspection. Because of this, the actions below reflect current adjusted practice on the basis we do not know exactly when we will undergo our regulatory inspection. The recommendations will further strengthen our oversight of continuous improvement. The QAF has been through recent amendments and now addresses the lines of accountability in 'closing the loop' of actions and learning from practice review and practice assurance stocktake cycles. **Actions** (i) Practice Reviews are now completed by Group Managers, Heads of Service, Assistant Directors and the Director CEF. Any exemptions have to be authorised at Assistant Director level and time extensions are not given. These reviews are now completed on a monthly basis. The Director CEF addresses any failures to submit a completed practice review to timescale. **(QA Lead Manager / Director CEF)** (ii) A moderation meeting is held by the QA Lead Manager with the Head of Service and Team Manager to ensure that agreed actions from Practice Reviews with an inadequate or RI outcome are tracked through to completion. **(QA Lead Manager)**	(i) End Jan 2023 (ii) End Feb 2023

	HOS will record on children's records when all moderated actions from practice reviews have been completed and this record will be shared with the QA Lead Manager for tracked oversight. **(All HOS / QA Lead Manager)**	End Feb 2023
	The terms of reference of the Performance Improvement Board will be updated to set out how recommendations from QA work including Practice Reviews and Practice Assurance Stocktakes will be followed through the Board to final sign off. **(QA Lead Manager)**	End Feb 2023
	Sign off that actions have been completed will be incorporated as a standing agenda item at Performance Improvement Board. **(QA Lead Manager / Director CEF)**	End Feb 2023
(iii)	On a monthly basis there are now 25 internal Practice Reviews completed, 50 case audits completed by external consultants and up to 100 dip sample audits completed by team managers to ensure full coverage upon which to establish information about the quality of service across the Department. **(QA Lead Manager / Head of Service Quality Improvement)**	(iii) End Feb 2023
(iv)	The Director of Children, Education and Families should give consideration with SLT, Portfolio Holder and PDS Chairperson as to whether an annual report concerning QA activity and its framework should be part of Members scrutiny on the PDS Committee cycle. **(Director CEF)**	(iv) End March 2023
(v)	The QA timetable will be a standing agenda item at each Performance Improvement Board and latest iteration made available to all board members as part of board papers. **(Director CEF / QA Lead Manager)**	(v) End Feb 2023

All iterations within a calendar year will be saved and stored in Sharepoint to ensure ready access to the evolution of the QA timetable. **(QA Lead Manager / HOS Quality Improvement)**	End Feb 2023
Meetings held by senior managers to establish and agree the QA timetable will have minutes and those minutes stored on Sharepoint to ensure ready access so that the methodology can be evidenced and tracked. **(QA Lead Manager / Head of Service Quality Improvement)**	End Mar 2023

2. Strategic File Management

Finding

We were advised that in addition to the Social Care Case Management system, the main data repository for the Quality Assurance process is a restricted access section of the Shared drive. We reviewed the contents of this as part of the initial fieldwork for the audit. We found the system to be ad hoc in nature, both in terms of file structure (high level and sub structure), and the actual documentation held.

We could not establish that all relevant documentation had been uploaded to the system and a full audit trail could not be determined from this data source. It is, however, acknowledged that further material is held in personal E mail boxes.

We noted during the testing that, whilst the majority of Practice Reviews were completed via the template held on the Social Care Case Management System, bespoke forms, held outside of the system are still required on occasion. Whilst the Case Management System contains a workflow of 'alerts' to the Team Leader and Head of Service, the system for those held outside of the system remains manual. It could not be evidenced through the filing system that the eight forms in the sample for audits completed outside the system had been seen by the Team Manager or Head of Service.

Risk

Lack of a full audit trail could lead to the overall opinion as to the quality of work in Children's Social Care being based on insufficient or inaccurate data and is therefore not robust.

