States of Jersey - Children's Service

Independent audit of the quality of front line practice and management

Phase one - enquiry and referral responses, strategy meetings and child protection enquiries

Context

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 implementation of rapid improvement plans and was augmented in April 2015 by a two year programme of 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 is taking place between May to early July 2015.

Scope

The independent audit is being conducted in four phases, each focusing on key areas of service delivery within which it is essential that practice and management are robust.

- **Phase one:** 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 two:** assessments and child in need planning.
- **Phase three:** child protection plans.
- **Phase four:** 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

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

Cases for audit were randomly selected by the auditor, from lists supplied by the children's service. These covered work undertaken between December 2014 and the end of March 2015 and 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.

22 case files were audited:-
5 contacts that did not meet the threshold for children's social work.
6 referrals that did not proceed to assessment.
5 referrals and re-referrals of children believed to be at risk of harm that led to an assessment or a child protection enquiry.
Strategy meetings in respect of 3 children, held within the MASH and subsequent child protection enquiries.
Strategy meetings in respect of 3 children who were subject to child in need plans, and subsequent child protection activity.

Auditing involved reviewing four types of records for each child and young person; the MASH record, Softbox, reports and assessments held in 'E folders' on the L drive and paper files. I appreciated the huge daily challenge that negotiating these multiple systems presents for staff in carrying out their work.

The current electronic records do not allow the aggregation of basic information about work coming into the service. Thus the case lists produced for this audit had to be manually collated, which is very inefficient. The impact of this for the service is that management oversight and performance management is compromised; it is very difficult to create samples so that practice can be dip sampled or audited.

The lack of a 'fit for purpose' electronic record and performance management activity would be viewed as fundamental system failures by current inspection regimes.

Criteria for the independent audit
These were derived from the Jersey Children Law (2002), Working Together (2013) and the inspection evaluation schedule used by Ofsted (2014) and covered compliance with statutory regulation as well as what is considered 'good' practice. The criteria were agreed in advance with the DCS and were discussed with staff during the audit.

Cases referred to senior managers
The staff and managers with whom I came into contact were committed to doing their best for children and are striving to achieve higher standards of child-centred practice. I requested that senior managers review work with eight families as these cases represent an important opportunity for wider learning.

Seven children (together with siblings in some instances) were referred to the DCS for review in relation to multi-agency practice and management oversight in the MASH. Although none of the children concerned appeared to be at immediate risk of harm, the cases raised significant concerns about missed opportunities, the extent to which risk and potential risk had been subject to multi-agency information gathering, exploration and analysis or demonstrated that practice or decision-making fell significantly short of expected standards. [REDACTED] relating to indications of child sexual exploitation, [REDACTED]

[REDACTED]

Key findings
In the light of the detailed verbal feedback already provided, and in the knowledge of the many improvements already in process, this is a summary of the review's key findings in relation to the 22 cases audited:-

- Managers responded positively and non-defensively to the opportunity to explore cases in depth and consider wider questions in relation to thresholds and risk.

- Managers were able to identify key areas for improvement, including where aspects of practice and/or recording were of an unacceptable standard.

- Children's needs and experiences were still not sufficiently understood or at the heart of practice. Errors made early in the child's journey through services tend to be repeated and in some cases compounded, unless promptly identified.

- Understanding of the impact of differences relating to diversity and equality was limited.

- The lack of co-ordinated targeted multi-agency early help continues to result in inappropriate referrals to MASH.

- Managers were under pressure to reach decisions as to the outcome of referrals in order to meet timescales. Decisions to close referrals were made without the benefit of clarification as research from partner agencies was delayed. Cases were prematurely closed before all information and risks were evaluated. Children's needs, including for protection thus remained unclear.

- Close attention to the level and nature of the harm that children had or might suffer i.e. explicitly considering it's nature, intensity, duration and whether it was 'significant' did not feature in the work and the recording of work with the children and young people in this sample.

