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Inspection of local authority arrangements for the protection of children

City of Wakefield Metropolitan District Council

Inspection dates: **29 October – 7 November 2012**
Lead inspector **Sheena Doyle HMI**

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 City of Wakefield Metropolitan District Council 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 Wakefield, the local authority and its partners should take the following action.

Immediately:

- ensure that all referrals receive a timely response at all stages of the enquiries, assessment and planning, thereby reducing risk
- ensure that all referrers receive feedback on action taken following their referral, subject to respecting the confidentiality of the child when the referral is made by a member of the public
- ensure that joint investigations between police and social care, including timely interviews of children, are undertaken where this has been agreed as the most appropriate way forward
- ensure that there is consistency of application within Social Care Direct and the joint investigation team regarding the criteria for Section 47 enquiries and initial assessments and the rationale for decision making is noted on the child's file
- ensure that formal supervision and annual appraisals for social workers takes place regularly, are well recorded and meet the professional development needs of staff

- ensure that letters to families where domestic abuse has occurred are amended to improve their sensitivity to circumstances and identify where families can access support

- ensure that management oversight of case work is recorded, includes reasons for actions taken and decisions made, referencing risks appropriately. Where progress on individual cases is not swift enough the reasons for this should be noted

- ensure that information collected by Social Care Direct and the joint investigation team from partner agencies is thorough, recorded well, clearly sets out the presenting welfare and protective needs of the child, and the expectations of the referrer

- ensure that all work carried out in children’s centres takes account of children and families’ ethnicity, religion and language and that these are noted on families’ records

Within three months:

- ensure that common assessment framework (CAF) plans set out clear targets, actions and responsibilities that enable progress to be assessed and are understandable to families

- ensure that social workers have sufficient time and support to undertake comprehensive, timely risk assessments and that risk and protective factors are fully recorded and effectively incorporated into the child’s assessment.

Within six months:

- ensure that children’s centres are effective and able to demonstrate the impact of their early help offer for children and their families.

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 five 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. Wakefield district has approximately 68,409 children and young people under the age of 18, representing 21% of the overall population. Around 6% of the district's children and young people under the age of 18 are from minority ethnic groups with more than 100 community languages spoken. The largest minority ethnic communities are Pakistani, Irish and Polish.

10. Referrals to children's social care services are routed through the Social Care Direct service which also provides the out of hours service and is managed by the council's adult services. Child protection enquiries are carried out by a joint investigation team of police and social workers, unless the child is already an open case in an assessment child protection team. Initial and core assessments are carried out by six assessment child protection teams. These teams also provide support for children in need and children who are subject to a child protection plan. Services for children with complex disabilities are provided by the children with complex care needs team. Three intensive support teams provide services which complement this work and also provide services to prevent children becoming looked after.

11. Early help for children and families is managed in the same directorate as social work services and consists of a range of services including 23 children's centres, targeted youth support, a young people's substance misuse service, and specialist services for young families and young carers. Some of these are commissioned services. The early intervention and prevention team supports these arrangements and comprises the area social work team, common assessment framework coordinators, and the community liaison team providing dedicated services for minority ethnic groups.

Overall effectiveness

12. The overall effectiveness of the arrangements to protect children in Wakefield is adequate. Children and families for whom the offer of early help does not sufficiently address their needs and where safeguarding issues become apparent are appropriately referred to children's social care. Where risks are clearly evident these are swiftly assessed and children are seen, and seen alone, where appropriate. Children receive appropriate help, and those children and families requiring help when additional needs are identified receive well-coordinated services which they value. Gradually increasing use of the common assessment framework (CAF) and 'team around the child' arrangements ensures more families benefit from multi-agency services, supported well by the CAF team and by area social workers located within early help settings. There is a good range of targeted services to prevent children and young people with higher levels of need entering the child protection process unnecessarily, including support for young parents and targeted youth support.

