

Inspection of local authority arrangements for the protection of children Herefordshire

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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 Herefordshire 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 Herefordshire, the local authority and its partners should take the following action.

Immediately:

- audit all cases closed in the last three months and risk assess all current cases within children's social care services; ensure that this leads to appropriate action to protect children effectively
- ensure that statutory child protection guidance is followed for all strategy discussions and section 47 enquiries, and that thresholds for child protection enquiries are consistently and appropriately applied, leading to a sound assessment of risk and effective information sharing
- ensure that children in need and those subject to child protection enquiries are visited regularly by social workers
- ensure that legal advice is consistently sought in a timely way and that this leads to timely legal planning meetings and interventions.

Within three months:

- ensure that inter-agency thresholds for statutory intervention are understood and applied by all agencies, leading to children and their families receiving appropriate and timely services in accordance with their assessed needs

- improve the quality and consistency of management oversight and decision making to ensure that the child's experience, risk and their needs are well considered, and lead to appropriate and timely action
- ensure that supervision is regular, reflective, challenging and monitors social workers' and their managers' compliance with statutory guidance policy and procedure
- ensure that assessments are analytical, timely, comprehensive and up to date, and robustly identify needs, risks and protective factors leading to appropriate and timely action
- ensure that assessments of children and families are dynamic and that new information or concerns lead to a review of the current plan for the child and when required additional action
- ensure that child protection case conferences effectively involve parents and children
- ensure that child protection and child in need plans are specific and measurable and focus on the key needs and risks and include robust contingency arrangements that are understood by parents as well as professionals
- ensure that core groups are regular and effectively develop and implement the child protection plan, and that these plans are monitored by child protection conferences
- ensure that first line managers have sufficient skills, knowledge and experience to effectively undertake their role
- ensure that referrals are appropriately risk assessed and prioritised within the family assessment and safeguarding team (FAST)
- establish a robust quality assurance framework for child protection enquiries, which monitors the quality of decision making
- ensure professionals from all agencies, including children's social care understand their responsibilities with regard to child protection and make use of escalation procedures if they believe that children are not receiving appropriate services
- ensure effective communication takes place between probation services and children's social care services when making plans for offenders who have significant contact with children and young people known to them.

Within six months:

- reduce the number of changes of social workers experienced by children and their families and improve the consistency and quality of direct work
- ensure that the Herefordshire Safeguarding Children Board has sufficient, high quality information so that it can effectively monitor and challenge the effectiveness of child protection practice
- ensure that effective performance monitoring and quality assurance arrangements are put in place which includes sufficient qualitative information including service users' views, to enable a clear understanding of current practice and performance in child protection, including the impact of services on children and their families
- ensure that there is a robust auditing programme that includes a focus on the experience of the child and the impact and outcomes of service provision and that this leads to the identification of themes and clear action plans which are robustly monitored and implemented.

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 Herefordshire Safeguarding Children Board (HSCB). 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 six of Her Majesty's Inspectors (HMI) and one seconded inspector.
8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Herefordshire has approximately 35,864 children and young people (0-17 years old) who reside within the authority. The 0-17 population accounts for around 20% of the resident population, a proportion slightly lower than both regional and national averages. The proportion entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for 4% of the total population, compared with 16% in the country as a whole. Within the 'White: other than British or Irish' category, though, is a sizeable White Eastern European group (2.0%). The proportion of pupils with English as an additional language is significantly below the national figure.
10. Early help for children and families in Herefordshire is provided within the children's provider services department of the local authority and in cooperation with other agencies. Services are delivered in a number of ways, including through two locality teams supporting eight multi-agency hubs and through a range of settings including 11 children's centres; an intensive family support team; schools and community settings; youth settings; and via partnership arrangements with, for example, children's and adult mental health services, and substance misuse services.

11. Child protection services in Herefordshire are delivered through one county-wide referral and assessment team, two children in need teams, and one children with disabilities team.

