Inspection of local authority arrangements for the protection of children

Medway Council

Inspection dates: **7-16 January 2013**
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Age group: All

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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 Medway Council are **inadequate**.

Areas for improvement

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

Immediately:

- ensure that decision making on contact and referrals is robust and managers consistently take historical information into account in identifying key risks and needs

- ensure that managers effectively monitor the timeliness of the initial visit to children where there are presenting child protection concerns and ensure that all children are seen promptly and are seen alone where appropriate

- ensure that thresholds for strategy discussions and child protection enquiries are consistently and appropriately applied by managers, which leads to a timely response, robust sharing of information between agencies and an effective assessment of risk

- ensure that assessments effectively identify risk, protective factors and children's needs ensuring all relevant information is gathered from other agencies and considered before an assessment is signed off by managers

- ensure that management oversight focuses on the effectiveness of the current plan, the impact of intervention and the current

experience of the child, and that managers ensure that agreed actions are followed through in a timely way.

Within three months:

- ensure that inter-agency thresholds for statutory intervention are understood and applied by all agencies and that this leads to effective decision making ensuring that children and their families receive timely and appropriate services

- ensure that there is greater participation of children and young people in child protection conferences and their views and experiences are effectively taken into account in decision making

- ensure that children in need and child protection plans are timely, focused on the key areas of risk and need, are specific, measurable and outcome focused and include clear contingency plans leading to effective and timely intervention

- ensure that core groups are regular and they effectively develop, monitor and implement the child protection plan

- ensure that case recording is comprehensive and up to date and includes children's views leading to a clear understanding of the child's experience and journey

- ensure that regular auditing of child protection practice takes place, leading to robust action plans which are effectively implemented and monitored.

- ensure that the Medway Safeguarding Children Board (MSCB) robustly holds other agencies to account for their participation in child protection conferences and within the common assessment framework (CAF) process and timely and appropriate information sharing and multi-agency decision making

- ensure that the MSCB effectively monitors child protection practice, is provided with regular and comprehensive information from children's social care and that thematic audits are undertaken where deficits are identified leading to improvements in practice

Within six months:

- ensure that the recruitment and retention strategy in children's social care services leads to sufficient permanent social workers and reduces the number of changes of social workers children and families experience

- ensure that an up to date and comprehensive integrated early help strategy is put in place which is focused on the journey of the child to enable more children and families to access timely and appropriate early help services

- ensure that there is a systematic approach to performance management and evaluation across child protection services, so that the impact of services is fully understood, leading to improvements in service provision

- ensure that there are effective mechanisms in place to quality assure the CAF process to help enable improvements in the quality of assessments, planning and intervention.

About this inspection

4. This inspection was unannounced.

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

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

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

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

Service information

9. Medway council has approximately 65,000 children and young people under the age of 19 years. This is 24.5% of the total population. The proportion entitled to free school meals is 15%; this is below the national average. Children and young people from minority ethnic groups account for approximately 20% of the total school age population, compared with 17% in the country as a whole. The largest minority ethnic groups are 2.7% Black African, 2.4% Indian, 2.0% White Eastern European. The proportion of pupils with English as an additional language is 11% which is lower than the national figure.

10. Medway Council has early help for children and families provided within the Inclusion and Commissioning divisions of the local authority and in cooperation with other agencies. Services are delivered through a range of settings including 19 children's centres; schools and community settings; youth settings; and via partnership arrangements with, for example commissioned services from the community and voluntary sector.

11. Child protection services in Medway are delivered through two children's referral, assessment and support teams, two safeguarding teams, and one children with disabilities team.

Overall effectiveness

12. The overall effectiveness of local authority arrangements to protect children in Medway is **inadequate**. Significant deficits in key elements of children's social care services leads to some children being inadequately protected. For example thresholds for intervention are inconsistently applied by children's social care. Performance management, performance monitoring and quality assurance are inadequate. In addition, there are deficits in key aspects of child protection practice.

