States of Jersey - Children's Service

Independent audit of the quality of front line practice and management

Phase two - initial and core assessments, child in need plans

Context for the audit

The States of Jersey has invested in and embarked on an ambitious programme to improve the quality of children's social work in Jersey. This commenced with the rapid improvement plans and was augmented in April 2015 by the two year plan for sustained improvement, (SIP) the key outcome of which is to have good and outstanding social work services for children.

Change and progress in key areas of service delivery will be tested through independent audit and inspection. The Director of Children's Services (DCS) commissioned this independent audit to provide a baseline of front line practice and management. It took place between May to early July 2015.

Scope

The independent audit was conducted in four phases, each focusing on a key area(s) of service delivery within which it is essential that practice and management are robust.

Phase 1: the multi-agency safeguarding hub (MASH), covering responses to and decision-making in relation to contacts and referrals and child protection enquiries undertaken under Article 42 whether these originated from the MASH or from social work teams.
Phase 2: assessments and child in need plans.
Phase 3: child protection plans.
Phase 4: care plans for children looked after.

Key themes, underpinned audit activity in all four phases. The extent to which:-

- Work improves outcomes for children and young people.
- Practice is child centred, reflecting the focus to 'think child'.
- Dimensions of equality are effectively addressed.

Audit approach

A set of audit criteria were developed. These were derived from the Jersey Children Law (2002), the department's mimimum standards document, Working Together (2013) and Ofsted's inspection evaluation schedule (2014). They cover compliance with statutory regulation as well as what is considered to be 'good' practice. The criteria were agreed in advance of the audit with the DCS and were discussed with staff during the audit.

My approach was that of a 'critical friend' i.e. evaluative and developmental. Case audits were undertaken alongside managers and these discussions offered the opportunity for reflection on practice and management. Positive practice, alongside learning from cases, was highlighted where possible.

Cases were randomly selected by the auditor, from lists supplied by the children's service. These covered work undertaken between January 2015 and the end of April 2015. They included children at different stages in their journey through services. The sample reflected, where possible, a spread of gender, age and ethnicity and included, where known, children with disabilities.

14 assessments and 5 child in need plans/planning were audited:-

Initial assessments

- Eight case files were audited. These included two initial assessments viewed during Phase one of the independent audit. Assessments were completed between January and April 2015.
- No initial assessment was a of a good standard or better.
- Three of the assessments met minimum standards, including one that showed good child-focused practice.
- Two assessments fell short of minimum standards.
- Two assessments were not recorded and although managers were confident that visits had been made, there was no evidence of this on the electronic record. In both cases the worker concerned was on leave.
- In one case, although recorded as an assessment, the work was appropriately undertaken as a child protection enquiry; this did not fully consider all known risks.

Core assessments

- Eleven case files were reviewed that would be expected to contain core assessments. Assessments were available on only four of the files and this included one core assessment viewed during Phase one of the independent audit. All assessments were completed between February and May 2015.
- No assessment was of a good standard or better.
- Three core assessments met minimum standards.
- One assessment fell short of minimum standards.
- One assessment, although apparently completed, had not been signed off as it was not of a sufficient standard. (case [REDACTED])
- In one case an assessment had been attempted but the parents refused to engage. (case [REDACTED])
- Three assessments should have been completed or updated but were delayed; this was attributed to competing workload pressures due to court work. (cases [REDACTED])
- One assessment was still in progress and was 'in time'. (case [REDACTED])

- One child was in receipt of a child in need plan but a decision was made, due to pressure of work, not to undertake a core assessment. It was the auditor's view that a core assessment was necessary in order to inform what appeared to be unclear planning. (case [REDACTED])

Child in need plans and planning

- Five child in need cases, covering work referred to the CiN team since March 2015 were reviewed and all contained a recent child in need plan.
- Four met minimum standards.
- One did not meet minimum standards and the child's case was referred to senior managers for further review.

