

# Inspection of local authority arrangements for the protection of children

Hertfordshire

Inspection dates: 28 January to 6 February 2013

Lead inspector Emmy Tomsett

Age group: All



# **Contents**

Inspection of local authority arrangements for the protection of	
children	2
The inspection judgements and what they mean	2
Overall effectiveness	2
Areas for improvement	2
About this inspection	4
Service information	4
Overall effectiveness	5
The effectiveness of the help and protection provided to children, young people, families and carers	7
The quality of practice	8
Leadership and governance	
Record of main findings	12

# 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 Hertfordshire is judged to be **adequate.** 

#### **Areas for improvement**

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

#### **Immediately:**

- ensure initial assessments are signed off by managers once agency checks have been received and considered
- ensure that all assessments have sufficient focus on the voice and journey of the child, their individual needs and contain an effective analysis of risk
- ensure that all children being stepped down from child protection plans receive support and monitoring appropriate to their assessed needs
- ensure that all child in need and protection plans are robust, specific and have clear timescales which enables parents to have an effective evaluation of progress
- ensure that action is taken to reduce waiting times for the cases held by the targeted advice service.

#### Within three months:

 ensure children and young people are able to access advocacy services and are routinely encouraged and supported to attend case

- conferences in order that their experiences, wishes and feelings are effectively considered by professionals
- ensure that chronologies are effectively used to inform assessment and planning processes and that these are updated regularly
- ensure that the equality and diversity needs of children and young people are effectively considered within assessment and planning processes
- ensure that performance management and quality assurance arrangements are fully embedded and lead to sustained improvements for service provision and support to children

#### Within six months:

 ensure service planning is better influenced by the views of children, young people, parents and carers.

## **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 seven 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. Hertfordshire has approximately 278,300 children and young people under the age of 19 years. This is 24.9% of the total population. The proportion entitled to free school meals is lower than the national average. Schoolaged children and young people from minority ethnic groups account for 24.1% of the total population, compared with 25.4% in the country as a whole. 2011 Census information shows that the largest minority ethnic groups in Hertfordshire are Asian (6.5%), Black African and Black Caribbean (2.8%) and a notable Eastern European population (1.3%). The proportion of pupils with English as an additional language is below the national figure with the main languages other than English being Urdu, Polish and Gujarati.
- 10. Early help for children and families is provided though the education and early intervention service group as part of children's services in Hertfordshire and in cooperation with other partner organisations through the Health and Wellbeing Board structure. Early intervention support is delivered through targeted youth support teams and newly established thriving families teams organized into five 'double-district' localities as well

- as in partnership including with 82 children's centres; school family workers; and integrated services for learning teams.
- 11. Initial contacts with the children's safeguarding and specialist services group are managed by Hertfordshire's customer service centre, and those identified as requiring further social care assessment are transferred to 11 referral and assessment teams including a joint child protection and investigation team established with Hertfordshire Constabulary. A multiagency targeted advice service (TAS) provides advice and guidance to professionals for cases which do not meet the threshold for children's safeguarding and specialist services. Children and young people assessed as requiring social care support or protection then transfer to safeguarding teams including 18 safeguarding locality and family support teams and two disabled children's teams. A dedicated out of hours service, hosted by Hertfordshire Constabulary, responds to children and young people who require support or protection out of normal office hours.

#### **Overall effectiveness**

- 12. The overall effectiveness of local authority arrangements to protect children in Hertfordshire is judged to be **adequate**. The strategic priorities of the council and its partners are clear, combined with a detailed action plan to address areas for development. There is strong political support from members and at a corporate level from the Chief Executive. The leadership team has implemented key changes such as improving the electronic recording system. Additionally the recruitment and retention strategy has resulted in a more permanent and stable staff group. The stability of the workforce has led to better engagement with agencies and enhanced partnership working. Improved performance has brought the local authority in line with statistical neighbours in key areas. such as timeliness of assessments and reduced numbers of repeat referrals. However more work is required to improve the consistency and overall quality of practice to achieve better outcomes for Hertfordshire's most vulnerable children.
- 13. Early intervention strategies are wide-ranging and well resourced, and have been effective at providing early help and support to children and their families. The interface between early intervention services and social care is effective and thresholds are consistently understood and applied. However at the time of the inspection there were a significant number of children assessed as low risk but requiring help from the TAS who had to wait too long for this support. Early intervention services to older children, provided through the targeted youth service, are consistently effective and delivering positive outcomes, including reduced offending levels, improved school attendance and reductions in episodes of children going missing.