13. Key basic elements of practice are inadequate in a significant proportion of cases, for example case recording, assessments, planning, management oversight and decision making. This contributes to a very high rate of re-referrals. In some cases there are delays in initial visits to children and children are not consistently seen alone. Practice is not sufficiently child focused. In a significant number of cases the focus is too much on the adults and their views rather than the experience of, and risks to, the child. Some practice is over-optimistic, lacks professional curiosity and is incident led. This results in risks and needs not always being comprehensively identified and some children not having timely and effective plans put in place to reduce risks to them and improve their situation. A lack of timeliness in the completion of some assessments leads to delay in assessing risk and need and families not accessing appropriate services in a timely way.

14. The lack of a sufficiently robust and comprehensive recruitment and retention strategy has contributed to a continuing reliance on agency social workers and managers, and a significant turnover of social work staff. This results in some families having to build new trusting relationships with social workers and retell their stories which impacts on the progress of the case. Whilst social workers are committed and hardworking they are faced with significant challenges, such as some high caseloads, systems and processes that do not support effective social work practice and recent instability at senior management level.

15. There is strong commitment to protecting children and young people by members of the Medway Safeguarding Children Board (MSCB) and evidence that the MSCB has had a positive impact in some areas of child protection practice. For example ensuring good multi-agency arrangements with regard to protecting children who are at risk of sexual exploitation. However, there has not been sufficient focus on the core business of child protection. The MSCB has not effectively monitored the quality of child protection practice and not sufficiently improved key elements of partnership working such as information sharing, application of thresholds and participation of agencies in child protection conferences.

16. Clear prioritisation of child protection by the council has not led to sufficient improvements in services. There is strong political support from

elected members and at a corporate level from the Chief Executive. The budget for child protection services has been protected and additional funding has been agreed for specific projects: for example, the new electronic recording system. The council has undertaken significant activity to address areas for development from the last inspection in November 2011. However, there is limited evidence of impact or sustained improvement. The pace of change has been too slow and the implementation of the improvement plan has not had sufficient rigour, resulting in a significant number of children receiving a service that is inconsistent and not sufficiently timely or effective.

17. Children subject to child protection plans are seen regularly by social workers and significant elements of good practice were identified by inspectors examining the child's journey through services. Evidence of good and sensitive direct work with children and families which has effectively reduced risk was observed by inspectors both for children subject to early help and for children who are subject to child protection plans. Examples of good assessments were also seen by inspectors and some very recent child protection plans are of better quality. Parents who have been provided services through early help are all positive about the service they receive and describe the positive difference this has made to their lives. Good interventions are reducing the need for referrals to children's social care services in some cases.

18. The recently appointed Director of Children's Services (DCS) has quickly understood the key areas for development and established a clear vision to enable systems to more effectively support the child's journey through services. The DCS is significantly increasing the pace of change. Audit work has been commissioned and is currently being undertaken to gain a much better understanding of the service and a new performance team is in place, supported by increased resources. However, some initiatives such as the recent improvements in some child protection plans have yet to become fully established.

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

Inadequate

19. The effectiveness of the help and protection provided to children, young people, families and carers is **inadequate**. Although no children were found to be at immediate risk, deficits in the quality of practice, case recording and management oversight leads to some children being inadequately protected. In a significant proportion of cases seen by inspectors there was evidence of drift due to delays in assessing risk and putting effective protection plans in place.

20. A combination of factors such as a lack of clear pathways to early help services, poor decision making and assessments has resulted in families experiencing a number of repeat referrals and assessments before accessing an appropriate service to meet their needs. A lack of timeliness in initial visits to children in some cases leads to delays in fully assessing the risks to children, and in some cases gives inappropriate messages to families about the seriousness of the presenting referral. In a significant number of cases seen by inspectors information gathering and assessment of risk were not sufficiently robust resulting in some cases being closed inappropriately or assessed as children in need when child protection processes should have been initiated. Consequently, some children and the families do not receive timely and appropriate help and protection.