Cases referred back to senior managers

- One case was referred as there were indications that the child was likely to suffer significant harm, but this had not been comprehensively addressed and there was evidence of significant drift in relation to completing required tasks. (case [REDACTED])
- Discussions were held with team managers about aspects of assessment practice and/or delays concerning five children. Managers agreed to take remedial action in relation to these.

Key findings:-

In the light of the detailed verbal feedback already provided, this is a summary of the review's key findings, some of which reflect the findings of phase one:-

- In general managers responded positively and non-defensively to the opportunity to explore cases in depth. Managers were able to identify key areas for improvement, including where aspects of practice and/or recording were of an unacceptable standard.

- No children were found to be at immediate risk of harm. One case was referred to senior managers for review and actions were agreed with managers in relation to aspects of five other cases.

- Practice is not consistently child-focused. There is too little emphasis on the child's daily experience and the impact of parenting on their health, development and safety.

- Understanding the impact of differences relating to diversity is limited.

- Fourteen assessments were reviewed and nine of these had been completed and recorded. Six met minimum standards, and three fell short.

- Assessments, child in need plans and reviews of plans are not yet 'good'. They are insufficiently outcome focused and are not 'SMART'.

- Appropriate recommendations for further support or closure were made at the conclusion of all assessments, including those audited as weak.

- Delays in completing initial assessments, transfer of cases to the child in need team and in completing core assessments mean that not all risks are fully clarified, children's needs are not met in a timely way and issues remain unresolved for too long.

- The volume of work, high caseloads alongside the responsibility to hold a case until after the first core group or child in need meeting leads to delay in completion of initial assessments.

- The demands of court work and children becoming looked after lead to delays in completing core assessments, as a significant proportion of staff in the child in need team are inexperienced in these areas of work.

- A lack of performance management information severely restricts managers' ability to monitor the progress of assessments.

- Aspects of the assessment process build in unnecessary delay e.g. that core assessments cannot be started following a referral.

- It is positive that despite delays in completing assessments, initial child in need planning commences following case transfer from the CIRT.

- All child in need cases contained a recently developed plan and four of these met a minimum standard.

- Child in need reviews do not systematically consider and record the progress that has been made in relation to the plan or changes in relation to levels and nature of risks and needs.

- A number of recent improvements have been made to the assessment and child in need proforma. A flow chart for the child in need process is now in place. This is a positive step on the journey to 'good'. However, it is too early to demonstrate any impact from this. Managers need to ensure that all staff make use of the new materials and their impact on the quality of work monitored.

- Recent improvements rightly include responsibilities for partner agencies to complete multi-agency chronologies and take part in professionals' meetings. The involvement of partners in securing agreement and commitment to these developments is unclear.

- Most case files showed evidence of management oversight, but the impact of this on tackling delay or improving the quality of assessments was variable.

- A lack of performance management tools severely impedes managers in monitoring and challenging the progress of work.

Outcomes

- Practice is not outcome focused.

- Explicit reference to the way in which outcomes were improving or worsening was not a feature of the assessments or child in need plans audited.

- Child in need meetings that agreed to end child in need plans did not clearly summarise what has changed and why. (e.g. case [REDACTED])

Child-centred practice

- Children were seen during assessments and child in need planning and this was recorded. However, delays meant that not all children were seen promptly and their needs met. (e.g. case [REDACTED])

- The electronic record and the plan review do not require workers to identify the dates on which children were seen. This necessitated trawling through a large number of case note entries to establish when children were seen and makes management monitoring unnecessarily time consuming.

- The extent to which assessment practice is consistently child focused was very variable. An initial assessment (case [REDACTED]) was a positive example of presenting a seven year old child's wishes, feelings and worries in an initial assessment. However, the core assessment for a five year old did not make any reference at all, in the context of longstanding neglect, to the child's everyday experience. (case [REDACTED])

- Positive practice was seen (case [REDACTED]) when direct work to address vulnerability to child sexual exploitation promptly commenced.