- Despite challenging contexts and volume of work, managers did not consistently ensure that all work is rigorously monitored and reviewed and that meetings, assessments and reports clearly identify and analyse risks.

Outcomes

- Improving outcomes and consideration of the impact of activity on children's outcomes is not at the centre of multi-agency planning for children.
- Positive outcomes are compromised as children's needs, including for protection, are not consistently responded to in a timely and effective way. There are delays in researching and evaluating information, initiating child protection enquiries or initial assessments and transferring cases.
- Historical and more recent drift and delay, together with a failure to improve outcomes are a feature of several cases, for instance cases [REDACTED], and [REDACTED]
- Improving outcomes includes clarity about standards and procedures to be followed. There are different understandings between workers and within teams about protection procedures. There are variable levels of knowledge of the Jersey Partnership Safeguarding Board procedures. Two sets of children's service child protection procedures are simultaneously used, dated 2005 and 2007.

Child-centred practice

- Referrals do not generally refer to children's views about their situation or their feelings about and responses to recent incidents. Referrals are often adult focused, for example case [REDACTED].There are positive example of child-focused work at some points in the child's contact with services, but they are exceptions. (e.g. cases [REDACTED]).
- Workers across all agencies rarely comment on what they know about the child's everyday experience when researching information.
- Social work recording does not evidence that children are at the centre of practice.
- Strategy discussions/meetings do not record child focused plans for child protection enquiries.
- Article 42 enquiries do not consistently record what children think and feel or their views of their situation.

Equality and diversity

- Very recent efforts have been made to record ethnicity and there is some improvement in this respect, in the most recent work.
- Very few records demonstrate that account has been taken of culture, religion, ethnicity or disability.

Thresholds between early help and specialist social work assessment

- Agencies recognise that the current threshold guidance is unwieldy and is not helpful in decision-making. The findings of the audit confirm this.
- Enquiries requesting social work involvement are made in circumstances where multi-agency early help would be an appropriate response. (e.g. case [REDACTED])
- In some instances (particularly cases [REDACTED]) cases were on the cusp of intensive inter-agency early help or children's social care assessment. There is no system to ensure that if a decision to signpost to multi-agency tier 2 work is made, that this will happen, or to track its impact and outcomes. It is thus unsurprising that management decisions offered 'the benefit of the doubt', (especially as research from key partners was not available to inform decisions) and judged that an initial assessment was needed to clarify need.

Identification and response to risk in the MASH

- Multi-agency identification and response to risk is compromised by a number of factors. If taken in isolation each would be of concern, but when operating together results in premature closure of enquiries before all presenting and potential risks have been clarified. These issues are inbuilt into the operation of the service and its current resourcing:-

1. Lack of clarity and specificity in enquiries.
2. Lack of action to clarify and probe information contained in enquiries.
3. Partners do not consistently and effectively research and record the information that they hold in a timely way.
4. Parents are not contacted by qualified social workers to explore issues contained in referrals.
5. Contradictory information is not clarified during the course of work with a family, for instance case [REDACTED].
6. Key reasons for referral can become lost early on in work with a child, as other risks are pursued e.g. possible neglect. (case [REDACTED])
7. Managers are under pressure to ensure that enquiries and referrals progress in a timely way. However, when research is delayed decisions are often made without the benefit of key information about family history, involvement with services and known risks.
8. Previous involvement with families and/or family history are not considered at the enquiry/referral, child protection enquiry and assessment stages of work.
9. Issues with the electronic record e.g. the lack of a facility to 'pull through' information about siblings, resulting in the need to 'cut and paste' and the potential for key pieces of information to get lost.

Enquiries to the MASH

- The quality of enquiries from partner agencies is very variable and they do not consistently show an understanding of the locally agreed threshold for children's service involvement.
- Poor quality referrals do not explain basic information, the reason for referral and what action had already been taken. (for example, cases [REDACTED]).