Overall effectiveness

Inadequate

12. The overall effectiveness of local authority arrangements to protect children in Herefordshire is inadequate. Systemic failures in children's social care services, for example in management oversight, decision making, performance management and quality assurance lead to some children being inadequately protected and other children not receiving timely provision of services in accordance with their needs. Child protection services do not consistently reflect a clear understanding of the experiences of children and young people: where this is the case it leads to a failure to put timely and effective plans in place. While clear thresholds for services have been agreed by the HSCB, inconsistency remains in the understanding and the application of these thresholds by the council and its partners. However the council is developing a multi-agency safeguarding hub to improve information sharing, decision making and the application of thresholds, as part of the strategy to ensure that children receive the most appropriate and timely service, according to their needs.
13. The lack of timeliness in a significant proportion of assessments in children's social care services leads to delays in the identification of risk and needs and consequently service provision. In cases seen by inspectors the focus more often is on adults and their willingness to co-operate rather than the risk to the child. However, in a minority of cases there was evidence of effective direct work with children and families being undertaken, which was having a positive impact. The quality of social work practice is inconsistent and is not sufficiently child centred through the child's journey. A high number of cases seen by inspectors were judged to be of inadequate quality. In a significant number of cases a lack of robust risk management and decision making, including on open cases where risk had increased, is leading to children and young people not being appropriately protected. Monitoring of front line management decision making is insufficiently robust.
14. Senior managers demonstrate an increasing understanding of the needs of children and their families in Herefordshire, mostly notably in locality working and action is being taken to match services to need. Senior managers and elected members have prioritised early help and child protection services, which is demonstrated, for example, by an increase in resources. A clear strategic vision is in place and significant activity is taking place to identify and address deficits. The council and its partners have achieved significant improvements in the provision and coordination

of early help services. The council has a good awareness of current challenges and a clear plan to develop these services further so that children receive help at an early stage. The combination of clear strategic planning in this area, good engagement with partners, effective performance monitoring and quality assurance arrangements is leading to positive outcomes overall for children and families who come into contact with these services.

15. Significant strategic activity and intent have not impacted sufficiently on front line child protection practice, due to an insufficient focus on the qualitative aspects of child protection, insufficient evaluation of the impact of changes, and an inability to sustain some improvements. Quality assurance arrangements are being improved. However these have yet to have a significant impact on both fully identifying practice deficits and ensuring that a performance management culture is embedded throughout children's social care. More positively, the council has achieved a reduction in caseloads for social workers, reduced reliance on agency staff, more regular supervision and increased confidence in the service by partner agencies.
16. The HSCB is well supported by partner agencies; however the Board has not been sufficiently effective at either identifying deficits or improving practice within child protection services. Messages from serious case reviews have been disseminated to staff across agencies. However, the inspection found that in some areas actions undertaken following serious case reviews have not yet had sufficient impact. Clear escalation procedures are now in place, however, professionals both from children's social care and partner agencies are not consistently effective in challenging decisions when children are being inadequately protected or escalating their concerns.

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

Inadequate

17. The effectiveness of the help and protection provided to children, young people and their families and carers is inadequate. Inappropriate responses to risk, delays in assessment and inconsistent quality of management decision making across the child protection service have led to some children being inadequately protected and delay in provision of services. While published multi-agency thresholds for services are clear, these are not consistently understood and applied across the partnership and by social workers and their managers to ensure that the right services are available to children according to their need in a timely way. Currently a high proportion of children are subject to child protection enquiries where the decision is made not to convene an initial child protection conference. The failure to consistently follow statutory guidance for

children who may be at risk of significant harm results in delays in some children being adequately protected. In a small number of cases the failure to properly investigate and respond to concerns has resulted in children suffering further harm. In other cases, there are unnecessary delays in assessing the immediate risk of harm to children and taking action. The combination of delays in assessments being completed and frequent changes in social worker impact significantly on the development of a relationship with families and therefore the effectiveness and timeliness of the service they receive. In a significant proportion of cases seen by inspectors outcomes for children were not improving sufficiently. Examples were seen of decisions to close cases inappropriately, leaving children at potential risk of harm.

18. Core assessments are not routinely updated and, as a result, changes in circumstances are not properly considered when assessing the risk for the child. At the time of the inspection, a small number of cases subject to child in need plans were not allocated to a qualified social worker and were not being routinely monitored by managers leading to some of these children not receiving an effective service. The timeliness of a significant proportion of initial and core assessments is inadequate and results in delays in families receiving the services and support that they need at the right time to help them to protect their children. This is compounded, in some cases by delays in the long term teams initially contacting families when cases are transferred following assessment. Delays in progressing plans were identified in some cases which undermined the effectiveness of interventions for children and their families. In some cases inadequate case planning and lack of contingency planning has resulted in children being left too long in circumstances that do not meet their needs.
19. Outcomes for those who receive early help for family, child development and relationship difficulties coordinated through the common assessment framework (CAF) services are good. Targeted support, including individual family support and through structured parenting programmes, results in positive changes in families and a reduction in the risk of harm to children. The Freedom Project is available to support women who are victims of domestic abuse, including those for whom English is not their first language. However, access to accredited programmes for perpetrators of domestic abuse is not sufficient.
20. Systems to identify and support children and young people and families who need early help are improving. Early help and intervention for young children are increasingly timely and focused well on the needs of individuals. Work with families with children in the early years age group is particularly effective as midwives, health visitors and children's centres work very closely to identify families at risk of poor outcomes and at potential risk of harm. Help is often provided through universally accessible services, although children's centre work targets and encourages take up by vulnerable families. Examples of successful

outcomes include improved attendance at school of older children, and overcoming practical and relationship difficulties that could place them at risk of harm, through help coordinated in schools.

