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# Inspection of local authority arrangements for the protection of children

## Isle of Wight

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**Inspection dates:** **26 November to 5 December 2012**
**Lead inspector** **Richard Nash**

**Age group:** All

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# Inspection of local authority arrangements for the protection of children

## The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

| | |
|---|---|
| Outstanding | a service that significantly exceeds minimum requirements |
| Good | a service that exceeds minimum requirements |
| Adequate | a service that meets minimum requirements |
| Inadequate | a service that does not meet minimum requirements |

## Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in the Isle of Wight is judged to be **inadequate**.

## Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in the Isle of Wight, the local authority and its partners should take the following action.

**Immediately:**

- review and audit all contacts over the last four months into the children's First Response unit that resulted in a decision not to provide a service
- review and audit all open section 47 enquiries and all cases involving children subject to a child protection plan to ensure that assessments and current plans reflect all the indicators of reported risk
- ensure that performance management and quality assurance arrangements are fully in place and that there is robust management oversight of all contacts, referrals and section 47 enquiries
- ensure that all assessments have sufficient focus on the voice and journey of the child, their individual needs and the presenting indicators of risk.

**Within three months:**

- review, strengthen and establish clear lines of accountability and governance between the Health and Well-being Board, the Local Safeguarding Children Board and the Children and Young People's Strategic Partnership Board

- review the range and type of management information reports made available to senior managers and elected members to ensure that there is robust and effective governance of child protection services

- ensure that all staff receives regular and effective supervision in line with the council's own supervision policy and that supervision supports professional development and service improvement.

**Within six months:**

- ensure service planning is influenced by the views of service users, their parents and carers and the outcomes of audit and performance management arrangements.

# About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of four of Her Majesty's Inspectors (HMI).

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

# Service information

9. The Isle of Wight has approximately 26,258 children and young people who reside within the authority. The 0-17 population accounts for around 19% of the resident population, a proportion lower than both the regional and national average. There is a significantly higher than average population of the 65+ age group. This group equates to approximately 24% of the island's population, but is predicted to increase to 36% of the population by 2035.

10. The proportion of children and young people entitled to free school meals is currently 19%; this is above the regional average (15%), but slightly below the national average of 21%. Child poverty levels are currently at 21.1% which is above the regional figure but in line with the national average. Indices of Multiple Deprivation 2010 show the Isle of Wight as within the 40% most deprived local authorities in England, ranked $126^{th}$/326.

11. Children and young people from minority ethnic groups account for 8.3% of the total population, compared to 14.3% in the South East and 17.2% in the country as a whole. Although lower than regional and national

averages the number of children from minority ethnic groups has trebled since 2001. The largest category within this group are 'White: Other' – this group consists of mainly Eastern European children. This is followed by 'Asian or Asian British'. The proportion of pupils with English as an additional language is significantly below the national average.

12. Early help for children and families on the Isle of Wight is provided through the Isle of Wight council's internal and commissioned services, together with partner agencies. There are four age related themes in the early help strategy and service is organised according to these themes:

    - The best start in life (0-5)
    - Growing up well (5-19)
    - Readiness for adult life (11-19)
    - Supporting parents and families (all ages)

13. Services are delivered in a number of ways, including eight children's centres, health visiting services, a parenting and family support service, targeted youth support service, schools and community settings, education welfare service, behaviour support service, youth services, community child and adolescent mental health service and Get Sorted, a substance misuse service. If parents or professionals are concerned about a child's progress or think that early help is required then they are encouraged to contact the children's First Response unit and speak with a common assessment framework (CAF) coordinator who can advise on what services are available and how to access them. They will also be able to advise on the CAF process which will coordinate early help services through a lead professional. Child protection services are delivered through the island-wide children's First Response unit, three short term assessment units, three child protection units and three units for children with disabilities.

