Inspection of local authority arrangements for the protection of children

Bath and North East Somerset

Inspection dates: **4 March to 13 March 2013**
Lead inspector **Richard Nash**

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 Bath and North East Somerset 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 Bath and North East Somerset, the local authority and its partners should take the following action.

Immediately:

- ensure that all cases that require social work intervention are allocated without significant delay
- take action to ensure a consistency of response to new contacts and referrals so that all cases requiring social care involvement are identified and progressed promptly.

Within three months:

- ensure that the performance management framework has sufficient focus on qualitative aspects of statutory casework
- ensure that weaknesses that have been identified by the local authority in relation to assessments, case conferences and children's plans are addressed.

Within six months:

- evaluate the impact of early help services and ensure an overarching strategy for early help is in place.

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. Bath and North East Somerset (BANES) has approximately 36,575 children and young people under the age of 19 years. This is 20.8% of the total population. The proportion entitled to free school meals is below the national average. BANES has 78 schools comprising 62 primary schools, 60 maintained and two academies, 13 secondary schools of which 10 are academies, three special schools, two of which are academies and no pupil referral unit. Children and young people from minority ethnic groups account for 9.1% of the total population, compared with 22.5% in the country as a whole. The largest minority ethnic group is Polish. The proportion of pupils with English as an additional language is below the national figure.

10. In 2012 an estimated 12% (4056 children) of children in BANES live in poverty, compared to an estimated 30% nationally. BANES is one of the least deprived authorities in the country, ranking 247 out of 326 English authorities, however within this, 32 of the 115 small areas analysed are within the most deprived 20% for one or more individual domains of social inequality. Early Years services provision is delivered predominantly

through the private and voluntary sector in over 93 settings; there are 11 children's centres and eight nurseries.

11. Early help for children and families in BANES is provided through a combination of direct and commissioned services, together with partner agencies. The local authority is in the final stages of a reorganisation that will structure the management of preventative services on a 0-11 years and 11-19 years basis. Services are delivered in a number of ways including through six social work teams, 11 children's centres, health visiting services, parenting and family support services, targeted youth services, schools, early learning and community settings, children missing education services, behaviour support, child and adolescent mental health services (CAMHS) and Project 28, a substance misuse service.

Overall effectiveness

12. The overall effectiveness of local authority arrangements to protect children and young people in Bath and North East Somerset is adequate. The council, together with partners, has continued to have a clear strategic focus upon the protection of children. This has enabled improvements to be made to some key areas of service delivery and for the council to have an accurate sense of areas that still require improvement. There have been improvements to the timeliness of both initial and core assessments and core assessments are now routinely undertaken after child protection enquiries. Progress in respect of qualitative measures is less secure. Despite the local authority being aware, for a number of months, of the need to improve key aspects of casework such as analysis of risk and the quality of child protection plans, inspectors found variable practice. Although no children or young people were found to be at risk of immediate harm during the inspection there were case examples that demonstrated delay in securing improved outcomes for some vulnerable children and young people.

13. Awareness of thresholds and the need to refer to children's social care is well established across a wide range of agencies. However a large percentage of referrals into the child in need and duty team (CHIN) do not meet the threshold for statutory social work services and there has been an increase in such contacts over the last six months. The local authority is aware and acknowledges that more needs to be done to understand the reasons for increases in contacts and also to recognise the impact of early help services on referral and assessment arrangements. The increase in work in the CHIN team coupled with some unforeseen staffing pressures has led to some work not being allocated immediately and caseloads for some social workers becoming too high. The early help offer is becoming more established and some very strong examples of effective direct work were seen for children, young people and their families across the age range. The council have increased resources to support the continued use of the common assessment framework (CAF) and team around the child (TAC) processes and are aware of the need to improve the overall quality of CAF assessments.

14. Children and young people who require immediate protection receive a prompt and appropriate service. Section 47 enquiries are timely and usually focus on relevant information to assess risk. Decision making by managers is not always consistent within the CHIN team and some individual cases were seen where management oversight was not effective and some children and young people involved in these cases experienced delays in getting the appropriate service. Strategy meetings take place promptly and usually involve a wide range of professionals. The quality of strategy meetings is variable and some become insufficiently focused on immediate risk and how best to proceed with robust child protection enquiries. Reports to case conferences are of variable quality with too

many being adult rather than child focused and being a commentary on events rather than an analysis of risk and protective factors. Consequently child protection plans are often generic and do not reflect clear measurable actions that are focused upon achieving improved outcomes for vulnerable children and young people.

