City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Children's Services to the meeting of Overview and Scrutiny Committee to be held on 7 February 2024

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Subject:

Audit Findings relating to the quality of Social Work Practice

Summary statement:

This report provides an update regarding the quality assurance and audit process in the Children and Families Trust, April 2023 to November 2023.

EQUALITY & DIVERSITY:

There is no direct impact in terms of equality and diversity from this report.

Amandip Johal
Assistant Director
Bradford Children and Families Trust

Report Contact: Amandip Johal
Phone: 07773 248040
E-mail: amandip.johal@bradfordcft.org.uk

Portfolio:

Children & Families

Overview & Scrutiny Area:

Children's Services

1. SUMMARY

This report provides an overview of the audit findings relating the quality of social work practice from April 2023 to December 2023 in the Bradford Children and Families Trust, focusing on the actions being taken to address practice that is requiring improvement or inadequate.

2. BACKGROUND

2.1 Auditing Arrangements

Case file auditing continues to be an essential part of our quality assurance arrangements. Regular quality assurance activity is a meaningful and useful method for understanding the experiences of our children and young people whilst examining practice against agreed Practice Standards, guidance, policy, and procedures.

Auditing generates themes and learning which are analysed to make recommendations for organisational practice improvement/development. Auditing is also used in service to identify case management issues for individual children. Feedback from auditing also provides information to identify learning needs and commission appropriate training and develop a learning culture by providing staff with an opportunity for in-depth reflection on their work.

The audit process is underpinned by a coaching model, with audits being completed with practitioners to provide them with an opportunity to reflect on their practice and develop professional competencies to improve their work. Training and guidance is provided to all managers and practice supervisors involved in auditing so as to ensure consistency in our auditing approach. A sample of completed audits are moderated each month at moderation panel to ensure quality and consistency in the auditing process.

2.2 Audit Outcomes

Since moving into the Trust we have continued to undertake monthly audit activity which includes individual audits of children's files alongside a schedule of themed audits and dip sampling. The return rate for individual audits is not yet at the level we would expect it to be and has reduced month on month over the period. Whilst it is important to note that individual case work audit is not the only measure of quality it is a key tool to understand progress of children and young people and the impact our work has on their outcomes. A review of the Trust's quality assurance framework is currently underway to strengthen the parameters around individual audit and reset the expectations and support that is provided to ensure managers are routinely completing monthly audit work.

The quality of casework is measured by both compliance and impact of intervention for the child and the aim is to reach a good or outstanding standard.

Continued challenges regarding the return of audits remain a focus. At the beginning

of January 2024, expectations were reinforced with regards to the return of audits for all levels of management with this being monitored closely by the Executive Director of social care and practice.

Outstanding Impact and compliance will be of a good standard with the child's lived experience understood and analysed to achieve the best possible outcome for the child. Cases graded as outstanding may still have minor learning points identified that do not affect the best possible outcome being achieved for the child.	**Good** Evidence of good practice and impact through case planning, direct work with children, professional decision making and case recording. Learning will be minimal in terms of compliance and impact to enable outstanding practice to develop to achieve best outcomes for children.
Requires Improvement Recognises that work meets our basic safeguarding responsibilities.	**Inadequate** Significant improvement is required to ensure immediate arrangements for children are safe.

Individual case file audit returns for the period:

Month	Audits Planned	Exempted	Scheduled	Audits Returned	% Returns
May 2023	91	8	83	44	53.00%
June 2023	105	2	103	42	40.80%
July 2023	97	10	87	27	31.00%
August 2023	79	4	75	33	44.00%
Sept 2023	124	9	115	33	28.7%
Oct 2023	110	9	101	27	26.7%
Nov 2023	124	7	117	23	19.7%

Overview of the grades for the audits completed (after moderations)

Month	Outstanding	Good	Requiring Improvement	Inadequate	Total Returns
May 2023	0	21	21	2	44
June 2023	0	7	31	4	42
July 2023	0	2	13	12	27
August 2023	0	10	4	19	33
September 2023	1	10	12	10	33
October 2023	0	6	14	7	27
November 2023	0	5	14	4	23
TOTAL	**1**	**61**	**109**	**58**	**229**

Learning

Strengths

- No children were found to be in unsafe situations in all the audit work that has been completed.
- Overall, the quality of audits continues to improve. There are identified areas for development but it is positive to note that the number of audits being downgraded is reducing in terms of quality.
- Feedback is now part of the audit process to understand the experience of our children and families.
- It is clear that there are pockets of good practice taking place across the service as evidenced within the audits that is making a difference to achieving better outcomes for our children and families.
- The audits have highlighted that there is evidence of some good quality Social Work taking place in Bradford and that for some children their plan is effective in keeping them safe and is supporting them to achieve positive outcomes.