Equality and diversity

- Assessments may make reference to racial and linguistic origins, but they rarely explore issues arising from this. (e.g. case [REDACTED])

- Class and cultural backgrounds were not consistently and explicitly explored e.g. the impact of social class, poverty, unemployment, housing conditions on parenting.

Enquiry and referral practice

This audit confirmed several key findings from Phase one.

- Thresholds for referral to the children's service are low and a high proportion of referrals do not evidence that they meet the agreed threshold.

- Referrers did not gain parental consent to make an enquiry to MASH, when this should have been done, for example because the parent did not speak 'good' English. (case [REDACTED] There appears to be a lack of understanding and confidence among local agencies and this puts the MASH service under unnecessary pressure in having to deal with this.

- Referrers were not routinely consulted to clarify information.

- In the absence of an early help offer, managers want to ensure that children get the help they need. Thus they 'err on the side of caution' and refer for initial assessment those cases that appear to be on the boundary of targeted multi-agency early help and social work assessment. (e.g. cases [REDACTED])

- Strategy meeting recordings do not clearly indicate the nature, level and type of harm or underpinning rationales for agreed actions.

- In contrast to the Phase one audit, this sample did contain a small number of examples of research by MASH partners, such as the police.

Chronologies

- Up to date chronologies are not available on almost all of the cases reviewed. Several files contained incomplete chronologies. The impact of this is that time is inefficiently used trying to establish key information such as whether a young person is still looked after. Some chronologies are an inappropriate and lengthy 'cut and paste' of case notes. (e.g. case [REDACTED])
- The multi-agency chronology has not been clearly disseminated to partner agencies and thus is not yet widely understood or completed.

Assessment practice

- Delays in starting, completing and recording initial and core assessments were too frequent. Managers acknowledged that this often delayed meeting children and young people's needs. They cited pressure from children becoming looked after, preparation of cases for family proceedings, the volume of assessments and delays in partner agencies providing information as key underpinning reasons for delay.

- Team managers have developed systems to agree extensions to assessments but revised timescales also slip. Staff were challenged about delays in completion, but the impact of this is yet to be evidenced.

- Assessments judged as meeting minimum standards shared a number of common features:- (cases [REDACTED])
    - relevant information was gathered, although there were sometimes gaps e.g. in relation to one parent or other key family members.
    - a reference to the views of key agencies.
    - children were seen and there was some consideration of their wishes and/or presentation.
    - key aspects of family history were taken into consideration, although sometimes gaps still remained e.g. in relation to one parent or a sufficiently full understanding of the impact of parental childhood experiences.
    - some reference (although limited) to previous agency involvement.
    - analysis of key risk and protective factors.
    - reference to the parents' attitude and response to the concerns raised.
    - an appropriate recommendation to ensure that the right level of service and/or protection was provided.

- Assessments judged as not reaching minimum standards also shared a number of common features:- (cases [REDACTED])
    - delays in commencing and writing up.
    - insufficient attention to gathering information at a level appropriate to the assessment.
    - too little evidence that the information held by other agencies was obtained or that other agencies were consulted.
    - although children were seen, they were virtually absent from the assessment.
    - a lack of exploration of the parents and carers family history and little reference to the involvement and impact of previous involvement.
    - lack of reference to siblings.

- confusion,lack of clarity and specificity about key areas of risk e.g. parental drug use and impact on children, current and/or historical evidence of domestic abuse.
- a very limited consideration of parental capacity and/or a failure to consider one parent at all.
- very limited and thus weak analysis; key risks factors known at referral were not considered.
- core assessments intended to assess risks in depth, together with the impact of intervention on levels of risk failed to clarify these issues and did not explicitly consider the evidence for/against significant harm.