15. Senior officers are effectively supported by elected members and the local authority has an embedded culture of challenge and scrutiny. The Local Safeguarding Children Board (LSCB) is meeting its statutory duties and the independent Chair ensures LSCB members have a clear focus on child protection within the locality. The council and the LSCB have a clear sense of the strengths and areas for development in terms of performance. Performance management and supervision has been focused on compliance issues and practice which has led to improvements in, for example, the timeliness of assessments but has had less impact on addressing known areas for development such as the quality of assessments. Supervision and management oversight of work has not yet been fully effective in improving analysis of assessments or in ensuring the full needs of individual children and young people are identified. It has also not yet led to improvements in the quality of children's plans.

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

Adequate

16. The effectiveness of help and protection provided to children, young people, and their families is adequate. Action is taken to protect children and young people at risk of harm and in need. In the majority of cases where children and young people are referred as a result of child protection concerns, strategy meetings are carried out promptly with good levels of multi-agency involvement. Immediate action to ensure children and young people are safe is taken in most cases. For example, children subject to Section 47 enquiries are seen promptly and decision making in respect of holding initial child protection case conferences was, in relation to cases seen by inspectors, sound. There is variability in risk assessment and analysis in case conference reports and initial and core assessments and this impacts upon case planning and plans for individual children and young people.

17. At the time of the inspection there were 35 unallocated children in need cases in the CHIN and duty team. Managers within CHIN had effective oversight of this work and ensured that where the needs of individual children increased these cases received input on a duty basis. The local authority recognises that unallocated work leads to delays in providing effective help for children, young people and their families and has made arrangements to use more agency social workers to address this issue.

Inspectors did not identify any children that were at risk of immediate harm during the inspection.

18. The quality of assessments, including initial and core assessments as well as CAF varies greatly with a minority seen by inspectors completed to a high standard and most achieving satisfactory outcomes. Most assessments identify risks appropriately but too many are descriptive and lack detailed analysis. In some of the cases seen, risks were clearly and comprehensively evaluated in determining where and how interventions needed to be focused. However, this is not consistent and in too many cases assessments were too focused on the needs of adults rather than of the children. Consequently, this can lead to drift in some long term cases. Where analysis is weak, case planning is less effective and the individual plans for children are too generalised and not supportive of timely positive change. The consideration of children and young people's identity, ethnicity, racial, cultural and linguistic needs in statutory casework and early help is variable and most cases seen failed to consider all individual needs appropriately. The importance of culture within White British families is not routinely recognised in assessments, and neither is the impact of social and economic circumstances.

19. The quality of child in need and child protection plans is too variable. In some cases the plans are detailed and outcome focused and there is evidence of effective monitoring of plans. However, most of the plans seen did not have clearly set out timescales, measureable goals or contingency plans to ensure actions identified to support children and young people are addressed. Consequently it is unclear as to the extent to which parents, carers, children and young people understand the intention or purpose of the help being offered or their exact role within the plan.

20. While inspectors saw evidence of some good outcomes for children and their families through multi-agency work using the CAF, there is emerging evidence of the effectiveness of CAF overall as the local authority has put in place arrangements to collect information to help inform further developments. Where inspectors saw multi-agency practice using CAF, outcomes for children were satisfactory. However, where there is more than one child in a family subject to a CAF the needs of each child are not always sufficiently considered. The use of the CAF and TAC approach has improved since the appointment of key posts to support the use of CAF in universal settings. The number of CAFs completed is rising and schools are beginning to complete more assessments on children and young people. When risks to children increase they are appropriately 'stepped up' to social care. Conversely, when statutory interventions are no longer required children in need receive appropriate support. The use of CAF with expectant teenage parents ensures that their needs are consistently considered well. The interface panel provides oversight of cases where children and young people have more complex needs and the panel provides direction in these cases to avoid drift. While this is a relatively

new development there are some positive examples where additional support provided has improved outcomes for children and young people.