13. Referrals to children's social care generally receive a prompt response and are passed to social work teams if more detailed assessment is required. However in some cases the response is insufficiently swift, in others the transfer process is inexplicably delayed. Whilst children who need an assessment or a child protection enquiry (Section 47) receive one, it is not always clear why one route is followed rather than another and therefore children receive differential services. Strategy discussions between agencies, primarily children's social care and the police, now mostly occur before child protection enquiries are initiated, but sometimes occur after unilateral action has been taken. Not all child protection enquiries which require joint investigation by both agencies benefit from this, with too many being conducted as single agency enquiries.

14. Leadership and governance within the council and partner agencies effectively prioritises safeguarding issues, despite significant turnover of senior leaders across partner agencies as national reorganisation arrangements have progressed. The council is taking active steps to recruit a new director of children's services, having just appointed an Interim Director to fill the existing vacancy, with the Assistant Director (Safeguarding) providing good stability and leadership within children's social care since commencing in post in March 2012. Whilst it is expected that the extra senior manager capacity just secured will assist with driving improvements at an accelerated pace, the turnover of senior staff across the partnership has impacted negatively on the pace of progress within children's social care services and partner agencies and impacted on the council's capacity to sustain improvements.

15. Senior managers within children's social care know their service well and are assisted in this with detailed and comprehensible performance reports.

Managers acknowledge that the auditing system currently in place informs their understanding of strengths and weaknesses, but is overly focused on process issues such as timeliness, and insufficiently focused on quality issues such as quality of assessments. The council is aware that progress is hampered by social workers having high caseloads and managers having large teams to manage, leading to crisis work being prioritised and recording being delayed. Steps have begun to be taken to address these issues with additional resourcing recently secured to increase the capacity in the referral and joint investigation team (JIT) services. This is relieving social workers of some additional rota duties to enable them to spend more time on their allocated cases.

16. Children's social care services benefit from a wide range of learning and development opportunities such as robust performance data analysis and reports, learning from serious case reviews and other research, and learning from a recent peer review. Whilst it is too early for learning from the latter to be incorporated into the improvement plan, other lessons learned have resulted in services being improved, such as Social Care Direct and in targeted youth support services.

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

Adequate

17. The effectiveness of the help and protection provided to children, young people, families and carers is adequate. Children referred to the SCD team have their circumstances appropriately assessed in terms of risk, and team managers ensure that where children are judged to be at risk or potential risk of harm they are referred to the JIT. Risks to children subject to child protection plans are specified in the plans with effective multi-agency support in place to reduce risk and improve the outcomes for children and families.

18. Children's views are well reflected in case files and reasons for absent views, such as children being too young to express a view, are appropriately noted. The wishes and feelings of children with complex care needs are also routinely included in assessments and plans. For example, one case reviewed by inspectors demonstrated skilled observations by the social worker of a child with disabilities which were used to inform the planning process well. Parents' views are noted and they are actively encouraged to participate in plans to protect their children.

19. Audits of child in need plans and reviews undertaken within the children with complex care needs team (CCCNT) have resulted in plans being 'smarter', measurable, and evidencing views of children and families. Plans seen in the intensive support team (IST) clearly set out timescales for the

completion of tasks and expectations of parents and partner agencies. The analysis of IST work demonstrates improvements in young people's behaviour, school attendance, substance misuse, and feeling safer.

20. Children and young people's participation at child protection conferences has increased, supported by a pilot children's advocacy and participation service. An analysis of its impact shows that of a total of 105 referrals, 73 children and young people who chose not to attend their conference were able to brief an advocate to represent their views, and professional staff report this to have a powerful impact on decision making. Families of children with complex needs also benefit from the early support, advice, information and liaison service which offers a range of support and advice for families caring for children with additional and complex needs and is subject to regular monitoring to ensure continued effectiveness.

21. Use of the CAF is continuing to increase and results in effective multi-agency assessment and support for children and their families. Inspectors spoke to parents about the early help services they receive. Parents reported understanding the CAF process and valuing the support offered. Although parents are positive about the benefits derived from early intervention, their views are not routinely captured during CAF reviews. Steps have been taken to address this but it is too early for the impact to be seen.