21. The quality of information sharing between agencies is variable. Good information sharing takes place in the Multi Agency Groups (MAGs) which meet regularly in localities to provide early help and meet children's assessed needs, for example through the common assessment framework and there is evidence that this has led to improved outcomes for a number of children and their families. However, in two cases inspectors identified a lack of clarity between children's social care services and probation services about the importance of sharing information about the risks posed by adults in the community to children. Important planning information, for example, prison release dates and license conditions about significant adults in a child's life are not always shared with social workers. Relevant information from multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conferences (MARAC) meetings is not always recorded on individual files or considered as part of assessments.
22. Most child protection case conferences, core groups and children in need meetings are well attended by a range of relevant agencies; however the effectiveness of these multi agency meetings is variable. Health services are represented at statutory meetings, but information presented to these meetings is not always sufficiently comprehensive with clear analysis. Where parents or carers experience mental ill-health, effective links are made with adult services to ensure that child protection concerns are properly understood and addressed.
23. Services are designed and delivered to reflect the rural nature of the area and many CAF reviews take place in children's centres and schools that are accessible and familiar to the families using the services. Although all child protection conferences are held in Hereford and Leominster, this is based on feedback from parents about preferring the anonymity of travelling to a neutral venue for sensitive meetings. For families for whom English is not their first language, translation and interpreting services are readily available as part of planned work and efforts are made to use the same translator with families to ensure consistency. However, when contact is undertaken at short notice, services are not always available and, in two cases seen by inspectors, children were inappropriately used to interpret sensitive information from their parents for professionals. In cases seen details about the ethnicity and religion of families were routinely recorded, but insufficient consideration is given in assessment and planning to the way diversity and culture impact on the ability of parents to protect their children from harm.
24. Awareness raising to identify private fostering arrangements has had limited impact. Where private fostering arrangements are identified these

are adequately supported. Good multi-agency arrangements are in place to track children missing from home and school, with robust information sharing which is enhanced through the multi-agency groups. This has led to a reduction in the number of incidents of children going missing.

25. User feedback is used well within the early help services to assess the success of support and to plan services. Feedback shows a consistently high level of satisfaction from parents and carers in improving their ability to support their children. This view was corroborated by parents seen as part of the inspection process. However, similar feedback systems are not in place for users of children's social care services. The local authority is aware of this and has plans to improve arrangements. Several parents of children who were subject to a child in need plan or a child protection plan were seen as part of the inspection; their views of the services that they received were variable. Concerns were expressed about the lack of clarity from social workers about how plans could be ended, and some reported delays in accessing support services. However, when families had a consistent social worker, this support was generally welcomed and was seen as helpful.

The quality of practice

Inadequate

26. The quality of practice is inadequate. The quality of practice in a significant proportion of cases seen by inspectors within children's social care was judged to be inadequate. Thresholds to statutory services are being applied inconsistently. The authority identified in April 2012 that too many children were on child protection plans who no longer met the threshold. This has led to a significant reduction in the number of children with child protection plans. In most cases partner agencies communicate and exchange information or concerns appropriately and have established close working relationships. However, in some cases seen by inspectors there were delays in information sharing. There is appropriate involvement and exchange of information between day time children's services and the out of hours service.
27. The timeliness of decision making on referrals has improved. However, inspectors saw examples of both delays in decision making in children's social care and in receiving referrals by partner agencies resulting in a lack of timeliness in initiating assessments. Decision making on referrals is not yet sufficiently robust.
28. A high number of domestic abuse referrals already risk assessed by the police are notified to children's social care services. Most are appropriately prioritised within children's services, but managers have recognised that decision making on domestic abuse issues needs to be improved. A risk assessment matrix is being put in place to enable more consistent and effective decision making.