Areas for development:

- Management oversight needs to be strengthened to ensure that team managers are driving the child's plan and that good quality reflective supervision is provided to social workers and actions are tracked to evidence impact and outcomes.
- The quality of case file management needs to improve, chronologies, case summaries, visit recording and demographics need to be completed in accordance with the Practice Standards to help care leavers to understand their journey.

- Assessments need to reflect greater depth, analysis and including of wider family members views to help decision making to be child centred and effective.
- Plans need to be completed and updated in line with Practice Standards and evidence SMART decision making.
- Good quality and effective safety plans and contingency plans need to be recorded.
- Direct work with children needs to be more strongly embedded to understand how their views and wishes are influencing the work that we are doing.
- Life story work needs to be consistently evidenced for children in care.
- Staff retention continues to be a significant concern which impacts on the quality and effectiveness of Social Work and contributes to contribute to drift and delay in care planning.

2.3 Moderation of monthly case file audits

As part of the monthly arrangements, moderations are completed to help understand thresholds of gradings to support consistency. The moderations also review the quality of the audits.

The moderation process involves the Quality Assurance Officers re-auditing a child's file and comparing the findings to the original audit grading; this can be subjective, so a moderation panel is held monthly which allows a 'check and balance' benchmarking sessions within the team.

To ensure that there is a shared understanding across the service benchmarking sessions have been offered to all since the beginning of the year which all auditors have the opportunity to attend as it is recognised that peer group learning is an effective method.

Audits graded as inadequate are reaudited every 3 months to ensure that actions have been completed and the child is receiving the right support at the right time; these findings are shared with HOS to track in their service areas.

Moderation completed in the period:

Moderation Grades	
Good	16
Requires Improvement	34
Inadequate	10
TOTAL	**60**

Percentage moderated	**26.2%**
Audit grade supported	29
Audit downgraded	31
Percentage downgraded	**51.7%**

2.4 Themed Audits

Monthly case file audits are supported by themed audits; these are completed by either the audit team or by managers / practice supervisors within the service to help provide a wider understanding of practice. A number of themed audits have been completed since the Trust went live in April 2023.

Children Open with No Current Plan

The purpose of the audit activity was to identify children with no plan, to understand why they had no plan to prevent drift and delay in care planning for children open to Bradford Children and Families Trust. The report looked at children taken from a sample in January. The sample was 361 children who had a completed assessment but no plan' of this 100 children were selected for dip sampling (27% of the cohort).

Out of 100 children in the dip sample, only 1 child did not have a Child and Family Assessment on the file. This shows significant improvement since the last dip sample of children without plans, which was undertaken in June 2020; at that point 77 children did not have a Child and Family Assessment. This is positive progress which needs to be highlighted. The application of threshold at the point of step down to the Early Help Services was also identified as appropriate.

The learning identified that there was not consistent oversight from managers regarding a delay in plans being completed or updated, which is essential in to ensure that children have SMART plans which are effective in supporting positive change. It was also identified that closures needed to progress in a timely way.

Public Law Outline

The audit was commissioned to understand delays for children through the Public Law Outline Process (PLO) and care proceedings and to identify any barriers to effective and timely care planning. 30 case files were reviewed.

The audit positively concluded that tracker meetings are taking place, the meeting ensures that there is effective challenge and actions progressed, alongside making sure that all the relevant documents are evidenced on the child's file. Learning identified that further work is needed to ensure that plans are SMART and that assessments impact the need to "front load" to prevent delay, minutes need to clear, and reviews need to evidence progress against the plan. Critically, there needs to be an understanding of the child's experiences to assess impact.

Children coming into care

The purpose of the audit was to understand why children came into care, reviewing whether the decision made at the time was right and in the child's best interests.