Some referrals were clearer, appropriately detailed and explained the action already taken (as an illustration cases [REDACTED])

- Agencies appear to be aware of the importance of obtaining parental consent prior to enquiries being made. Despite this, there is a lack of clarity about the circumstances in which parental consent should not be sought. In at least three instances the rationale for this was not in accordance with accepted standards of practice i.e. that this would put the child at potential risk of further harm. (such as cases [REDACTED])
- MASH recording pro forma (including the referral form) do not clearly require a record of which parent has parental responsibility. One impact of this is that consent was obtained from fathers who do not hold parental responsibility for the child.

Practice and decision-making in relation to enquiries and referrals

Initial screening, i.e. decision one that an enquiry does not meet the threshold for the children's service

- Threshold decisions in relation to meeting the criteria for children's service involvement were appropriate in most of the enquiries that were defined as no further action. However, it is not consistent practice to record that previous involvement with the children's service or key aspects of family history have been reviewed before making this decision. (e.g. case [REDACTED])
- In none of the cases were referrers contacted to clarify information. Many referrals required clarification and amplification about needs and risks to which children are exposed before a robust decision about further action could be made. This is a missed opportunity to discuss and clarify agreed threshold and what information is needed in making an enquiry. In some cases this lack of clarification had avoidably negative consequences. (e.g. case [REDACTED])
- The social work presence in the MASH consists of one senior practitioner. The lack of social workers (other than the decision-maker) is a significant limiting factor in being able to contact referrers and undertake rigorous research of case files in the light of the high volume of enquiries received.
- Current practice is that either a full multi-agency information gathering exercise is undertaken (and the enquiry is progressed to a referral) or a decision to take no further action is made without the benefit of information other than that included in the enquiry. This is not always appropriate. Several cases were seen that would have benefited from a more limited research exercise obtaining information from key agencies, usually the police and/or schools and/or health. (e.g. cases [REDACTED])
- The client services officer is tasked to undertake work that would be more appropriately undertaken by a qualified social worker. For example, some initial contacts with parents and writing and signing letters about the outcome of referrals to parents.

Information gathering and sharing in the MASH

- Partner agency information gathering was generally incomplete, untimely and therefore ineffective overall.
- Twelve cases were examined where decisions were correctly made to proceed to multi-agency research. In nearly all cases, timescales were not met. This meant that decisions about further action were made without the benefit of critical information to assist in analysis of risk. Strategy meetings were held without the benefit of research e.g. cases [REDACTED].
- Only one of twelve MASH records evidenced that research had been undertaken by the police, and only one of the cases of school age children contained information from schools. This is particularly concerning given the information that the police hold about adults, and that school hold about children's needs and presentation. Thus it is not possible to comment on the quality of this research.
- Evidence of children's service research is patchy, despite the vast majority of enquiries examined having previous contact with the service e.g. case [REDACTED].
- Information re agency involvement is often vague and insufficiently explicit. (e.g. case [REDACTED] 'getting into vulnerable situations')
- In completing research, all agencies rarely summarise the reasons for their involvement, the risks they have been dealing with, the actions and interventions they have undertaken and the difference that this has or has not made. (As an illustration see case [REDACTED]). The impact of this is to make the task of evaluating risks unnecessarily challenging.
- It was confirmed to me that there is no written guidance or standards about what is expected in researching information.

Informing parents and referrers of the outcome of referrals

- In most cases the referrer making the enquiry was not informed of the outcome. Referrers did not appear to follow up non- receipt of information. I was informed that e mails are sent, but this could not be evidenced from MASH records.
- Letters sent to parents were not in parent friendly language e.g they can refer to the referral being 'processed in the MASH'.
- [REDACTED]

Strategy discussions and meetings

- Strategy discussions and/or meetings were appropriately held for five of the six children and young people. In one instance this was not a proportionate response. (case [REDACTED]) In another, a strategy meeting should have been convened earlier in the child's contact with services (case [REDACTED].
- The strategy discussions and reconvened meetings were timely. All were appropriately chaired by a senior practitioner or team manager and usually involved the social worker undertaking child protection enquiries or the case holding social worker.