- Partner agencies are generally consulted during assessments (e.g. case [REDACTED]). However, the impact of professionals meeting is difficult to discern and there are examples of partners providing limited information about young people's history and behaviour. (e.g. case [REDACTED]) On occasion, a lack of clarity about concerns and partner's changing views made the assessment task more complex and contributed to delay. (e.g. case [REDACTED])

- A positive finding is that social workers recommended all but one of the children and young people to receive a suitable level of support and protection at the conclusion of assessments. This included assessments audited as weak. The exception related to an assessment (case [REDACTED]) where due to a lack of information in the assessment, I was unable to confirm that no further action was the correct decision.

- Clarification of the circumstances in which all children in large families need to be subject to an assessment is required. In one example, although the referred young person was assessed, there was evidence of negative impact from their behaviour on brothers and sisters. Initial or core assessments were not undertaken, nor was the impact addressed during assessments of the index young person. It was presumed that this was due to the volume of work this would entail. (case [REDACTED]) However, as a consequence the needs of several children were not assessed.

- In a number of instances, it was clear at the outset that a core assessment would be required. Systems are not flexible enough to permit a referral to move straight to a core assessment without an initial assessment being completed. The impact of this was significant delay in assessing children and young people's needs (e.g. case [REDACTED]) and the need for families to engage with two social workers.

- The approach to the assessment of unborn children appears to be to delay this until 22 or 24 weeks into the pregnancy. This does not allow for the initiation of an initial assessment on a date that is in keeping with the risks and needs identified, or to move straight to a pre-birth core assessment.

- Systems are insufficiently flexible to determine that a core assessment may, on occasion, require longer than 35 working days to complete.

- Managers report that assessments are shared with parents. In the case of initial assessments copies are sent though the post, with a request for feedback that is rarely received. Core assessments are more likely to be discussed face to face. However, there is no administrative process to record that sharing has taken place.

- Managers undertake oversight of assessments. Allocation decisions generally made brief reference to key issues to be considered. Some assessments are reviewed during supervision, but not all. Positively, one of the four assessments, audited as below the expected standard, had also been identified as poor by the manager and had been returned for further work to be undertaken. (case [REDACTED])

- Staff in the CIRT team hold case responsibility until either the first CiN meeting or the first core group. They are also expected to write up the CiN plan. Caseloads are high and were evidenced as consisting of 25, 26 or 27 assessments. It appeared that staffing levels were insufficient to ensure that these responsibilities are consistently carried out to the expected standard.

Child in need plans

- Parental consent to undertake a core assessment is sought at the first child in need/transfer meeting. I saw evidence of this taking place and some sensitive work undertaken as parts of a child in need plan with a parent who refused to take part in a core assessment. (case [REDACTED])

- Child in need plans that met a minimum standard (cases [REDACTED]) contained the following features:-
    - the plan clearly followed from recommendations contained the initial assessment.
    - partner agencies had a clear role in the plan.
    - there was a basic understanding of what needed to be different, although this is not yet expressed as desired outcomes.
    - risks were identified, although on occasions these were somewhat understated.
    - actions were generally appropriate to needs or risk.
    - responsibilities for actions were assigned.

- timescales were agreed, although too much use was made of 'ongoing' which is not helpful.
- contingency plans had been considered and briefly outlined when appropriate.

- In some cases, child in need planning commenced as core assessments were initiated. This is positive practice and meant that children still received some services even though the completion of their assessments was delayed. (e.g. case [REDACTED])

- Child in need plans were reviewed within an appropriate timescale. Case [REDACTED] was an exception to this.

- Social workers chair and minute child in need reviews, which is a challenging task, particularly since some workers are still gaining experience in child protection/child in need work. Appropriate consideration was given to circumstances in which chairing was more appropriately undertaken by a manager, which is positive practice. (case [REDACTED])

- Records of reviews do not demonstrate that there is systematic consideration of three key factors; changes in family circumstances and their impact on children's welfare, evidence of progress against the plan's objectives and changes in the level or nature of needs and risk(s).

- Not all child in need plans were updated and changed following reviews.