21. Effective early help and prevention is provided via the specialist children, young people and family service with services being delivered by the children and family support team and the 117 Project. The early help offer for children, young people and their families is in place. However, there is a lack of a shared strategy by the wide range of agencies that contribute to early help. Measures to judge the effectiveness of early help overall are underdeveloped. However, work is effective at supporting children, young people and their families where they have emerging needs and when they experience crisis. Children's centres contribute well to keeping children safe through effective links with children's social care and specialist support services. For example, they provide effective oversight of vulnerable children through regular monitoring, home visits and support by family support workers and children's attendance groups. Universal groups provide an appropriate gateway for parents, carers and children to other help services that meet their individual needs. The youth service is increasingly providing effective support to vulnerable young people, including those with disabilities. They develop trust and good knowledge of individuals and tailor support closely to their specific needs that builds resilience and their social and life-skills well. Young people are able to gain more specialist help through attending, for example, youth clubs and projects.

22. Parenting programmes build the capacity of parents well to ensure that their children are kept safe and develop well. Parents told inspectors how highly they value the help they receive in this respect. They said that they are able to accrue a range of skills and knowledge that enables them to support their children. This includes developing strategies that help them manage their child's behaviour, use praise to re-enforce positive behaviour and spend more time playing with their children at home. Behaviour and attendance panels enable additional support for children and young people to be put in place to meet their emerging needs. Information is shared reasonably well to plan packages of individual additional support. However, the information on families is not always complete and this can lead to delays in support being put in place.

23. Inspectors saw examples of positive individual direct work carried out by the children and family support team. This included work carried out with a young child to understand and make sense of their situation. The work undertaken was sensitively done and the voice of the child communicated well in the records. There was evidence that the children and family support team canvass the views of children and families and use this information to inform practice. Overall there is currently no formalised process to measure outcomes and effectiveness of services provided.

24. There is clear awareness across the partnership of domestic violence and a range of services to support children and families, such as the New Way Project working with both male and female victims and perpetrators, and the Freedom programme. Support to children experiencing domestic violence is provided by Southside and plans are in place to re-establish a support group for children and young people using the models and tools from Barnardo's. Clear joint multi-agency children missing protocols have been established to respond to children who may go missing. Children benefit from return interviews and where necessary additional help is provided to children, young people and families to work through the issues. However, risk assessment is not routinely carried out and in one particular case this would have supported effective planning to safeguard the young person. The arrangements to manage and address issues of child sexual exploitation are in place and are appropriate. However, casework seen by inspectors indicates that awareness in relation to sexual exploitation is not fully embedded in practice. For example, in one case concerns and indicators of possible sexual exploitation were not recognised despite there being different concerns over a number of weeks. When a strategy meeting was held actions were focused upon the support needs of the young person rather than risk and protection.

25. Schools receive good support from youth workers and education welfare officers to enable children and young people at risk of missing education to improve and maintain school attendance. Effective arrangements are in place to monitor those children educated at home to ensure that any concerns about the child's welfare are promptly identified and plans implemented to keep them safe.

The quality of practice

Adequate

26. The quality of practice is adequate. Contacts and referrals receive a timely response from the child in need and duty team, with relevant information obtained and recorded. Initial screening in most recent referrals is sound, with prompt responses and appropriate actions taken, including where the outcome is no further action. However, in some cases initial decision-making was not sound, with circumstances that clearly indicated a need for a prompt children's social care response being signposted or progressed too slowly. For example, a very small number of cases were seen where concerns about a child, including possible excessive physical chastisement, were deemed to require no further children's social care investigation or assessment. These cases were referred back to the local authority during the inspection and appropriate action was then taken. Similarly, historical factors, including very recent history, were not always used fully to support the development of a full understanding of risk and need.

27. A very large rise in the number of contacts and referrals and recent unavoidable staffing pressures since December 2012 have combined to cause delays of up to one month in the allocation for assessment of a significant number of cases. These factors have also contributed to very high caseloads for some social workers. While effective management oversight has ensured that no children were placed at risk of immediate harm as a result of this, there have been delays in assessing and responding to children's needs.