## Overall effectiveness

14. The overall effectiveness of local authority arrangements to protect children in the Isle of Wight is inadequate. During this inspection a significant number of cases were brought to the attention of the local authority where children and young people had not been adequately protected and the circumstances of these cases indicated that there are significant weaknesses and systemic failures in core child protection business. Services delivered by the children's First Response unit and short term teams were found to be providing inadequate responses to children in need of protection. There were significant weaknesses in relation to the quality of assessments across all social work teams. Quality assurance and performance management systems have been ineffective at both identifying areas of weaknesses and also addressing known deficits. Improved performance is reported by the council in some important areas such as the timeliness of assessments and the numbers of completed common assessment framework (CAF) assessments. However these quantitative measures have not enabled the council to gain insight into the impact and outcomes of their child protection work.

15. The local authority has embarked on significant change during the last two years in relation to children's services. The post of Director of Children's Services has been merged with the equivalent post in adults services, a new disability service has been created that provides services from birth to 25 years of age and the Reclaiming Social Work model has been implemented in the statutory social work teams. Whilst staff morale has benefited from this new model there is little evidence of sustained impact on the quality of core child protection work. Clear progress has been made in relation to the number of completed CAFs and there is evidence of early help work having a positive impact on addressing the needs of some children and young people and preventing the escalation of concerns.

16. First Response provides a single point of contact for professionals and members of the public who have concerns about a child or young person. Despite there being a clear and relevant threshold document it is not consistently being applied. The quality of contacts into First Response and decisions by them are often of poor quality leading to delays in providing services to those children in need of protection. Inspectors saw a number of cases where section 47 enquiries were not progressed within statutory timescales and as a result children and young people were not appropriately protected. Professionals from other agencies reported experiencing delays and a lack of responsiveness from First Response when raising concerns about children.

17. Although the focus upon risk and the need to improve outcomes for vulnerable children is more advanced in the disability service and to an extent in the child protection teams than in the First Response unit and short term teams, assessments of children's needs across the service are

highly variable and too many are poor. The voice and journey of the child is often given insufficient attention in assessments and some are too focused on the adults' needs with little analysis of risk to children. Consequently, case planning is frequently poor and child protection plans ineffective at promoting sustainable change for children and young people.

18. Performance management systems are not well developed across children's services, in part because of difficulties with the current electronic recording system, but also because insufficient attention has been given to developing systems that enable managers to have clear oversight. The disability service is in the process of developing a more comprehensive quality assurance system but this is not yet having an impact. The quality assurance systems currently used are inadequate and have failed to identify and address major failings in child protection services identified in this inspection.

19. The Local Safeguarding Children Board (LSCB) is under developed in terms of its role and impact. It does not meet its statutory duties in terms of its role and function and does not have effective oversight of child protection services. The newly appointed independent Chair has recognised the urgent areas that need addressing and is currently putting in place a number of changes to strengthen both governance and impact.

20. As a result of this inspection the local authority has developed an action plan to immediately address some of the key areas of weaknesses in child protection services. Once senior managers understood the areas of poor practice in individual cases they acted promptly to safeguard and protect individual children and young people..

## The effectiveness of the help and protection provided to children, young people, families and carers

### Inadequate

21. The effectiveness of help and protection provided to children, young people and their families is inadequate. Despite a clearly outlined thresholds document the initial response to referrals is variable, lacks consistency of decision making and fails to correctly identify risk. As a consequence not all children are being correctly identified as at potential risk of harm, they are not always being protected and in too many cases their needs are not being responded to in an effective and purposeful way. There is concern amongst some professionals that cases which have had a CAF assessment and where risk has increased are not immediately accepted by children's services as meeting the threshold. Inspectors found a number of case examples where, after consideration by the local authority, there was recognition that inappropriate decisions that exposed

children and young people to the risk of harm had been made by First Response, the council's duty service.