- 14. The pace of improvement across quality of practice has been slow and some key areas for development remain within core child protection work. Some initial assessments completed by social workers are signed off prematurely before agency checks have been completed and as a result some assessments of need or risk are not well informed. Support for children in need who do not meet the threshold for child protection plans but do require targeted social work support is variable. Some of these children are not receiving the right level of support and for others work is not being informed by a clear and regularly reviewed assessment and child in need plan. Child protection plans are not sufficiently clear about how risk will be reduced and do not enable effective reviewing arrangements by the core group. Step down arrangements to a child in need plan are inconsistent and as a result in some cases the ongoing monitoring of children's welfare is not sufficiently robust. Some cases seen by inspectors demonstrate evidence of drift in planning arrangements for children which does not ensure that risks are effectively monitored in a timely way.
- 15. There is a good level of attendance and commitment to the Local Safeguarding Children Board (LSCB). There is effective partnership working across Hertfordshire with clear reporting arrangements between the LSCB and its member organisations. Multi-agency responses to the risks associated with the trafficking or sexual exploitation of children are well coordinated and have resulted in effective identification and provision of support to children identified to be at risk. The LSCB has an active learning and development sub-group which has been responsible for coordinating and quality assuring the delivery of a range of child protection training programmes. Learning from serious case reviews and partnership case reviews is effectively disseminated by the LSCB to front line staff and lessons learned influence strategic development and inform reviews of policy and procedure.
- 16. Performance management is adequate. Whilst performance management systems are in place and all managers receive regular performance information, there are key omissions. The use of comprehensive and detailed performance indicators to drive and shape improvement is not sufficiently embedded and sustained improvements in some areas are not yet evident. Service development is not sufficiently influenced by children and young people who have experienced child in need and child protection services.
- 17. The council's quality assurance processes are adequate and becoming increasingly focused on the quality of practice rather than on an evaluation of process. The quality of management oversight is variable and the impact of this scrutiny is limited and does not consistently ensure that children are well protected through effective assessments and plans. Whilst a wide range of audit activity has taken place across the partnership, the impact of this work has been limited. The audit

framework does result in a collation of findings and an action plan however many areas for development are repeated and the pace of change and drive of improvement has been slow.

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

#### **Adequate**

- Outcomes for children and families in receipt of early help are adequate overall with some good examples seen by inspectors. Responsive services in local communities are effective in identifying and helping children and families with a wide range of needs. Through the early intervention and prevention strategy the council has worked hard to ensure partner agencies and professionals are aware of the early help offer. The common assessment framework (CAF) process is well embedded across the county and it is being used effectively to assess the needs of children. Children and their families receive good support from family support workers and link family workers based within schools, which are making a positive contribution to supporting families. Children's centres are also improving the well-being of families through the provision of strong, integrated early help to children under five and their families. The most effective centres are working successfully with schools through team around the family (TAF) meetings to ensure a whole family approach is implemented to address identified issues and concerns. Children who require social work support as children in need are not consistently receiving the right level of help.
- 19. The work of the targeted youth support (TYS) service is effective in providing well planned and timely interventions for older children and young people which is reducing numbers of young people entering into the care system and the youth offending service. An effective consultation phone line to schools is also provided by the TAS and this is valued highly by school staff and offers helpful guidance and advice regarding potential referrals of children and families for targeted support. Effective partnership working has led to children and their families achieving better outcomes, for example improved school attendance and attainment, improved parenting skills and better access to specialist services.
- 20. The TAS is well-established and benefits considerably from the contribution of a wide range of professional workers on the team. It is readily accessible and there has been a steady increase in referrals from a range of agencies and the general public. However as a result of staff shortages referrals prioritised as needing early help experience significant delays before this is provided. This adversely affects the local authority's ability to provide support to some families at the earliest opportunity.