29. Decision making is not sufficiently rigorous in addressing immediate risks. Some cases are managed as children in need when risks indicate that child protection processes should be instigated. The lack of timeliness in fully assessing the needs of children and the associated risks leads to delays in service provision and leaves some children at potential risk.
30. Child protection inquiries are undertaken by suitably qualified and experienced social workers. Some child protection enquiries are undertaken in a timely and effective manner. However, statutory child protection guidance is not consistently followed. In some cases seen by inspectors full child protection enquiries are not undertaken, which means that risk is not fully assessed by relevant agencies. Thresholds for initiating strategy discussions are not consistently applied and there are examples of strategy discussions not involving the police or other partner agencies; this practice does not enable effective information sharing and decision making. In addition decision making where child protection concerns are identified is not sufficiently robust.
31. The quality of assessments seen by inspectors is too variable. Overall the quality of CAF assessments is good and focuses well and effectively on the needs of children. However, within children's social care services, assessments do not consistently identify risk and need and are not sufficiently focussed on the experience of the child. In addition the assessment of risk and need does not consistently lead to appropriate action. In a number of cases seen by inspectors changing circumstances and new information did not lead to a comprehensive re-assessment of the child's needs and the current risk to the child.
32. Inspectors found a number of cases known to children's social care services, where there had been delays in protecting children. Within these cases risk assessment and decision making by social workers and managers was ineffective. In a small number of cases children had suffered further incidences of harm and in others they had been exposed to unnecessary risk. These examples included children subject to child protection and child in need plans. During the inspection the council took prompt action to ensure that these children were protected.
33. In the majority of cases seen by inspectors children are regularly seen by social workers, and where appropriate are seen alone. However, in some cases there are significant gaps between visits to children, including some cases where children are the subject of child protection concerns. Visits are appropriately conducted by social workers both by appointment and unannounced. Social workers do not consistently build close or effective relationships with children and case recording indicates that there is limited direct work undertaken by social workers. This is exacerbated in many of the cases where there are repeated changes in social worker. In some cases this results in delay in progressing work and lack of consistency in the work that is being undertaken with the family to

improve the child's situation. In many cases seen there is a lack of purposeful intervention, resulting in drift. Effective strategies are not consistently considered in work with resistant families. However, there were some examples of better work, where families had been engaged effectively by social workers, with evidence of good and effective direct work with children and focussed intervention, leading to improving outcomes for children and their families.

34. Direct work and effective relationships are better evidenced in the work of early intervention and family support services, where interventions are based on the identified needs of children and there is evidence of good engagement with children and their families. Children's views are recorded in assessments, although it is not always evident how their views are considered in case planning. However, in cases involving older children, there is clearer evidence that their views influence case planning. An advocacy service is in place for children who attend their child protection conferences, there is some evidence of children's participation and work is being undertaken to improve this.
35. The council has recognised that the children with disabilities team needed to improve its service, with respect to increasing capacity and improving safeguarding practice. Action is being taken to address deficiencies in the service. However, the inspection identified that child protection practice is not consistently effective.
36. The timeliness of initial child protection conferences has improved. The HSCB has recently established a requirement for conference participants to provide written reports to conference and this has resulted in improved information sharing. The sharing of reports with parents prior to conference has improved from a low base but in some cases parents have limited time to read the report. Conference chairs are suitably experienced, although not all conferences are effectively chaired or involve parents appropriately. Conference chairs are linked to individual children, which helps to manage risk by providing a level of continuity for children and families, particularly those where there are several changes of social worker. Very recently the quality and review service has strengthened its quality assurance role, to improve the effectiveness of conferences and the quality of work of participants. However, this remains at an early stage of development. In the majority of cases core groups are well attended by partner agencies and regular. However, core groups are not consistently rigorous in developing, reviewing and implementing the protection plan.
37. The quality of plans is variable. Child protection plans and children in need plans are not always focussed on the key risks and needs, a number are not specific and measurable. Contingency planning is not routinely in place and is not consistently effective in ensuring that timely and effective action is taken to protect children; this contributes to delays in legal planning meetings taking place. Some case planning was inadequate and

plans are not always put in place promptly following the identification of concerns. However plans following CAFs are overall of good quality and child focused.

38. The regularity of management oversight has improved since the Safeguarding and Looked After inspection in October 2010. However there were significant gaps in the recording of management oversight and decision making in a number of cases. Management oversight is insufficiently focussed on the experience of the child, the presenting risks and the changes necessary to ensure the child or young person is safe from harm. In those cases where inspectors identified children at risk, management oversight and decision making was not effective and the risks had not been fully recognised. Inspectors saw a significant number of cases where managers had made poor decisions in respect of ensuring that children are protected from harm. Decisions and actions from supervision were not consistently followed through. Too many records seen indicate that supervision is task orientated and does not consistently include appropriate challenge, is not reflective or does not lead to improved outcomes.
39. Social work staff report being well supported by managers, and additional support is given to newly qualified social workers. Social workers have regular access to training and personal development opportunities to enhance their practice.
40. In the majority of cases recording by social workers is reasonably timely and up to date. However this is not yet consistent. Although the quality of recording in most cases is sufficient to understand the progress of the case, recording does not always evidence the work being undertaken with children and their families. In the majority of cases seen by inspectors the analysis of information required to inform assessment is inadequate and managers often support recommendations made by social workers that do not reflect all the indicators of risk to children. An increasing number of files now contain chronologies. However the chronologies are not always up to date or focussed on significant events, and do not enable social workers to quickly understand the child's history.