22. Risks to children are not always well assessed and managed. The majority of assessments seen are of poor quality, lacking sufficient analysis of risk and indicating a lack of understanding of risk factors. Whilst there were some examples of more comprehensive assessments most of these were CAFs. In some cases assessments were delayed by late allocation of work and in others closed or 'stepped down' inappropriately, relying on other agencies to monitor and evaluate a high level of risk that is inappropriate. This has resulted in some children and young people not getting help and protection at the right time and in some cases left in situations where there is risk of significant harm. Quality assurance processes are not robust and are not embedded in the work of short term and child protection teams. As a result there is a poor level of understanding and learning in relation to cases of concern and a lack of recognition of core issues of risk.

23. The disability service has a clearer focus upon the protection of children and young people and the majority of assessments identify risk and take into account the child's disabilities and safeguarding needs. This service has extended its scope to work with children, young people and adults up to the age of 25, enhancing the ability to deliver a more seamless service and avoiding transition issues.

24. There is evidence that children on child protection plans are seen regularly with statutory visits held within timescales. However the needs of individual children are not always identified and inspectors saw a number of case examples where assessments of sibling groups were not individualised to the needs of the child, including one of a large sibling group having the same child protection report copied for each child. Core groups are being held regularly with good attendance by parents and agencies. However they are not informed by good assessments and planning and therefore are limited in being able to effectively develop the child protection plan. Basic information is recorded in relation to ethnicity and diversity with some appropriate and thoughtful work seen relating to linguistic needs. However there is little evidence that the consideration of the individual needs of children, are routinely taken into account in terms of ethnicity, culture, language, religion and disability.

25. Too many strategy and legal planning meetings are ineffectively led by consultant social work staff demonstrating a lack of planning, decision making, recognition of risk and appropriate actions to minimise risk. This has led in some cases to delayed or insufficient interventions in cases and subsequent drift. While many families receiving early support services indicate that they feel effectively helped and well supported, the number of cases open to social care where there are deficits in risk assessment, planning and intervention means that effective help has not been available

at the point of need in social care. Children and young people receiving early support and targeted youth services told inspectors that they felt supported and that help was available and accessible.

26. Early help is available and accessible for all ages and most direct services are good quality, with a focus on building good relationships and meeting the needs of the child, particularly in the short term. Children's centres are located in the areas of most need and provide good quality services with those that have been inspected by Ofsted being rated as good or better. For example parenting courses provided in children's centres are felt to be effective in improving parenting skills for parents who are receiving more targeted services as well as for parents who lack confidence. Families also value the 'freedom' programmes for those at risk of domestic abuse. Schools and some academies are now using CAF procedures extensively and this is having an impact on improving the attendance and achievements of targeted pupils as well as enabling schools to identify any child protection concerns promptly. Generic youth services are located in the areas of most need. Targeted youth services use effective strategies to engage young people and the level of engagement of young people are good.

27. Common assessment framework services are well coordinated with good strategies to improve the consistency of CAF practice. CAF practitioners use the framework document well. In the majority of CAF cases seen the help offered has stopped or prevented escalation to social care services, preventing family breakdown and has improved children's well-being, learning and development.

28. Consistency of early help in children's centres and early years private and voluntary provision is well coordinated. Support to improve CAF practice through training and mentoring is good and well organised. Team around the family (TAF) processes enable practitioners to coordinate their services and share resources.

## The quality of practice

### Inadequate

29. The quality of practice is inadequate. While all contacts are assessed by qualified and experienced social workers in the First Response team decision making on these contacts is not consistently timely and recording of decisions made is not always accompanied by a clear rationale for each decision. Too many cases are kept at contact stage that should be escalated to a referral and initial assessment. This exposes some children and young people to unnecessary risk and inspectors found too many cases where there was not a timely and robust response to their need for protection. During the inspection and as a result of inspectors identifying cases where children were not adequately protected the local authority took action to ensure children were safe. However the council did not

initially recognise all the weaknesses inherent in their practice and partner agencies also report with some frequency that cases that meet the threshold for assessment are not escalated by the First Response team and these are too often held at CAF level or given no service at all.