- Insufficient consideration is given to the circumstances in which a face to face meeting would be a more appropriate and robust response (e.g. case [REDACTED])
- Multi-agency attendance is variable. The police are consistent partners, but referrers or agencies having considerable knowledge of a child are not routinely included.
- It is agreed that the pro forma for recording strategy discussions needs to be revised and that it does not support systematic recording of key issues.
- None of the strategy discussions reviewed, whether originating in the MASH or other teams, clearly identified the nature and level of harm(s) and potential harm(s) that children suffered or distinguished between known and potential risks. Protective factors are rarely identified. Records do not outline the underpinning rational for why the harm was thought to be likely to be significant.
- When it was decided to hold a child protection enquiry, directions for how the enquiry would be undertaken, its conduct and timing were not recorded.
- Strategy discussions held in the MASH, are not consistently recorded on the required pro-forma. There is also some confusion as to whether discussions recorded as strategy meetings were in fact case or triage discussions, for example case [REDACTED].
- The recording of strategy meetings originating outside of the MASH, needs to be reviewed. They are currently recorded by an administrator who takes verbatim notes of each participant's comments. As a result contradictory information or statements are recorded without clarification of discrepancies and the reader cannot distinguish between facts or evidence and opinion. This does not facilitate a systematic and clear consideration of the matters that are required to be discussed.
- There is variable practice in relation to the prompt circulation of minutes. One example was found of a prompt circulation (case [REDACTED]) but evidence could not be found of circulation of records for those strategy meetings held in the MASH.
- Discussion with managers confirmed that this is not just a recording issue. There is no structured and consistent approach to chairing discussions or meetings to make sure that a systematic consideration of the required issues and clarification of evidence and opinion consistently takes place.

Child protection enquiries

Child protection enquiries followed for two of the three children where strategy meetings had been held in the MASH.

This was inappropriate in one instance, where an initial assessment would have been a proportionate response. (case [REDACTED])

An initial assessment followed for the third child, which was appropriate.

The following comments are therefore based on a very small sample of cases.

- The child protection enquiries were timely and were led by qualified and experienced workers along with a police colleague.
- The enquiries were generally completed in one visit as an ‘event’ relating to the precipitating incident rather than as holistic enquiry into broader risks and harms.
- ‘Index’ children and young people were seen during enquiries and their explanations clearly recorded which is positive practice. ([REDACTED])
- Fathers were not always seen and one child was inappropriately interviewed before parents had been informed that an enquiry was taking place.
- I was informed that it is accepted practice in the MASH that if there is a need for further work following a child protection enquiry, an initial assessment is always completed. At the conclusion of the IA a decision is made as to whether to proceed to child in need plan or an initial child protection conference. This approach may not be the most helpful in cases of long term neglect and/or emotional abuse where there is sufficient information to proceed immediately to an in-depth core assessment. The impact of this approach was that the initial assessments audited were completed in depth, with an impact on the timeliness of this and other assessments.
- In one case, relating to a child in need, consideration was not given to the child becoming looked after under Article 17, despite the States of Jersey being instrumental in maintaining the child’s ‘placement’ with relatives and written agreements with the parent that they would not remove their child. (case [REDACTED])
- [REDACTED]

Recording

- Recording was generally up to date.
- A proportion of cases contained a chronology, which is improved practice. However, they are of inconsistent quality. Chronologies contained gaps and key information, such as when a child ceased being on a child protection plan or looked after. Sometimes there is more than one, as subsequent workers have started again. It is possible to find letters or e mails cut and pasted within chronologies.
- Recording does not consistently show that concerning pieces of information that could represent risks to children are followed up or that contradictory information is clarified.
- Discussions that have underpinned managerial discussion are not always recorded (case [REDACTED]).
- There is a need to clarify and use consistent terminology. For example, case discussions appear to be recorded as strategy discussions or child protection enquiries are sometimes referred to as ’clarification interviews’.