The audit also considered whether the children were coming into care in a planned way or in an emergency, reviewing the effectiveness of the Public Law Outline process, contingency planning, quality of the child's placement and their permanence plan.

There was a total of 287 children who came into Local Authority care in the six-month period from January 2023 to July 2023. For the purposes of this audit, siblings were removed, leaving 209 children. A total of 77 audits were completed, representing a sample size of 27.2%.

This audit report has highlighted that we need to relook at how we work with our children, young people, and families so that they are receiving the right support at the right time. The report identifies that by improving practice we can make a difference earlier in children's lives. This will then ensure that children are not experiencing lengthy and repeat periods of social care intervention.

Children subject to Child in Need Plans over 12 months

The audit looked to understand themes behind any drift and delay identified for children who were subject to long term Child in Need planning. 48 children were reviewed from 28 families. The audit identified that 71% of children were receiving regular visits, with 74% of children were being reviewed and 21% of children had their assessments updated. It was also identified that a number of children (46%) who had regular scrutiny through the Child in Need Clinics.

The learning identified that management oversight and supervision is an area that needs to be strengthened by ensuring that clearer actions and timescales to be more effective in driving progress against the plans. Further work also needs be completed to ensure that we are supporting families with no recourse to public funds through the correct framework, linking in with the specialist council Immigration and Asylum Team. Whilst it was recognised that safety plans were being included for some children in case summaries, this needs to be achieved consistently to ensure that we are addressing risk appropriately.

The quality of planning was an area that was identified for further development in terms of focusing plans to be SMART, plans to be updated to reflect the progress and any other options explored when actions have not been effective as expected. This links to making sure that the review of plans also captures who has attended and how the voice of the child is helping to ensure that our practice is chid centred.

Children subject to repeat Child Protection Plans

The purpose of the audit was to understand the reasons for children to have more than one Child Protection (CP) Plan. Over the 6-month period to 31st April 2023, 700 children were placed on a Child Protection Plan. Of these 700 children, 169 (24%) had previously been on a plan at some point in their lives. A total of 64

children and young people were reviewed totalling 36 families.

- There is a small proportion of children on repeat CP plans whose first CP plan lasted only 3 months. In one instance this was due to a baby being joined to a CP plan alongside siblings which resulted in step down at first review.
- A significant number of repeat CP plans are underpinned by domestic abuse with an incident mostly arising with the same partner resulting in a second period of CP planning. However, there are instances of themes of domestic abuse taking place with a new partner. Therefore, there is evidence that plans are stepped down on the basis that there are no more incidents or because partners have separated however the underlying reasons for why domestic abuse happens in relationships has not been resolved. This area of learning has been incorporated into training and the CP coordinators are providing challenge in this area.
- There is evidence of unborn babies being overlooked in planning where siblings are subject to a CP plan resulting in late presentation to Initial Child Protection Conference. This learning has used to develop the prebirth panel as well as support early planning for children.
- It was positive to note that in many instances (more the norm) there was evidence of child in need planning being undertaken as part of step down.
- There was evidence of a number of families whereby step down from CP had taken place but there was outstanding work as well sometimes missing a clear understanding of the narrative from the children/young people who were saying that ‘things are better now’. This related to the threshold for significant harm no longer being evident to support an ongoing CP plan but further support being identified that can be completed with a family as part of a Child in Need plan.
- Where Public Law Outline (PLO) had been initiated, work needs to be undertaken to prevent drift.
- There was evidence of over optimism, especially in regard to parents who had separated and where chronic neglect was evident.
- Further work to be completed to ensure appropriate thresholds for CP planning when supervision orders have not been effective.

2.5 Summary

It is clear that there is improved work underway across the service that is meeting the needs of some of our children and families. The next step is to strengthen practice to ensure that this is consistent for all children and families across the district to support better outcomes and respond with the right service at the right time.

There is no doubt that the lack of permanent social workers has had an impact. Some children and young people have experienced changes in social worker which has meant that we have not always been able to form and develop good working relationships; this is necessary to provide a platform for good quality direct work to be undertaken and ensure that children’s views are central to decision making.