30. Referrals that meet the threshold for a child protection enquiry are not always responded to promptly and information gathering and the coordination of a response with the police is often delayed. Whilst section 47 enquiries are always undertaken by qualified social workers, there is a lack of a well-coordinated, robust and effective response to safeguarding children. Strategy discussions are consistently taking place between police and social care: however, these are not always timely and consequently the welfare of children is not safeguarded adequately. There is often insufficient attention to the immediate protection needs of children subject to section 47 enquiries and case records do not always evidence how children will be kept safe until the initial child protection conference is held.

31. The timeliness of initial and core assessments has improved. However, the identification, focus and subsequent recording of the analysis of risk factors in most cases seen are not robust. A number of assessments seen by inspectors had overly optimistic conclusions that did not sufficiently reflect risk or the child's journey in terms of the use of historical information and prognosis for positive change. Too many risk assessments do not consider patterns of behaviour, family history or previous events and as a result risk is assessed based on one specific incident rather on a comprehensive overview. Chronologies were seen on some case files; however these are not used by social workers as a tool to inform assessments and future planning. In some cases this has led to drift in escalating cases to child protection or to court proceedings.

32. There is some good personalised work with families at the early help stage where the needs of children and their families are below the threshold for statutory social work intervention. Practitioners delivering early help and preventative support build positive working relationships with children and their families. Lead professionals for CAF work teams see children frequently on an individual basis. CAF assessments are generally of good quality when completed by practitioners in universal services. Case recording through CAF reviews is timely and in sufficient detail for effective partnerships. High quality work by appropriately skilled professionals takes place in children's centres, schools, pre-schools and in nurseries through therapeutic play sessions. Children and their parents value the specific help and support of these professionals. In early years, families helped by the team around the child approach are engaging with midwifery, health, family learning and early years foundation stage services.

33. Child protection and child in need assessments do not routinely inform planning and planning does not always adequately focus on the risks and needs identified in assessments. Whilst plans are reviewed regularly, there is insufficient evidence in case records that indicate they are always used by social workers to promote positive change for children and secure sustainable improved outcomes. Children in need plans and protection plans are not consistently outcome focused, specific or measurable and do not always have clearly identified outcomes and clear timescales. There is insufficient consideration of contingency planning for children and young people and plans do not always enable parents to understand expectations of them or the consequences of not meeting these. Step down processes for children who no longer need to be subject to a child protection plan are mostly timely. However step down monitoring arrangements are not sufficiently robust or rigorous and monitoring is mostly achieved through a CAF. Partner agencies and social workers have reported to inspectors that this has led to some reluctance to step down child protection arrangements for some children as the transfer from a protection plan to a CAF is felt to be insufficient to adequately monitor children's welfare at that stage in the case. Some child protection and child in need cases are closed prior to sustained improvements being made by parents which can expose children to further harm.

34. Core group meetings are taking place regularly but there is limited evidence that core groups are fully effective at developing the outline protection plan into an effective working tool. Core groups and case conferences are mostly well attended; however attendance by some key agencies such as the probation service and GPs is inconsistent. The quality of child protection reports is variable and whilst some are detailed and identify risk factors, others do not focus on risk or protective factors adequately. Child protection case conferences are chaired by a single Child Protection Officer using the strengthening families model and this has enabled parents to feel well engaged in the process. However, the potential impact of the model has been diluted by the lack of capacity in relation to Child Protection Officers, the venue for conferences, which is poor, and the quality of child protection assessments.