21. Some children in need cases are closed without families having been redirected or signposted to another service or offered appropriate support. Although most child protection plans are concluded at an appropriate stage, there is some evidence that ongoing monitoring arrangements, once children are no longer subject to a child protection plan, are not sufficiently robust. The outcome of this for families is that they do not consistently access appropriate services at the right time and this does not consistently enable early intervention to improve the family's situation.

22. Information sharing across agencies is not sufficiently robust. Some assessments are signed off by managers and decisions made before children's social care has gathered all relevant information from other agencies. A pilot project is being evaluated for the sharing of information regarding domestic abuse incidents which is good. However, in areas outside the pilot project, information sharing following domestic abuse incidents is not sufficiently robust. A significant number of conferences are not quorate; attendance by some agencies at child protection conferences is too variable. This, combined with some agencies not consistently providing reports, has impacted on the effectiveness of information sharing and partnership working. This does not enable effective risk assessment and decision making in all cases and contributes to delays in putting a comprehensive plan in place to reduce risks.

23. The lack of systematic evaluation of early help services does not enable sufficient information to inform both commissioning of services and their development. An integrated early help strategy with clear pathways to services has not yet been fully developed and updated. A number of examples of effective individual services were seen by inspectors. Children and families accessing early help services receive a good service. However there is not always timely access to these services.

24. Good partnership working between children's centres and different agencies is is leading to the provision of effective help which in some cases is reducing the need for referrals to children's social care. Intervention strategies are good and there are examples of staff

identifying potential crises in families and intervening at an early stage. Effective intervention programmes are in some cases improving parenting skills which is leading to improvements in the child's circumstances.

25. The CAF process is not sufficiently robust. The commitment of professionals to the CAF and to taking on the lead professional role is too variable. There is appropriate multi-agency training for staff combined with good support and advice from the CAF team. Regular meetings of the lead professional forum and CAF champions provide staff with the opportunity to give feedback on needs and share good practice. The council does not have an embedded system in place to quality assure and evaluate the CAF process. Consequently, the impact of the CAF is not being systematically monitored and evaluated.

26. Parents and carers who access early help services reported to inspectors that they receive good quality help, support and guidance. Over time, parents report improvement in: parenting skills, personal circumstances including financial, general well-being and self-esteem; and housing and good transition to school, all of which contribute to children making better than expected progress and families becoming more resilient and settled. Parents report that the children's centres value people equally. Young parents spoke highly about the effective work carried out following the step down to preventative services from children's social care which is helping in sustaining improvements in their families' situation.

27. Parents held mixed views about the quality of the relationships with social workers. Some parents were critical of the support they received, did not feel listened to, and stated that they did not receive minutes and reports in a timely fashion, whilst others had more positive views about their social worker's communication with them and engagement with their children.

28. Some projects and services effectively capture the views of service users. However they are not collated and therefore do not contribute to a full understanding of the effectiveness of services. In some cases, changes of social worker at key points in a child's journey results in drift and parents and children having to build new relationships and retell their stories.

29. Inspectors saw some good examples of direct work with children and families. Family support workers are providing a range of individual and group work services that are improving the child's situation. The group work programme includes services for victims of domestic abuse which is increasing awareness and understanding of the impact of domestic violence on children. Some good and sensitive direct work was seen within the safeguarding team which led to identifiable improvements in the child's situation and reduced risks. In discussion with social workers and parents it is evident that in some cases effective and valued relationships have been established with children.

30. Ethnicity is routinely recorded on children's social care files and inspectors found some good examples where social workers have taken into account children and families' distinct ethnic and cultural needs. Social workers spoken to reported that they are able to access interpreters quickly and easily. However, the consideration of cultural issues overall was limited in assessments. Inspectors did find some good culturally sensitive work undertaken with some families, particularly the Roma community. Training has been delivered to staff about cultural issues. Staff reported that this led to a significant improvement in their work with different cultural groups.

