# LEARNING BRIEF – JUNE 2019 DRIFT & DELAY

SCRs, Ofsted reports, research articles all discuss the impact that Drift & Delay has on children at different points in their journey through social care services. This learning brief will highlight the key findings and learning from the audits undertaken in June. Whilst this is only a snapshot, these findings are significant in terms of reflecting on what we do, when we do it, how we do it, and more importantly what impact this has on the child and their family.

 **SO WHAT DID WE FIND OUT?**

WHAT ARE WE WORRIED ABOUT? –

Record keeping was not in compliance with statutory requirements. Block inputting of records made it difficult to establish what had taken place and when. – This has a significant impact on the ability to analyse risk and make decisions in a timely manner. - *SCR child Elias reported that case recording by workers and managers in many case files was so poor that it was not possible to tell how decisions got made* .

Assessments lacked analysis and many contained irrelevant and out of date information as a result of the pull through function – this contributes to delay as information is not readily available, relevant or accurate. - *Good quality assessments are essential to build an accurate picture of a child’s circumstances and to ensure they are given the right support for their needs. Without it, social workers may find it difficult to identify whether children are being harmed or are at risk of harm. As a consequence, action to protect children may be hindered. – Ofsted 2015.*

 A number of Strategy discussions and minutes from other meetings were found to have delays in being compiled, signed off and circulated - One agency reported in their feedback that it would be helpful to be sent review notes so we can be kept upto date. -The cumulative effect of delay in processes does not appear to have been considered in terms of Agency working and safeguarding of children/ young people. – *SCR child AK found that there was not an effective process for management oversight or a process to review the decision of the strategy discussion.*

Audits identifed that Core Groups lacked focus and therefore revewing and driving forward plans was difficult to evidence. This was echoed by prof feedback who felt Core Groups could be more proactive in looking at next steps as opposed to looking back over history.

****SMART planning was not consistently evident within the audits, more significnatly it was often not possible to follow the progress or future direction of a case. Contingency planning, Trajectories and Bottom Lines were not located within this audit cohort. One Parent fedback she did not know what was expected of her. Another parent scored involvement as **0 out of 10** as he did not know the case was still open - Without parental participation and engagement, plans will be delayed in achieving change and positive outcomes for children.- *. RIP reports - Where care planning is weak, (not linked to high quality assessment and without clear goals being set) there is evidence of drift.*

Several audits identified that referals had been closed prematurely due to non engagement of the parent. Parental avoidance can cause delay in the provision of intervention and analysis of risk.

Drift in decision making was highlighted at various stages of a child’s journey, referrals were found to be closed due to non-engagement, QA and sign off for assessments and reports were late. Frequency of supervision was variable. – These factors all contribute to drift and delay in planning permanence and safeguarding of children. - *The longer a child is left inadequately protected from abuse and neglect, the greater the chance that their long-term well-being will be compromised*. RIP



 **WHAT DID WE FIND THAT’S WORKING WELL?** -

* Some good samples of Direct Work with children, including a Words & Picture Story that was started prior to a baby’s birth and can be built upon as the baby gets older
* A parent was appreciative of having their plan made in pictures
* 0 to 25 services had some Good with Outstanding features identified in a case where services and advocacy had made a difference for a child, and as a result for their family
* A parent stated that ‘the SW does what she says she will do’
* A school informed us that the SW was approachable and listened
* The Audits found one case where pursuing a kinship placement was active, efficient and in line with the children’s wishes
* A Young person gave the SW 4 out of 5 Smiley faces for explaining things
* Outstanding elements of creativity and advocacy made a significant difference for a family with no recourse to public funds
* One parent fedback ‘Whether or not we disagree she helps explains things, and does her job.’ – Honesty and transparency are key tools in building effective working relationships

 **SO WHAT NEEDS TO HAPPEN NEXT?**

For us to counter the reported research and messages from Serious Case Reviews (Baby AK and Child Elias), we need to develop our understanding of cumulative effect in terms of consequences to process, and impact for the child, in terms of drift and delay in acheiveing permanence and safety

We need to ensure we are statutory compliant with our recording of chidrens records, and remember this is not only a procedural process but it is also an account of the childs story

Better integration of Trajectories, scaling and bottom lines would help to identify where drift is occuring and what steps are needed to unblock this. –this would also help to prevent families from feeling uclear of what is expected or required of them

We need to find ways to embed SMART principles into assessments, plans, reviews and superivsion.

Core Groups and Review Meetings need to focus on the next steps and what these look like, we need to remember that Goals consist of a series of mini steps, and that often families may need help to navigate their way through these

We need to build on practitioners creativity and encourage outside the box thinking

Supervision needs to be consistent in frequency and quality. -*High Quality supervision needs to enable practitioners to develop and test hypothesis, develop confidence, challenge and drive forward plans. RIP*

 **KEYS TO SUPPORT LEARNING –**

<http://www.northamptonshirescb.org.uk/about-northamptonshire-safeguarding-children-board/scr/childak/> Child AK

<https://fosteringandadoption.rip.org.uk/wp-content/uploads/2014/04/Impact-of-avoidance-and-delay.pdf>

<https://www.gov.uk/government/news/ofsted-improvement-in-the-quality-of-assessment-for-children>

<http://www.childrenandfamiliestrust.co.uk/wp-content/uploads/2010/09/Elias-SCR-Overview-Report-FINAL.pdf> SCR Elias.