Management oversight and supervision in the MASH

- It is positive that decisions 'one' and 'two' were consistently recorded, but identification of the underpinning rationale for decisions is not routine.
- Management decisions to close referrals were made without the benefit of clear information about risks, and this has led to the need to re-open several of the cases audited in this sample.
- Some decisions reference assumptions about the extent to which children are protected, that were not evidenced by the information available in the case record. For example, case [REDACTED].

Management oversight and supervision of strategy discussions and Article 42 enquiries

- Managers did not consistently give or record explicit guidance or instructions to workers undertaking enquiries. Case [REDACTED] is an example of giving appropriate directions.
- Child in need cases that proceeded to child protection conference or looked after status were regularly supervised. However, the impact of this in picking up practice deficits was limited.

Quality assurance and monitoring

- Managers within the MASH, including those from partner agencies, should be regularly dip sampling work and recording their findings. However, the lack of a facility to electronically compile lists of enquiries that did not proceed to referrals, referrals that did not proceed to assessments compromises their ability to identify patterns and themes and makes random selection of work for audit very difficult.

Recommendations

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

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.

2. To offer support for children and young people before concerns become indicative of possible significant harm, accelerate multi-agency progress towards implementing targeted early help for children at tier two along with systems for quality assuring and monitoring the impact of this work.

3. To improve the quality of enquiries, offer support, training and consistent feedback to partner agencies in relation to the threshold for children's service involvement and the information required when making an enquiry, including the circumstances in which consent must be obtained.

4. To ensure that the MASH is effectively resourced to carry out its responsibilities, review the allocation of staff to the service, so that social work trained staff have the time to thoroughly respond to enquiries, including holding and recording consultations with referrers, discussions with parents and researching previous involvement with the family. To ensure that partner agency and social work staff are able to complete good quality research within required timescales and that appropriate use is made of administrative staff.

5. To ensure that all staff are aware of expected standards, develop a standards manual for all MASH staff, that clearly outlines responsibilities, timescales and expected standards for the required content and presentation of research. Support staff to implement these through the provision of mentoring and management assistance.

6. To provide an effective response to enquiries, ensure that social work staff in the MASH consistently clarify information with referrers and where appropriate with parents. That cases are not prematurely closed without key information and analysis of known and potential risks or without informing enquirers about the outcome.

7. To ensure rigorous management oversight, ensure that MASH decisions1 and 2 consistently record the underpinning reasons and that these are directed towards the focus of the enquiry as well as other risks/needs identified by research.

8. To ensure that work is of a consistently good quality, ensure that managers regularly dip sample the quality and effectiveness of enquiries and referrals to the MASH, that this covers the actions of all partners and is recorded and reported to senior managers and the Jersey Partnership Safeguarding Board.

9. To minimise delay and changes of social worker for children, consider the circumstances in which it is appropriate to proceed directly to a core assessment when a referral is accepted or when completing a child protection enquiry.

10. To improve the quality of strategy discussions and meetings, accelerate progress to revise the pro-forma. Ensure that this covers all the areas required by statutory guidance and that it is accompanied by clear guidance.

11. To ensure that strategy discussions/meetings are effective, provide mentoring and oversight to managers responsible for chairing. Ensure that they are clear and confident in their understanding of their core purpose, the range of decisions that must be reached and recorded and that they ensure that these are systematically considered in all meetings.

12. To ensure that child protection processes are robust, clarify the actions that are required and the actions to be taken if allegations of significant harm, or potential significant harm occur while children are subject to child in need or child protection plans. Ensure that these are followed.

13. To ensure that children looked after are safeguarded and protected, ensure that no looked after child or young person returns home without a statutory review, a consideration of the extent to which care has reduced risks so that they are no longer significant and that it is safe for the child to return home. Ensure that a comprehensive support and safety plan is in place.

Mary Varley
Independent auditor
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