31. Inspectors found evidence of inconsistent decision-making by managers in the referral, assessment and support teams in the application of child protection thresholds for children with disabilities. In some cases, a timely and effective response to ensure that risks are fully assessed is not evident. No work has been undertaken to understand the reasons for the low numbers of children with disabilities subject to child protection plans, and whether thresholds are being applied appropriately.

The quality of practice

Inadequate

32. The quality of practice is **inadequate**. Key basic elements of practice such as case recording, assessments, planning, and management oversight and decision making were inadequate in a significant proportion of cases examined by inspectors.

33. While there are clear written threshold criteria in place, they are not consistently understood and applied by key agencies. This, combined with the lack of clear pathways for early intervention services and a CAF process that is not sufficiently robust and embedded, is contributing to the high rate of referrals. Lack of clarity about the difference between a contact and a referral leads to additional pressure being placed on the referral assessment and support service and contributes to a very high proportion of referrals ending in no further action.

34. Decision making on referrals is timely, although not sufficiently robust. Thresholds are not consistently applied by children's social care and inspectors saw evidence of some poor decision making. Lack of effective identification of risk and consideration of historical information results in some referrals being closed inappropriately or child protection processes not being initiated when the presenting information indicates that the child is at potential risk of significant harm. In some cases seen by inspectors key information was missing, risks had not been fully identified, and a lack of analysis had led to cases being closed inappropriately. This is contributing to an exceptionally high rate of re-referrals.

35. A police officer is co-located within the referral assessment and support service which enables prompt information sharing, and timely decision-making in cases that have been identified as child protection. Schools report inconsistencies in the timeliness and quality of the response at the point of referral and state that they are not always kept well informed about the status of referrals or the progress of cases. Schools do not consistently use escalation procedures where they are concerned about decision making. In the majority of cases, agencies refer promptly, although this is not yet consistent.

36. Child protection enquiries are carried out by qualified social workers. They are timely once a strategy discussion or a strategy meeting has taken place. Other agencies contribute effectively to strategy meetings. In a number of cases there are delays in children and young people being seen and children are not consistently being seen alone. Inspectors observed delays in seeing children when there were presenting child protection concerns, due to the risks not being appropriately recognised and child protection processes not being initiated. In most cases the quality of section 47 investigations are adequate.

37. Whilst social workers are clearly conscientious and committed to delivering a good service, high referral rates, high caseloads and competing demands impact negatively on the quality of practice. Managers are keen to improve the quality and timeliness of social work assessments and inspectors did see some examples of managers not signing off assessments, either because they were incomplete or because the standard of the assessment was poor. However, in a significant proportion of cases completed assessments remained of insufficient quality. Some assessments are signed off before information from other agencies has been requested or before those agencies have responded to the request for information. Too many assessments do not sufficiently challenge the views expressed by adults and do not adequately consider the experience of the child. Most assessments are under-developed in terms of analysis and do not explicitly identify risk and protective factors. Some core assessments seen were based on a limited number of visits to families and consequently were not comprehensive. Comprehensive and up to date assessments are not consistently in place for children in need and children subject to child protection plans.

38. The quality of CAF assessments is too variable, compounded by a range of CAF forms being used by agencies. Some assessments are detailed and provide clear and analytical background information which contributes to identifying specific targets that are well linked to a period of time and next steps. Others lack depth and clear actions and as a result, there is drift. The views of children and families are not consistently recorded and there is insufficient evidence that professionals from different services identified in the CAF attend meetings. The council does not have an electronic system to support the CAF process. There are early indications that the

new CAF format currently being piloted is supporting better quality assessments.

39. In a high proportion of cases seen by inspectors, the voice of the child is not sufficiently evident in case records, assessments, child protection enquiries, or reports for child protection conferences. This leads to the voice of the child not being sufficiently considered in assessment, planning, intervention and decision making and does not support child centred practice.