22. CAF arrangements are kept under review by partners to ensure consistency and effectiveness: for example, CAFs are audited to help improve their overall quality and identify areas for improvement. These reviews help to ensure that intervention and planning is timely. Evaluation of CAF arrangements shows that the increasing number of children receiving early help is having a direct impact in terms of reducing referrals to children's social care. CAF arrangements are also effective in supporting children and families who are being 'stepped down' from children's social care services. However the number of children subject to child in need plans within children's social care remains too high and is over three times the size of comparator authorities. This indicates there is significantly more work to do to ensure early help service providers are sufficiently skilled and confident to support children and families with more complex needs, thereby reducing families' need for statutory services.

23. The overall impact of some early help provision such as children's centres is not known as there is a lack of benchmarking to establish families' progress over time, as noted in inspections of the centres. There is also insufficient gathering and collation of service user feedback regarding participation and outcomes. The council acknowledges these shortfalls and has remedial plans in place.

24. There are a range of targeted services that effectively divert young people from statutory child protection and other services. For example targeted

youth services offer effective group work and individualised programmes for young people, and address issues such as sexual exploitation and domestic violence. Risk assessments are used to divert children and young people on the edge of crime, and numbers of first time entrants to the criminal justice system are low. Robust missing from education arrangements are in place and effectively reduce the risks these children face. Effective action is taken in respect of children who are withdrawn from school and educated at home to ensure their needs are being met. The intensive support team offers a range of successful group and individual interventions such as 'strengthening families' and therapeutic crisis intervention, and data shows improved outcomes in young people's behaviour, school attendance, substance misuse and feeling safer. The young families' service demonstrates improvements for the majority of those attending in terms of parenting, access to support services, employment education and training, security of tenure and income. Arrangements to tackle domestic violence early are resulting in more men seeking advice and being reflective about their behaviour.

25. Issues regarding diversity are generally well considered. Managers know the demography of the area well. The needs of minority ethnic groups are appropriately taken account of in service planning and delivery such as in the work of the specialist community liaison team which also includes a specialist domestic violence adviser to help meet the needs of minority groups. This service promotes sensitivity to, for example, different cultural traditions and sexuality issues. There is good access to interpreters. The Wakefield and District Safeguarding Children Board (WDSCB) ensures effective safeguarding training for different faith groups. International links with overseas welfare services and local multi-agency work contributes to reducing potential abuse such as forced marriages. However in some services, such as children's centres, referral forms do not routinely capture information on the language or religion of service users and ethnicity is not always recorded, so it is not clear how the centres cater for the diverse needs of all families.

26. There are a small number of children subject to private fostering arrangements and all are appropriately monitored. Awareness raising about private fostering and the need to refer has been provided to a range of partners. However numbers remain small and indicate under-reporting.

The quality of practice

Adequate

27. The quality of practice is adequate. Partner agencies have a clear understanding of thresholds for making referrals to children's social care services. The SCD team offer professional consultation to partner agencies seeking advice as to whether a child meets the threshold for referral to

social care, ensuring consistency of application. This is further strengthened by area social workers located in early help services providing advice on thresholds.

28. Decision making within children's social care is undertaken by qualified and experienced social workers but is not consistently timely and the recording of activity undertaken by SCD and JIT is variable in quality. Some files examined by inspectors lack basic information, some had confusing accounts of activity and lacked a clear rationale for the actions taken. Other cases examined did not record whether referrers had been advised about what actions were being taken. Where there are clear indicators that a child is, or may be, at risk, initial decision making and action in both the SCD and JIT is appropriate and timely. However, in some cases there was escalation to Section 47 enquiries when it was not clear that the threshold was met and an initial assessment might have been more appropriate. Strategy discussions are held between the police and children's social care and further actions are agreed between them. However inspectors saw some examples of the police not being involved in child protection investigations when it would have been beneficial for them to jointly investigate matters. Children are protected during investigations and interim protection plans are in place for children until the initial child protection case conference. Children and families are not unnecessarily subjected to formal child protection processes.