Leadership and governance

Inadequate

41. Leadership and governance arrangements are inadequate. There has been insufficient impact on the quality of child protection services despite improvement in a number of areas.
42. Elected members and senior managers within the council and partners have prioritised child protection and early help. This is demonstrated by elected members agreeing additional resources to increase social work and front line management capacity within children's social care. The

council has improved engagement with schools, health and other agencies and the impact is evident in the positive developments in early help services. This work is underpinned by a comprehensive needs analysis that enables individual localities to understand need and plan appropriately in their particular area. A restructuring of the council in 2011 led to a significant reduction in senior management; it is recognised that senior management capacity within children's social care is not sufficient. The Director of People's Services, the statutory Director of Children's Services, was permanently appointed in January 2012.

43. There is clear evidence of strategic vision and significant activity is taking place to identify and address deficits. An audit undertaken in April 2012 of 108 cases identified that thresholds were not being consistently applied and consequently a significant number of children were not receiving the most appropriate service to meet their identified needs. This led the council to scope and commission a peer review to specifically investigate the issue of thresholds. This shows an increasing self awareness by the council. The council has a strong determination to improve the quality of service and action is on-going. For example the council have responded to the decrease in timeliness of assessments by employing additional agency staff. However, the findings from this inspection are that thresholds are inconsistently applied, including on cases already open to children's social care services when circumstances change.
44. Performance management and quality assurance arrangements for children's social care are inadequate, as they have failed to fully identify the deficits within child protection services and have had very limited impact on improving the services to the most vulnerable children and their families. User views, while increasingly sought, are not fully utilised to inform service development. However, quality assurance arrangements are effective in ensuring that the CAF process overall is well used. This includes monitoring the satisfaction of parents, which is high. A clear framework for undertaking case audits is now in place. However, case audits focus on processes and in many cases do not sufficiently consider the impact of intervention and the outcomes for the child. Outcomes from case audits have not been systematically used to identify themes that lead to clear action plans for improvement. In addition audits have had limited impact on improving services. Management information is improving although it remains underdeveloped and this information is not used effectively by front line managers to manage their services. For example there has been ineffective oversight of assessments that are overdue.
45. The HSCB is supported by lay members and an independent chair who also chairs the Adult Safeguarding Board. The HSCB has supported and driven forward improvements in service areas such as the provision and strategic ownership of domestic abuse services, the MAG process and has disseminated learning from serious case reviews. HSCB has been effective in improving practice with regard to missing children which has led to a

reduced number of incidents of missing children in the last year. Effective single and multi-agency child protection training is in place, however the HSCB has recognised that attendance is low from some key statutory agencies and is taking action to address this. However the Herefordshire Safeguarding Children Board (HSCB) has yet to publish an annual report for 2011/12. The audit activity in the partnership has provided increased awareness of areas of development and practice including the effectiveness of case conferences and the multi-agency contributions to children subject to child protection plans. In addition the HSCB commissioned an audit to understand why there were high numbers of children subject to child protection plans. However, the HSCB has not effectively monitored the quality of child protection practice, audit and other quality assurance processes have not provided HSCB with a full understanding of the weaknesses in current child protection practice and this greatly reduces its effectiveness.

46. The council has made significant investments in workforce planning over a number of years and the support given to newly qualified social workers (NQSW's) and training opportunities to other key staff including first line managers is valued and positive. Additional staffing has been put in place to enable NQSWs to have reduced caseloads and have access to good support and development opportunities. The council has developed good links with educational establishments and supports its own staff to become qualified social workers. The impact of these initiatives has been to reduce the reliance on agency social workers, to create career development opportunities and to address staff retention issues. The role of the advanced practitioner is being developed to support social work practice in addition to a Head of Casework who undertakes the role of the Principal social worker. The impact of this workforce development activity on improving the quality of social work, ensuring children are safe and particularly the effectiveness of first line managers is limited given the evidence of inadequate work across all the child protection social work teams.

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