- 21. Many parents whose children are subject to a CAF spoke positively about the guidance that has been provided to them and how swiftly agencies offered support. However, some whose children were subject to child protection and child in need services and were spoken to by inspectors, felt that social workers were not always open and honest with them and that limited support had been provided. Families subject to child protection and child in need plans do not always understand why they are subject to a plan and what they have to do to achieve targets within the plan. There are good examples of the views of parents and children being used to inform and develop early help services. However, practice in recording the views of children and carers is variable within the social care assessment and planning process.
- 22. Clear policies and procedures are in place to respond to and protect children and young people who go missing from home and education. Arrangements for family group conferencing are effective and well-targeted and deliver improved outcomes for children and families. Private fostering arrangements in Hertfordshire are not fully embedded. The number of children subject to private fostering arrangements is relatively low and not all those who have been identified are receiving regular monitoring visits. The council acknowledges that further development work is required to raise awareness of private fostering across the county.
- 23. In the majority of cases sampled, the child's ethnicity and culture is recorded. However, the child's cultural needs and identity are rarely reflected or considered within assessments and planning stages.

  Arrangements, through the use of language line, are in place where a caller's first language is not English and an interpreter is required.

### The quality of practice

#### Adequate

- 24. Whilst most children are seen and are consistently seen alone by their social worker, some children on a protection plan are not seen as frequently as they should be and this does not ensure effective monitoring. Visits to children and families are promptly recorded, however the purpose of the visit and an analysis of the outcomes are not consistently included. Children's views, when sought, are well documented and there are some sensitive observations of pre-verbal babies.
- 25. Thresholds for access to services are well understood by partner agencies and there is an effective and timely response to most referrals. However a significant number of low risk cases in the TAS have not received a timely offer of early help or intervention. Rates of referrals and repeat referrals have fallen as a result of a well targeted strategy by the local authority. The out of hours team provides a good response to referrals and has the

capacity to undertake welfare checks. All child protection enquiries are carried out by qualified and suitably experienced social workers and those completed by the joint child protection investigation team are timely and robust.

- The quality of assessments is adequate. Although the quality of CAFs 26. continues to be variable these are becoming increasingly effective in identifying, preventing and intervening with early offers of help to support the most vulnerable families. The views and wishes of children and young people are not routinely taken into account in assessments. The quality of initial assessments is variable and do not always give adequate consideration of historical events which results in insufficiently focused assessment of risk. The contribution of partners to assessments is inconsistent and some assessments are authorised as completed before full agency checks have been received. This does not enable the local authority to have an accurate overview of the overall needs of the child. The timeliness and quality of core assessments has improved and examples seen by inspectors include some of very high quality. Chronologies are inconsistently used as a working tool and lack focus and rigour and prevent the effective identification of significant events.
- Work with children in need is not supported by effective planning 27. arrangements. Children in need plans vary in quality and content and are not regularly reviewed. The local authority has identified key weaknesses in current conferencing arrangements and are in the process of implementing the Strengthening Families model. Whilst multi-agency conferences are regularly attended by professionals they are not well attended by young people. The use of advocates for children and parents is not sufficiently widespread across the service. Parents do not receive reports in a timely manner which prevents families and professionals preparing effectively. Whilst conference chairs do raise individual issues of poor practice, they do not complete a quality assurance or performance monitoring role and this is a key omission. Child protection plans are not sufficiently focused on the risks to children, they are not specific and do not consistently support clear outcome focused planning. The consequences of families failing to comply with the plan are not always sufficiently clear. The timeliness of initial conferences is poor and performance information is inaccurate in that it captures timeliness of decision making from subsequent strategy meetings. The outline plan produced by the conference chair is not always effectively developed by core groups and the frequency of these meetings is variable. Step down arrangements lack rigour, for example, where children no longer need to be the subject of a plan, and poor planning and monitoring of risk is evident in too many cases.
- 28. Decision making is undertaken by suitably qualified and experienced social work staff. Social workers have manageable caseloads. The academy is highly valued by newly qualified social workers who have protected

caseloads. However newly qualified social workers are undertaking complex work and the support provided to them by senior practitioners is variable. Social workers and their managers have good access to training and value the visibility and accessibility of senior managers. Supervision arrangements have recently been reviewed and improved practice is evident. Management decisions between formal supervision sessions are promptly recorded. However cases of long standing neglect are not effectively scrutinised and in some cases there are significant delays in both considering and in initiating care proceedings. In some cases seen the legacy of previous poor practice was not always addressed sufficiently robustly.