35. There is a clear commitment by practitioners and managers to working in partnership with parents. In some cases this leads to adequate outcomes enabling children to remain at home with their parents. However in some cases seen, parent's needs are prioritised over those of children and this has led to on-going exposure of some children to risk, particularly in cases where there is domestic violence. In many cases, assessment, intervention and planning are predominantly focused on supporting the adult rather than focusing on the experience of the child. Whilst children and young people mostly report that they feel listened to and their views are sufficiently considered and represented, this is not consistently reflected in case recording or at assessment and planning stages. The use of advocacy arrangements for children and young people is variable and this is not

sufficiently embedded in practice or promoted by social workers and other professionals.

36. The out of hours service offers a satisfactory level of support to children and their families. Staffing arrangements and capacity demands on this service are leading to a reorganisation of service delivery and structure to ensure a more timely and effective response to service users. Information exchange between the out of hours service and the day time services is concise and clear.

37. Caseloads for social workers are high and competing demands generated by these caseloads are adversely impacting on the offers of help or protection provided by social care services. The local authority is in the process of developing a coordinated, multi-agency approach to identifying and protecting young people at risk of sexual exploitation. However this is a very recent development and whilst there is commitment from partner agencies, this work is not yet embedded and the impact cannot be evidenced.

38. The quality of management oversight is highly variable and has failed to improve inadequate casework. Electronic case files do not reflect effective management oversight and this lack of scrutiny does not ensure that children are well protected. There is no clear evidence that shortfalls in practice have been effectively identified or challenged by managers and conference chairs. Recording of management oversight does not consistently articulate why specific decisions regarding children have been taken.

39. The frequency and quality of formal supervision to social workers is variable. Not all social workers receive regular supervision although all social workers spoken to during the inspection described good access to informal supervision. Supervision records lack reflection and analysis and do not, therefore, promote professional development or learning. Newly qualified social workers receive increased support and have protected caseloads. Annual appraisals for all staff are also variable in frequency and in quality with some not completed in recent years. Access to training is adequate and although staff appreciated the programme of courses this has not led to any significant service improvements.

## Leadership and governance

### Inadequate

40. Leadership and governance is inadequate. The strategic priorities of the council and its partners are not sufficiently explicit about the need to safeguard and protect vulnerable children. Too many children and young people are not effectively protected from harm; management oversight and quality assurance measures are not robust and have failed to identify serious systemic weaknesses in the quality of child protection services.

41. Whilst there has been some progress against areas for development identified in previous inspections the council has not yet succeeded in ensuring that previously identified weaknesses in core child protection work have been addressed. A Local Safeguarding Children's Board (LSCB) audit in 2010 found that in seven out of 10 child protection cases, assessments of risk were weak and child protection plans were poor or incomplete. This inspection has found that no significant progress has been made in these areas and other previously unidentified serious weakness in child protection services exist. These include inconsistent application of thresholds, failure to recognise and act upon child protection concerns and failure to adhere to statutory guidance. As a consequence, inspectors identified a number of children who were not appropriately protected and had been exposed to further significant harm. The initial response by the council when individual cases of poor or unacceptable practice were brought to their attention was not robust and staff initially failed to understand or accept the view that some children had not been adequately protected. This was however, subsequently addressed and the second response to inadequate casework was appropriate; it accurately identified failures in practice and procedures and immediate action was taken to ascertain the safety of those most at risk. Senior officers have now constructed an action plan to address all the concerns that have been raised.

42. The Lead Member and the Leader of the Council have supported significant change within children's services since 2010. This includes combining the Director of Children's Services (DCS) post with the equivalent post in adult services and the creation of commissioning manager posts. However, the latter posts are not held by qualified social workers and this impacts negatively on the professional line of management accountability between senior managers and front line practice. The council have recognised this as a serious weakness and are in the process of addressing this issue. Child protection services have recently been re-modelled with the creation of the First Response duty services and the formation of social work teams that reflect the Reclaiming Social Work model. In addition, the strengthening families model is now used in child protection case conferences and the council have successfully transformed the children's disability service to a children's and adults 0–25 years old service. However these service changes have not led to significant improvements in child protection and child in need services and too many children are inadequately protected.