- Advocacy is not available to children and young people who are 'in need'.

- A child in need flow chart to guide planning has very recently been implemented and is beginning to lead to greater clarity about what is expected and when. This requires further development, alongside partner agencies, to agree and implement core standards for multi-agency practice.

- A new format for child in need plans and review of plans has recently been developed to strengthen their quality, in particular requiring the identification of desired outcomes.

- Professionals meetings have been introduced to strengthen child in need planning and the sample contained examples of these meetings in circumstances where clarification of concerns was needed. (e.g. case [REDACTED]) Attendance is generally appropriate. Recording needs to be strengthened to highlight concerns, risks and the evidence for these.

- Managers do not sign off child in need plans and updated plans following reviews, as is the case with assessments. This creates a missed opportunity to ensure that plans are SMART and correctly focused.

- There was evidence of management oversight of all child in need plans and linked planning through supervision discussion, although the plans themselves are not necessarily reviewed in the session.

Other issues

- I have seen examples in Phases one and two of the audit where it appears that when children make a historical or current disclosure re harms they are experiencing, there is a practice of expecting the child to make a complaint and that if the child does not wish to do this, then the disclosure is not necessarily followed up. This has been referred to senior managers for clarification.

Recommendations

The sustained improvement programme is overseeing a number of actions. These recommendations are intended to underpin or supplement this and to target the most important priorities for change:-

To ensure that children are at the centre of practice and management:-

1. Develop a programme of learning and development that enables front-line staff to develop skills in direct work and risk assessment and to consistently use those skills.

To ensure that children and young people's needs are met promptly and reduce unnecessary delay:-

2. Review the assessment process to clarify those circumstances when, following referral and research, a child's needs would be best met by proceeding directly to a core assessment.
3. Ensure that pre-birth assessments commence at a point that is appropriate to the risks and needs of an individual case.
4. Urgently provide front-line managers with performance management information about the progress and timeliness of assessments.
5. Managers ensure that they closely monitor and challenge delay in supervision and set clear timescales by which work must be completed and recorded.
6. Managers and staff in partner agencies provide timely and evidence-based information about needs, risks.
7. Review the resources required to ensure that the recently developed case transfer process is effective. In particular, review staffing levels in the CIRT to ensure that staff can fulfill all their responsibilities in a timely way.

8. Review the circumstances in which cases transfer out of the adolescent hub and ensure that staffing resources and skills are sufficient to cover the range of work that is undertaken.

To ensure that all assessment meet minimum standards and become 'good':-

9. Provide mentoring and development to staff so that they understand the features of a good assessment.
10. Ensure that when allocating assessments, managers consistently give and record guidance at the outset of and do not sign them off until they meet a minimum standard.
11. Ensure that staff in partner agencies are aware of, committed to and confident in their completion of multi-agency chronologies and their participation in professionals meetings.

To ensure that child in need planning is robust:-

12. Develop multi-agency standards for child in need practice, including timescales and respective responsibilities of all partners.
13. Ensure that all staff consistently use the new format for plans.
14. Further develop the child in need plan to ensure that it identifies the occasions on which a child has been seen by a social worker, the dates that partner agencies have had contact with the child and/or parent, and whether the child or young person attended the review of their plan.
15. Ensure that all social workers are confident in and prepared to undertake their chairing responsibilities.
16. Ensure that all child in need plans and updated plans are signed off by a manager.

To ensure that managers and senior managers have an accurate understanding of the quality of front-line practice:-

17. Further develop and embed the routine of dip sampling and auditing the quality of enquiries and referrals, assessments and child in need plans.
18. Provide training to ensure that auditors share a common understanding of what is 'good' practice.

The following recommendations from Phase one are also relevant to the findings of Phase 2 of the independent audit:-

1. To improve the lives of children and young people, ensure that staff across all agencies understand the basic features of outcome - based practice and that they consistently consider, review and record the impact of their work on improving outcomes for children.

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31 May 2015