#### Leadership and governance

#### **Adequate**

- 29. Leadership and governance are adequate. There has been progress with the development of new structures and processes in children's services but many of these are not yet firmly embedded and as a result the impact on outcomes for children and families is limited. Appropriate focus and priority has been given to the recommendations of the most recent inspection and as a result some improvements in services are clearly evident, for example the implementation of the revised recruitment and retention strategy. The local authority have an accurate and realistic self assessment in place and this is used to prioritise areas for development. There is a clear commitment from members, the Chief Executive and senior officers to protect and invest in services for vulnerable children. Safeguarding is a clear priority for the local authority. There is a comprehensive range of strategies and initiatives in place that demonstrate vision and an ability to identify and prioritise the commissioning and provision of child protection services.
- 30. There is a comprehensive quality assurance framework with casework audit activity at all levels. Templates for monthly and quarterly audits do not require sufficient information on the quality of practice and insufficient progress has been made in improving social work practice with repeated areas for development being identified in succeeding audits. Considerable work to improve the completion and quality of chronologies has not been successful. The majority of chronologies seen by inspectors insufficiently focused on key events and contained too much information on process. Whilst senior managers have identified key priorities for development and are active in promoting the need for better standards, improvement activities are not demonstrating sufficient qualitative change. Whilst cases of concern are identified on a regular basis and scrutinised by senior management, themes are not identified on a systematic basis and effectively disseminated to staff.

- 31. Performance information and reporting is well established with a range of information on indicators and targets. However the validity of some of this information is unreliable, for example data regarding the timeliness of initial conferences. Data collection is lacking in key areas including how quickly children are seen following a referral as well as tracking how many child protection plans are stepped down to child in need plans. The complaints process is robust and these are acted upon swiftly and result in lessons disseminated to staff.
- 32. The Local Safeguarding Children's Board is appropriately constituted and has recently appointed two lay members as well as an apprentice who is a young person who has previously been in care in Hertfordshire. There are clear accountabilities and responsibilities in place between the LSCB Chair, Director and Lead Member. Attendance and commitment to the Board by partner agencies is good. The Board provides clear leadership. There is a comprehensive range of training provided and the programme is tailored to ensure good levels of attendance by staff from all agencies. The Board has created five local safeguarding forums based on district councils in order to facilitate better communication between the Board and front line staff and ensure that safeguarding is a core element in service activity at district and borough council level. The LSCB website is comprehensive, easily accessible and provides clear and detailed information for staff and the public.
- 33. The LSCB commissioned five multi-agency audits in 2011/12 including babies subject to non-accidental injury. These audits were subject to action plans with outcomes including changes to policy and procedure on a single and multi-agency basis. However the Board does not routinely receive reports or summaries on single agency audits and therefore does not have a comprehensive overview of safeguarding effectiveness across the partnership. The Safeguarding Board business plan appropriately identifies five themes for the development of safeguarding together with a range of actions. However the plan does not include sufficient targets to be able to track progress of improvement effectively. There have been no serious case reviews commissioned since 2010 but the Board has commissioned a number of partnership case reviews on cases of concern. These have resulted in effective identification and dissemination of lessons learned and have informed strategic planning.
- 34. Workforce planning is effective. The development of the Hertfordshire social work academy has enabled the authority to focus on the development of newly qualified staff with staff vacancies and use of agency staff now at low levels. There is also a focus on staff development through secondments to qualifying courses and opportunities for post qualifying training. The grade of consultant social worker has been created to provide an alternative career path to management and to act as a source of information and as a role model for best practice. The use of

temporary agency workers has reduced and social workers describe good quality support and access to development opportunities.

## **Record of main findings**

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