Recommendation	Rating
We recommend that:- (i) The contents of the Shared drive and individual E mail boxes are reviewed, realigned and standardised to ensure that a full audit trail is available. File naming conventions and contents should be agreed. Going forward, Sharepoint should be the repository for documentation which cannot be held on the Social Care Case Management system.	Priority 2

(ii) Team Leader and Head of Service sign off of Practice Reviews completed on bespoke forms outside of the Social Care Case Management system off is included in the filing system.	
Management Response and Accountable Manager The findings are agreed. Recommendation ii is partially viable on the basis that information recorded in auditing work is not always suitable to be stored on children's individual social care records and have implemented a process change to evidence this recommendation that is most consistent with what the Department considers is in children's best interests regarding information stored on their personal records. **Actions** (i) File naming conventions and contents should be agreed with written guidance if necessary. **(QA Lead Manager)** Sharepoint should be the repository moving forward and relevant Shared drive material transferred. Any Sharepoint training need will be taken forwards with the IT Tutor, Workforce Development to ensure all who would need to use this Sharepoint are fully trained. **(HOS Quality Improvement / QA Lead Manager)** Email correspondence that is relevant and evidences methodology and the auditing/practice review process should all be moved and stored in the agreed filing conventions on Sharepoint, and stored for all future cycles in Sharepoint. **(HOS Quality Improvement / QA Lead Manager)**	**Agreed timescale** (i) End March 2023 End April 2023 End April 2023 for each cycle

(ii) The QA Lead Manager will complete a case note on each case file where a Practice Review has been completed to set out the date of the Practice Review, key findings and actions. The team manager and HOS will then evidence tracking and completion through social work supervision records. **(QI Lead Manager and all HOS)**	(ii) End March 2023

3. Practice Review Forms – Standardisation of completion	
Finding We noted during testing that the completed Practice Review forms on the Social Care Case File Management varied in terms of the sections completed. Additionally, there were examples of forms where although sections had been graded, the specific questions had been marked 'Not Applicable'. Whilst we accept that not every section will be relevant for each review, we recommend that a standardised process is implemented for recording where sections of the Practice Review Form are not applicable, and therefore should not be graded, to provide a robust audit trail that all sections of the form have been considered. We noted that discussion with the Practitioner is at the heart of both the Practice Review and the Practice Assurance Stocktake process. From a review of the documentation held, it could not be established definitively that the Practitioner had been involved, although this is clearly the intention as stated in the guidance. We noted that one non standard Practice Review Form does not provide the option for the reviewer to bullet point examples of 'Excellent Practice'. **Risk** Without a standardised approach to form completion, there is a risk that assumptions may be made when completing the forms leading to inconsistencies and oversights.	
Recommendation We recommend that:- (i) A standardised process is implemented for recording where sections of the Practice Review Form are not applicable, and therefore should not be graded, to provide a robust audit trail that all sections of the form have been considered.	**Rating** Priority 3

(ii) For absolute clarity, we recommend that it is confirmed in each Practice Review that the Social Worker has been involved and the outcome of the Practice Review discussed with them. (iii) Non standard/bespoke Practice Review Forms are reviewed and amended to ensure that the option to bullet point examples of Excellent Practice is included.	
Management Response and Accountable Manager The recommendations are agreed and viable. **Actions** (i) Guidance will be issued by the QA Lead Manager to ensure all completing practice reviews are recording any sections that are not applicable as such. **(QA Lead Manager)** (ii) All staff completing Practice Reviews have been issued guidance that the involvement of the Social Worker must be captured and the outcome discussed with them. If this is not possible, the Practice Reviewer must set out who was involved and the reasons why the Social Worker was unable to take part. **(QA Lead Manager)** (iii) All audit templates, including Practice Review forms, now include a space for exemplars of excellent practice to be recorded. **(QA Lead Manager / HOS Quality Improvement)**	**Agreed timescale** (i) Guidance issued in Dec 2022 (ii) Guidance issued in Dec 2022 (iii) Completed in Dec 2022

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APPENDIX B

OPINION DEFINITIONS

Assurance Level

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Recommendation ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.