29. SCD provides a 24 hour service and this ensures consistency of responses to children and young people regardless of the time of the referral. Actions taken outside office hours are notified to the day time service promptly and are recorded on the shared electronic client recording system.

30. All notifications from the police regarding domestic violence in families where there are children are assessed by a team manager in SCD and scrutinised for risk factors as well as patterns of escalation and frequency. Subsequent decision making is comprehensive and appropriate, but some follow up actions are delayed, although inspectors did not see any children at risk as a result. Standard letters sent to families who have experienced domestic abuse do not sufficiently convey the offer of support and do not specify where non-abusing carers can access help.

31. Caseloads for social workers across the teams are high and competing demands on their time adversely impact on the timeliness of the recording of assessments. Workers are also on several rotas to increase capacity in other areas such as the work of the JIT, which reduces the time they have to dedicate to their allocated cases. High caseloads have resulted in too much work being crisis led and delays in recording. The quality of assessments is variable with some not evidencing robust analysis of risk factors. In contrast, social workers spoken to by inspectors knew their cases well and could sensitively describe detailed assessments of children's circumstances including risks and protective factors.

Assessments, despite recording shortfalls, lead to clear plans, offers of help and protection, and improved outcomes for children, young people and their families. Plans are mostly outcome focused, specific and measurable. The majority are reviewed regularly and reflect the changing circumstances of children and young people. Whilst all protection plans seen are adequate, some are not sufficiently clear to enable parents to understand their role in the plan, what needs to change and by when. Contingency arrangements for children are evident in only some of the plans seen.

32. Support arrangements for children who no longer need to be subject to a child protection plan are timely and include sufficient monitoring. Information sharing between agencies is mostly effective enabling a coordinated response to the protection and welfare needs of children and young people. Services from the intensive support team are provided swiftly. Children are seen regularly and are seen alone when appropriate. Social workers engage well with children and young people. Effective use of direct work techniques has led to improved understanding of children's perspectives. Children and young people report that they feel listened to and their views are mostly well considered and represented. There is good use of advocacy arrangements for children and young people in the child protection system, and this is actively promoted by professionals who report positively on the impact seen so far.

33. Parents spoken to during the inspection report that they are well listened to, helped and supported, and that social workers mostly understand and consider their wishes and feelings. Parents are generally clear about the processes in place to protect the welfare of their children and most felt well prepared for meetings and conferences, having received timely written reports from the social worker. Other professionals do not routinely share their reports with parents prior to meetings and the parents reported that this increased their anxiety about attending and contributing to meetings.

34. Reports to child protection conferences are variable in quality but are at least adequate. They identify and clearly evidence risks, but the analysis and evaluation of those risks and other vulnerability factors are not always fully developed and not all identify protective factors. In consequence, some child protection plans lack specificity regarding goals and actions that enable parents to know what needs to change. There is good multi-agency participation in most child protection conferences and core groups. Conferences are timely and chaired by skilled independent reviewing officers who actively engage parents and young people in a sensitive manner. They are proactive in ensuring families are able to fully participate and create ways to enable wishes and feelings to be shared with all those present.

35. CAF recording remains variable although overall the quality is adequate. Children's case files generally include the views of parents and children, where the child is old enough to express a view. Chronologies generally include sufficient detail to show progress in progressing plans, but many plans do not include clear targets with timescales for the completion of tasks. Previous plans are not always reviewed before setting new targets.