28. Referrals made out of hours receive an assured service from the emergency duty team (EDT), with sufficient qualified and experienced social workers to ensure a skilled response. There are good links between EDT and day services as well as with key partners including the police and acute health providers. Some referrals are made directly to the disabled children's team and these receive a response that is timely and appropriate. Children's social care services and a wide range of partner agencies share information effectively, appropriately and in a timely way. This ensures social workers and others working with children and their families develop a sufficient understanding of their circumstances and shapes work undertaken. Case-level information sharing with the EDT is effective and enables informed responses to problems that emerge out of hours.

29. Thresholds for access to children's social care services are well understood by partner agencies including universal services, and are appropriate. This understanding goes beyond the immediate children's workforce. For example, a local housing provider has made timely referrals in respect of domestic abuse and anti-social behaviour that was impacting on the safety and well-being of children and young people. Thresholds are mostly applied appropriately by children's social care services at the point of referral, though inspectors saw some examples where cases had been deemed to require no further action or were progressed too slowly. Social work advice and guidance is readily available to professionals in other agencies who report that they value the support and advice provided in helping them to determine whether a referral should be made or another form of help offered. The co-location of an 'inter-face worker' with children's social care teams enables prompt and informed information-sharing, discussion and decision-making for children who are on the edge of requiring a social care response or who no longer need statutory social care services but may still require further help from universal services.

30. Section 47 investigations are timely and always carried out by qualified social workers, and where necessary with police colleagues. Information is routinely gathered from partner agencies and is used to support assessment and decision-making. In some cases seen it has also contributed to the development of good quality chronologies within assessments. Risks and protective factors are identified and decision-making in respect of significant harm is sound. Child protection

conferences are triggered where appropriate and where no further protective action is required, there is appropriate consideration of alternative forms of help.

31. Case decision-making is undertaken by suitably qualified and experienced social work managers and there is evidence of well-considered managerial oversight. However, while management decisions are mostly clearly recorded in case files, the rationale underpinning them is too often absent. This creates the potential for weak planning and inconsistency of response. Strategy discussions and meetings involve all relevant professionals. The wide participation ensures that they are effective in sharing relevant information and identifying risks, actions to be taken and in some cases contingency plans. However there is some evidence that larger strategy meetings have followed a broader agenda than is necessary to determine the need for and scope of investigations. On occasions this led to loss of focus on the details of the investigation.

32. Initial child protection conferences consider and analyse detailed information, for example from social work reports. However, child protection plans are, in most cases, too general and focus insufficiently on the reduction of risk. Contingency plans are largely formulaic and do not address the specific circumstances of the case. Some child in need plans are similarly lacking in an outcomes focus. While core groups now take place in line with statutory guidance, and most are well attended and recorded, too many are not effective in developing the outline plan from the child protection conference into a specific and measurable plan that sets out clearly the required changes. Plans are routinely shared with family members, but the lack of specific and measurable objectives does not support them in understanding what needs to change. The local authority has very recently introduced visits by the conference chair to families prior to and following the initial conference. Feedback from families is that this is beneficial and has helped them in their understanding of the concerns, but it is too early to see the full impact.

33. While review child protection conferences and core groups monitor compliance with actions established in the plan, weaknesses in planning, including contingency planning, mean that they do not explicitly address the extent to which risk has reduced. As a result progress, or its absence, for children receiving help under child protection and child in need plans is not routinely identified and this has in some cases led to drift and delay. For example in those cases where the threshold for care proceedings maybe met. There are arrangements in place for children and young people involved in child protection processes to have an advocate through an arrangement with a third sector provider. The local authority has identified low take up as a cause for concern and has taken action to improve this, though the full impact remains to be seen.

34. Children and young people who are the subject of assessments and other interventions are routinely seen, including alone where appropriate, though records do not always indicate this clearly. Social workers make unannounced visits to children on child protection plans, and see children's bedrooms where appropriate. In some cases social workers have been effective in using a range of direct work approaches to build relationships with children and to secure their views, which are incorporated in records and inform work undertaken. However, inspectors saw other cases where children's views had not adequately informed assessments, planning and interventions. In a number of these cases, there has been an undue focus on parental behaviours and needs at the expense of those of the children. In some cases, the views of children aged six and seven years were not sought by social workers and child protection conference chairs because they were seen as too young.