Audit activity has identified that there are common threads of learning which has informed our focus on doing the simple things well and a clear obsession to improve the key areas identified for learning. Doing the simple things well will enable us to create a strong foundation to make a difference to children and young people. This approach was launched in September with a focus on –

- **Children are seen**
- **Safety arrangements are in place**
- **Children have an up to date assessment**
- **Children have a plan**
- **Children's plans are reviewed**
- **Children's voices are influencing their plans**
- **Supervision is reflective and of good quality**
- **Decision making and evidencing practice**

Alongside this we have launched Practice Obsessions which is an 18-month programme focusing on doing the simple things well; embedding good practice and ensuring that there is a shared understanding of what 'good looks like'. The six obsessions have been identified from our audit findings as this practice needs to be strengthened if we are to provide a consistently good service to our children, young people, and their families.

Our six obsessions are -

- **Case Recording** – What is a good case recording, how to capture the voice of the child and their lived experience.
- **Case Summaries** - What is a good case summary, how to capture key information, including the voice and lived experience of the child.
- **Chronologies** - What to include in a chronology and why a good chronology is important to understand the journey of the child. Looking at history to understand what has happened previously and what this means for what is happening now to inform our plan of work. Understanding what is needed for a court chronology.
- **Voice of the Child** - How to plan and complete direct work with children and young people, direct work tools, importance of observations and using what children tell us to inform their plans and what we do to make sure that they are safe and heard.
- **Effective working relationships with parents, carers and professionals -** How to build good relationships with parents and carers, the importance of inclusive practice that is respectful and curious. Exploring relationships with family, close networks, and community to support children and families.
- The importance of working relationships with our colleagues in various agencies to support children and families to be safe and well.
- **Assessments -** Pulling the threads of the work done over the last 5 months to create a good assessment that is evidence based and analytical.

Each obsession will be a focus for a period of a month, allowing a series of learning activities to take place through different forums with an aim to develop consistently good practice across the whole of the service. While some of the development activities will be led by the Workforce and Learning Service it is essential that practice learning is driven by managers, peer reflection and a range of different methods of learning.

Work is underway to ensure that there is connectivity between the strands of the improvement plan and the relevant audit activity to allow reflection and improvement. This will help understand how the learning from audits is being considered whilst determining the impact of training / development to effectively "close the loop".

This will be further supported by the training that is being offered by Leeds Relational Practice Centre, particularly in relation to the Management Oversight and Reflective Supervision as we know and understand that having managers who feel confident to support and challenge will be pivotal to help drive forward practice change. In addition, we are embarking on a recruitment drive to permanently secure practice supervisors in role to help strengthen practice and identify areas of development through reflective discussions and dip sampling.

2.6 Next Steps

Continue to review and strengthen the auditing process to enable improved engagement to increase the number of audits returned but also to reflect on how learning is shared and cascaded so that the wider workforce is able to understand what is happening and why this is important for learning and development. This includes reviewing the audit report format through a restorative approach to support high support and high challenge.

Strengthen and widen the moderation process to include newly appointed Assistant Directors in the Trust.

Develop learning circles and the quality assurance activity outside of the monthly auditing arrangements to strengthen and drive engagement.

3. OTHER CONSIDERATIONS

3.1 None.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 None.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 None.

6. LEGAL APPRAISAL

6.1 Effective quality assurance and audit processes support the Trust to comply with its statutory duties, including under the Children Act 1989, regarding the protection and welfare of children and young people.

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

Not applicable.

7.2 TACKLING THE CLIMATE EMERGENCY IMPLICATIONS

Not applicable.

7.3 COMMUNITY SAFETY IMPLICATIONS

Not applicable.

7.4 HUMAN RIGHTS ACT

Not applicable.

7.5 TRADE UNION

Not applicable.

7.6 WARD IMPLICATIONS

Not applicable.

7.7 IMPLICATIONS FOR CHILDREN AND YOUNG PEOPLE

Improving practice will improve service delivery for all children and young people.

7.8 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

Not applicable.

8. NOT FOR PUBLICATION DOCUMENTS

8.1 Not applicable.

9. OPTIONS

9.1 Not applicable.

10. RECOMMENDATIONS

10.1 That next steps are endorsed to continue to support practice improvement.

11. APPENDICES

11.1 None.

12. BACKGROUND DOCUMENTS

12.1 None.