36. Management oversight of social work practice through supervision is variable. In almost all cases tracked there is evidence on case files of regular managerial direction through informal and ad hoc supervision although the reasons underpinning decisions are not routinely recorded. All social workers spoken to during the inspection feel well supported and describe good informal supervision and ease of access to managers. Newly qualified social workers receive increased support and have protected caseloads. The quality of staff supervision files varies greatly across teams and inspectors saw some good examples of regular supervision with good support and development for practitioners. However, this is not consistent and in two teams almost all supervision files were inadequate, with long gaps in recorded supervision. These demonstrate insufficient focus on training, development, annual appraisals and a lack of reflective discussion. Access to training is good and a highly appreciated programme of courses ensures staff are able to keep up to date with professional development.

Leadership and governance

Adequate

37. Leadership and governance is adequate. There are established, effective lines of communication between the Chief Executive, the cabinet Lead Member for children's services, the Chair of the Scrutiny Committee, the Director of Children's Services, and the Assistant Director (Safeguarding), and regular liaison between the Chief Executive and the independent Chair of the Wakefield and District Safeguarding Children Board (WDSCB). This ensures that all senior leaders and managers are aware of current issues within preventative and children's social care services. The director of children's services is also a member of the shadow health and wellbeing board and crime and disorder partnership, ensuring effective communication and clarity about responsibilities, the latter of particular significance in terms of ensuring a coherent approach towards supporting victims of domestic abuse. Direct influence regarding safeguarding issues is enabled by the independent Chair of the WDSCB being able to report to the local services board, a multi-agency group of local chief executives chaired by the Leader of the Council including: the council, police, housing services, probation and employment services.

38. The scrutiny committee considers the WDSCB annual report and this is presented in person by the independent Chair, thereby assisting members

to understand the key issues. This ensures the committee is aware of current priorities such as the need for better partnership working and swifter progress on current initiatives, and exercises its authority to seek reports of progress in these areas.

39. Priority areas for improvement are identified in the WDSCB action plan, which forms part of the Children and Young People's Partnership's (CYPP) action plan, ensuring coherence between the two bodies' activities. The priorities are appropriate and based on a regularly refreshed joint strategic needs analysis, incorporating emerging priority areas as they emerge, for example, from the learning from serious case reviews. Whilst the WSCB's action plan sets out clear priorities it lacks timescales for implementation of actions, so the intended speed of progress is unclear.

40. Strategic groups such as the CYPP, multi-agency risk assessment conference (MARAC), which considers high level risk, and the WDSCB are well attended by relevant agencies. The CYPP is chaired by the Lead Cabinet Member, the independently chaired WDSCB includes a GP representative and a lay member, the latter providing good challenge to the board. The GP has been instrumental in cascading information, such as the learning from serious case reviews, and encouraging interest in key issues within primary care services thereby increasing the priority given to safeguarding children in GP practices across the district.

41. Other priorities identified by the WDSCB have resulted in improved services to children and improved outcomes for them, such as reconfigured arrangements for children missing education and additional arrangements to support head teachers in executing their safeguarding responsibilities. Strategic partners and leaders ensure that learning from inspections, serious case reviews and from case file audits is consolidated and reviewed at a senior level. Learning is then appropriately cascaded to staff across the partnership. Action is being taken on emerging findings from the four serious case reviews currently underway prior to reports being finalised, to reduce delay in service improvements. Commitment to creating a learning culture is also evidenced by a recent peer review, the findings yet to be reported. Within the council, complaints are analysed in detail to identify learning, but no particular themes for children's social care have emerged.

42. The WDSCB takes an active role in ensuring that partners demonstrate how learning has led to improved arrangements within individual organisations as well as jointly. This includes annual audits of arrangements via self-assessments, interrogated via multi-agency challenge panels. A particular strength of this process has been the incorporation of young people as well prepared and supported members of challenge panels, calling senior officers to account for how well they execute their safeguarding duties.

43. The WDSCB and council accept that some areas identified as priorities have not progressed as swiftly as they should, such as joint working between the police and children's social care. This was an area for development identified in previous Ofsted inspections, and remains incomplete although recent significant improvement is noted.