40. Children subject to child protection plans are visited regularly by social workers. However, children are not always seen alone. Children's participation in child protection is underdeveloped and very few young people attend child protection conferences. There is limited use of advocacy. This leads to the voice of child not being sufficiently evident during conferences. Most child protection conferences observed by inspectors were well chaired. There is a clear structure, parents are engaged and professionals are encouraged to actively contribute both to the discussion and to the child protection decision-making process.

41. Core groups are well attended by agencies, but in some cases the impact of the core group is undermined by a lack of frequency of core group meetings and by the quality of the child protection plans. In addition, core groups are not always sufficiently focused on the key areas of risk and plans are not consistently well developed.

42. Some plans are not based on a comprehensive assessment of risk and needs which undermines their effectiveness. A high proportion of child protection and children in need plans are of poor quality: they are not outcome focused, specific or measurable, listing tasks to be completed rather than clearly defining what difference the plan is designed to achieve in terms of reducing risks and improving the child's situation. Plans examined by inspectors were not sufficiently focused on the key areas of risk and clear contingency plans are not consistently in place. As a result, protective strategies and interventions are not sufficiently explicit and parents are not always clear about what they have to achieve, by when and what the consequences of not achieving this are. Similar deficits have been seen in CAF plans. Decision making with regard to stepping down children from child protection plans is mostly timely and appropriate. The vast majority of plans are reviewed regularly.

43. Social workers receive regular monthly supervision and report that they feel supported by managers who are highly visible and accessible. However, the quality of supervision across the service is variable and records do not demonstrate that reflective supervision is taking place. Overall management oversight is regular and there are detailed directions about what needs to be done and by when. However, there is not always effective follow up by managers leading to actions not always being

completed. In addition, in some cases there is insufficient focus and challenge on the current risks to the child and on the effectiveness of the current plan and interventions aimed at reducing the risks. In some cases this has led to delays in initial visits to children, and implementing plans which reduces the effectiveness of interventions for some families, whose situation does not improve quickly enough.

44. In a high number of cases seen, the quality of recording is inadequate. For example, inspectors saw cases files which were not up to date, were lacking sufficient detail and had significant omissions, such as records of key meetings with children or parents, making it difficult to gain sufficient understanding either of the current situation or the child's journey. The recording of visits was also very limited, with key information not being recorded. In too many cases seen, the purpose of the visit and the outcome are not recorded, and there is a lack of analysis. Inspectors found chronologies on some case files but they were of variable quality; some chronologies were good, but others were either very limited or out of date. The current electronic recording system does not effectively support social work practice. The quality of decision-making and recording is variable and inspectors found some cases where strategy discussions or strategy meetings were not recorded on the case file. The outcome is that in some cases it is not clear whether children have been adequately protected.

Leadership and governance

Inadequate

45. Leadership and governance are **inadequate**. While the strategic priorities of the council and its partners are clear, the council has not sufficiently identified the mechanisms to ensure that the most vulnerable children are effectively protected. The pace of improvement across the partnership has been slow.

46. While there has been some progress against areas for development identified in previous inspections, the council has not yet succeeded in ensuring that weaknesses in core child protection work have been sufficiently addressed. For example, the council has been unable to demonstrate an effective strategic response to repeat referrals, which are exceptionally high.

47. There is a good level of attendance and commitment to the MSCB and clear reporting arrangements between the MSCB and its member organisations. However, the MSCB has not been sufficiently effective in improving the quality of child protection practice across the partnership. Monitoring of child protection practice is inadequate. This has been significantly hindered by the lack of sufficient and regular performance management information from children's social care services. The MSCB has recently developed a multi-agency performance management

framework that will enable it to be more proactive in identifying risks and holding agencies to account. The MSCB has been effective in some areas, for example in reducing the number of plans that have been in place for two years or more. 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. Children missing from home and school are effectively protected through good partnership working. In addition, private fostering arrangements are monitored effectively.