35. Managers and front line practitioners receive regular supervision that is planned and recorded. Supervision records indicate that there is attention to staff welfare and development needs as well as case discussions. However, there is little evidence of reflective supervision and only in a very small number of cases is there clear evidence of robust challenge about performance. Managers do not consistently support those they manage to develop effectively and in too many cases sign off work that has too little focus on risk and analysis. A skills audit approach has recently been introduced and this has the potential to support improvement by enabling a focus on professional development and performance. However, its effectiveness is currently limited as these audits are not the subject of a development plan and are not routinely reviewed in supervision.

36. Case recording is largely up to date. However, records do not consistently include chronologies and this, combined with a largely task-focused approach to recording, means that the child's experience and circumstances are not fully considered and readily understood. As a result, most records do not give the reader a sufficiently clear picture of the child.

Leadership and governance

Adequate

37. Leadership and governance is adequate. Strategic leaders, including the Strategic Director, People and Communities Department, the independent Chair of the LSCB and key partners have developed an appropriate strategy in relation to the provision of child protection services. The Children and Young People's Plan 2011-14 articulates the strategic plan in relation to keeping children and young people safe. The LSCB business plan and the inspection improvement plan are focused upon addressing known areas of weakness and have enabled the council and its partners to take appropriate action in a number of areas. These include improving

compliance and practice in relation to the timeliness of assessments, ensuring consistent management sign off of work and that core assessments are undertaken following child protection investigations. The inspection improvement plan is suitably ambitious in that it seeks to ensure that service improvements are embedded and sustained.

38. Less progress has been made however, in relation to the overall quality of work. The council is aware, as a result of audits of casework that took place in October 2012, that there are inconsistencies in relation to issues such as the quality of assessments, the effectiveness of plans and the extent to which the individual needs of children and young people are taken into account in assessment and case planning. However, performance management and evaluation is under developed in some areas, particularly in relation to casework inconsistencies and the evaluation of early help services. Children's services are aware of increased demand for statutory social work services but are not yet in a position to judge the full impact or overall effectiveness of early help services.

39. Clear accountabilities and responsibilities exist between the LSCB, the Director for Children's Services (DCS), the Chief Executive and the Lead Member for Children's Services. The quality of performance management information continues to improve and performance monitoring is clearly prioritised by senior officers, elected members and partner agencies. Senior officers have developed an accurate sense of the strengths and areas of development of children's services. The local authority has created a new Principal Social Worker post and extra capacity within the management structure of the CHIN duty team. Recent pressures in relation to the duty service have been recognised and strategic leaders and elected members have enabled extra agency staff to be recruited.

40. The LSCB has developed significantly over the last 12 months and the independent Chair has ensured that the appropriate representatives from the right agencies attend board meetings. In addition, proactive work has taken to place to ensure that there is a full commitment to the completion of Section 11 audits. The LSCB promotes effective inter-agency working and now is regularly attended by key staff from across the partnership. LSCB business is driven via four distinct sub-groups; professional practice, training and workforce development, serious case review (SCR) and policy procedures and performance. The LSCB monitors the inspection improvement plan and uses effective performance data to monitor effectiveness. The LSCB recognises areas where it has been effective, for example the celebrating fatherhood initiative, which began as a result of practitioners recognising that casework lacked a focus on fathers. It equally recognises those areas where more work is needed such as preventing drift in casework and improving the effectiveness of case plans. There is also acknowledgement that more needs to done to improve the depth of service user feedback and the extent to which feedback is used

to inform service delivery in the future. The LSCB has commissioned a service user and professional feedback audit with the findings scheduled to be available in June 2013.

41. The impact of management oversight of casework and performance exercised by senior and middle managers is too variable. Despite awareness of weaknesses in practice highlighted in audit activity a significant number of these performance issues have not yet been fully addressed. Supervision records of managers do not indicate that sufficient action is being taken to ensure first line managers address weak performance and case work decision making through robust quality assurance arrangements, including quality assurance for CAF.

42. Workforce planning has been effective across areas of the whole partnership. There has been an increase in the numbers of front line health visitors within the locality and training for staff across the partnership has enabled a wide range of professionals, including professionals such as police community support officers, to use CAF and TAC to respond to identified need. The creation of a Principal Social Worker post, the establishment of skill sets for all social care posts and the commitment to fully establish reflective supervision demonstrates the extent to which workforce development is prioritised.

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