44. Child protection guidance and procedures are widely available and regularly updated, ensuring staff across the partnership as well as members of the public are clear about what to do if they have a concern about a child or are working within child protection services. However some arrangements to protect particular groups of children are yet to be finalised and have required lengthy consolidation. This includes the joint arrangements to protect children at risk of sexual exploitation, the missing from home guidance and the information sharing protocol, although the latter is now being finalised and will be updated on the WDSCB website.

45. The WDSCB sponsors a wide range of multi-agency training which is evaluated for its immediate effectiveness and is reported on positively by delegates. Staff within children's social care have good access to relevant training to support them in their role effectively and which they report positively on. There are clear professional development pathways in place for all staff, and newly qualified social workers are well supported with protected caseloads and frequent supervision. The longer term and sustained impact of training is not yet systematically evaluated although this is identified as an area for development.

46. The council has a good understanding of the profile of its workforce including ethnicity and disability profiles which reflects the profile of the local population. Social work vacancy rates are relatively low and retention of staff is good. The council has employed a range of effective measures to achieve this including parity of remuneration with neighbouring authorities, sponsoring social work students and strong partnerships with local higher education providers. Staff sickness is actively managed and has reduced as a consequence.

47. Performance management and evaluation is well established within the local authority and partner agencies and is effective. The consolidated corporate action plan includes all actions from previous inspections and is regularly scrutinised. While there has been progress against most of the areas identified, some remain incomplete with further work to do, for example improving the timeliness and quality of assessments undertaken by social workers.

48. The WDSCB performance sub group provides detailed and accessible performance reports for the WDSCB, so all board members are fully informed about safeguarding strengths and weaknesses. Thematic information such as young people and substance misuse is also analysed, to enable the board to judge effectiveness of services and establish if

changes are required. A multi-agency audit of the work of the joint investigation team was undertaken, with a repeat event planned, to measure improvement. This has resulted in a clear plan to further improve joint working by co-locating staff and widening membership to include other agencies such as health. Multi-agency file auditing by the board remains at an early stage of development.

49. Children's social care managers and quality assurance staff undertake frequent case file audits, the summary findings of which are cascaded to practitioners and managers, to continuously improve performance. Managers receive detailed and accessible performance information reports on a weekly and monthly basis and performance is reviewed at monthly senior management meetings. The audits ensure that the service knows itself well, including those areas of practice and management which require further improvement. Some service areas such as SCD are subject to additional scrutiny with weekly management meetings informed by detailed performance information. Despite good quality performance data and high levels of auditing, progress in all areas is not consistent. The local authority's own audits identify ongoing shortfalls in the timeliness of assessments, the quality of recording, including service users' views, management oversight, referral gathering information and case planning. Audits are used well to remedy deficits in individual case records. Findings also inform the staff development programme to raise standards of practice more widely across the workforce.

50. Leadership within children's social care has been affected by the post of Director of Family Services, which incorporates the role of DCS, being vacant at the time of the inspection, with the Assistant Director (Safeguarding) acting up. The council has just appointed an Interim Director pending recruitment to the permanent post. Stability has been assisted by the Assistant Director (Safeguarding) who has a detailed understanding of the strengths and weaknesses within the service. Staff and managers report confidence in the leadership despite the recent changes, and report positively on recent information and consultation events. Key areas requiring attention such as social work rotas, joint working, service design, deficiencies in the electronic client recording system, and high caseloads are known to senior managers, although progress in addressing these issues is at an early stage of development and it is too early to see any impact from the proposed changes.

51. The views of children and young people have been proactively sought and are beginning to make a significant impact on service delivery, for example the WDSCB enabling young people to share their views on safeguarding issues and supporting them to produce a leaflet on safeguarding for young people. Similarly, children and young people have been involved in the tendering process for the advocacy service to support them within the child protection conferencing process, following the successful pilot scheme currently operating. The council seeks service user

feedback including from children and young people in respect of additional services it commissions. This informs the contract monitoring and re-commissioning processes to ensure that commissioned services are robust, achieve their aims, and are valued by children and young people who access them.

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