48. There is evidence of some challenge from the MSCB. However, the Board has not been sufficiently effective at addressing key multi-agency aspects of working such as information sharing, application of thresholds, and participation of agencies in the CAF and child protection conferences. The MSCB has an active learning and development sub-group which has been responsible for coordinating and quality assuring the delivery of a good range of child protection training programmes. The training is well regarded and valued, and the MSCB is now developing a process to monitor the impact and effectiveness of child protection training.

49. Performance monitoring and performance management of child protection services are inadequate. Performance management is undermined by insufficient quantitative and qualitative data. While data collection and dissemination to key managers have improved recently, these do not provide comprehensive or effective tools for managers to monitor performance. The culture of performance management is not yet fully embedded and there are clear omissions in essential data collection. For example, data does not capture the frequency of visits to children on child protection plans, core groups and whether children are being seen alone. Quality assurance processes are inadequate and are predominantly focused on an evaluation of process rather than the quality of practice. The quality assurance role of the child protection chairs is underdeveloped.

50. Case audits within social care are undertaken by managers. The majority seen by inspectors had limited information and different formats have been used. The audits have not been effectively drawn together and therefore themes have not been identified or shared. There is no evidence of individual action plans arising from case audits and these being monitored, and therefore this work has not had an impact on improving the quality of child protection practice. Service based audits have not been undertaken in the last 12 months. However, there has been some thematic auditing undertaken by the MSCB. Audits have not been undertaken on key elements of child protection practice such as decision making on referrals, re-referrals and child protection enquiries. However, the council has recognised that this is an area for development and has commissioned an independent agency to complete a number of audits across the service. The MSCB are undertaking multi-agency case audits,

although the impact of this work is limited. Although significant activity has taken place to disseminate key messages from serious case reviews across the partnership, these have not been effectively disseminated to social workers and their managers. As a result, long standing areas for development, such as the quality of assessments, have not been effectively monitored or addressed.

51. The absence of a comprehensive recruitment and retention strategy is not enabling the effective recruitment and retention of experienced social workers and managers. Overall progress has been made in reducing the high numbers of agency staff within social work teams. However, there is still too much reliance on agency staff within specific teams, which is contributing to a significant turnover of social workers. A more robust recruitment and retention strategy is now being developed and work is being undertaken in order to appoint permanent staff to key management positions within children's social care. A principal social worker post has been put in place for child protection services and this is providing the council with additional capacity to deliver improvements. The principal social worker is currently undertaking audits and monitoring actions to ensure that progress is made and identifying key areas for improvement.

52. Good work has taken place in 'growing their own staff' by supporting staff in gaining social work degrees. In addition, a good programme of support is in place for newly qualified staff and the training programme is well regarded. However, this has not been sufficiently informed by key priorities relating to practice. All staff have recently had an annual appraisal, which is a positive development and while their training and development needs have been identified, these have not yet been used to systematically inform the development of the training programme.

53. Some managers and social workers report that changes in senior management have led to them experiencing a lack of clear leadership. In addition, some practitioners and managers describe that changing practice, guidance and priorities have led to difficulties in delivering improvements and, in some cases, to staff feeling undervalued. The new senior management team are making significant efforts to engage staff, as this is a clear priority for the council.

54. The new senior management team has been able to quickly identify key areas for development within social work teams and has spoken to a significant number of staff and is committed to ensuring that the views of social workers are included in future service developments. Recently, a clear vision has been developed to ensure that services are more focused and responsive to the child's journey. A detailed action plan has not yet been developed to support the clear vision, although a project manager is being recruited to undertake this work. The new leadership team is planning to implement key changes rapidly such as the introduction of a new electronic recording system, recruitment and retention strategy, and

a multi-agency triage system, as well as clear governance arrangements for schools. Targeted work to support the completion of assessments which are out of time scales has been effective and there have been very recent improvements in the quality of some child protection plans. Due to strategies only being recently developed and some not yet being implemented, there is currently limited evidence of improvements across child protection services.

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