43. The Lead Member, the Leader of the Council and scrutiny committee is actively focused upon the performance of children's services and they provide regular challenge to the DCS. However, although there has been some successful change and improvement, evidenced through some quantitative performance indicators, the focus on the quality of core child protection work has been insufficient to fully address known weaknesses

and has been unsuccessful in identifying key deficits that have, until this inspection, remained hidden.

44. The quality assurance processes put in place by the council have not identified the serious deficits in practice highlighted by this inspection. The quality assurance activity that is in place is predominantly limited to an evaluation of quantity of processes rather than quality of outcomes for children and young people. Improvements in some indicators, such as the timeliness of assessments and reduction in re-referrals have given senior managers and elected members an ill-placed confidence that child protection services are more robust than they actually are.

45. Thematic audits of child protection work have identified both strengths and areas for development. However, these findings are not routinely used to develop an overall improvement plan and it is unclear what actions have been specifically taken by senior managers to improve performance. Currently case audits are undertaken through dip sampling by group managers and monthly thematic audits. There has only been one service based case audit in the last year, in February 2012, on child protection cases and one is planned in relation to contacts and referrals in February 2013. There are no planned audits in relation to short term teams. This audit profile is a potential weakness as it does not enable auditors, staff and management to develop a clear picture of the quality of the services for vulnerable children. Managers routinely authorise assessments that are of a poor quality and there is little evidence of effective performance management of staff in the statutory child protection social work teams. However, the management oversight of the disability service is more effective, the recruitment of a consultant social worker with extensive child protection experience has brought valuable safeguarding skills to bear on practice and children in these units are effectively safeguarded.

46. The performance management of children's centres through commissioning and annual 'conversations' is systematic and detailed. The local authority uses RAG (red, amber, green) rating against national indicators and results of Ofsted inspections and quality assurance procedures of the host organisation (three private and voluntary sector partnerships) to monitor performance. As a result, performance against the core purposes of children's centres across the island is very good and outcomes for staying safe are good or outstanding.

47. Workforce development is adequate. Although the council does not have a recruitment and retention strategy it has successfully reduced the previous number of vacancies by offering salaries similar to local comparator authorities. The small numbers of vacancies are covered by agency staff. The council has also increased the number of qualified social workers through a positive relationship with Bournemouth University and supporting students financially, four social workers are about to graduate

and two have secured employment with the department. The council has a comprehensive learning and development programme which has recently been reviewed to ensure it meets the competency requirements of the service. The current programme is targeted to developing the competencies of staff who receive an annual programme of courses they should attend.

48. The LSCB is inadequate; it does not have an effective oversight of practice. The engagement and attendance by some key partners from health, probation and education has been poor. The LSCB is chaired by a recently appointed interim independent Chair. Whilst she has been effective in identifying a number of aspects of governance, structure, membership and performance that need to be urgently addressed, it is too early to measure what impact this work will have on the overall effectiveness of the LSCB.

49. The relationship between the Children and Young Peoples Strategic Partnership, the LSCB, the new Health and Well-being Board and their strategic priorities is at present unclear, leading to confusion and a lack of effectiveness and preventing the LSCB from holding these other boards to account. The LSCB sub-groups do not function effectively, with poor attendance and a lack of focus. For example the quality assurance sub-group is ineffective and no multi-agency audits have been completed. The number of serious incidents and serious case reviews (SCR) is high and currently the LSCB are managing seven different incidents which will have a major impact upon available resources. The LSCB has a comprehensive multi-agency training programme but although the quality of training is highly regarded the take up and attendance at courses is very poor and the impact on improving services and delivering improved outcomes is therefore poor.

## Record of main findings

| **Local authority arrangements for the protection of children** | |
|---|---|
| Overall effectiveness | Inadequate |
| The effectiveness of the help and protection provided to children, young people, families and carers | Inadequate |
| The quality of practice | Inadequate |
| Leadership and governance | Inadequate |