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Herefordshire

Inspection of children's social care services

Inspection dates: 11 June 2018 to 22 June 2018

Lead inspector: Pauline Higham
Her Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Requires improvement
The experiences and progress of children in care and care leavers	Requires improvement
Overall effectiveness	Requires improvement

Leaders and managers have not secured an environment in which good-quality social work practice can flourish, and the majority of core practice requires improvement. Senior leaders acknowledge that insufficient progress has been made in key aspects of their service, and many weaknesses found during this inspection mirror many of those identified in 2014. The pace of planning and action to remedy some long-standing deficits has been too slow. This had led to drift and delay for children before, during and after care proceedings, and means that outcomes have not improved for children in a timely way.

Since the last inspection in 2014, senior leaders have made some progress and have improved practice in some areas, for example in strengthening assessments for disabled children and in ensuring that information about children who go missing is shared effectively and is robustly analysed by partner agencies. The vast majority of children in care live in good placements, where their outcomes improve.

Children identified as at risk of immediate harm receive prompt and responsive intervention, ensuring that they are safeguarded. When risks increase, and children are no longer able to live safely at home, the local authority is making increasingly good use of its legal powers to safeguard and protect children. Decisions about whether some children who experience neglect need to become looked after are not taken swiftly enough. The quality of management oversight and decision-making across the wider service is too variable.

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What needs to improve

- Senior leadership urgency in implementing a robust and timely action plan to deliver improvements and to address deficits in social work practice.
- The sufficiency of social workers and managers with capacity to cope with the need for services and the volume of social worker caseloads.
- Senior managers' interaction with social workers to enable staff to feel listened to.
- The pace of progressing child protection and child in need plans and the quality of practice with children in need.
- The regularity and quality of social worker supervision.
- The quality and purposefulness of management oversight and decision-making and the existing quality assurance and performance management system.
- The quality of life-story work for all children

The experiences and progress of children who need help and protection requires improvement

1. No children seen during the inspection were found to be at risk of immediate harm. The Multi-agency Safeguarding Hub (MASH) is responsive and ensures that good-quality information sharing results in strong decision-making. Children who need immediate help or protection receive appropriate interventions.
2. A significant number of contacts are signposted away from children's social care, which means that too many children are being referred who do not need this level of support. A number of children who would benefit from early help services experience delay because thresholds are not appropriately applied or understood. This is an area that needs to be strengthened so that children and families who might benefit from early help are quickly identified and do not experience any delays in receiving the help they need.
3. Despite this, early help family support services received by families are responsive and an intense package of support is provided. Early help plans are of good quality and detail clearly ongoing actions that are required in order to make and sustain change. These plans are reviewed

regularly and changes in needs are quickly responded to, resulting in demonstrable positive change for children and their families. When concerns escalate, thresholds for stepping cases up to statutory social care are well understood.

4. The majority of contacts into the MASH are progressed within 24 hours. Children identified as at risk of immediate harm receive a timely and responsive intervention, ensuring that they are safeguarded. Strategy discussions in the MASH involving the appropriate range of partner agencies take place promptly. Subsequent strategy meetings are well attended by professionals who know the children well, and planning for children is appropriate and well informed.

5. Similarly, section 47 child protection investigations are carried out in a timely way and appropriate decisions are reached. Poor recording in some cases means that there is not always evidence in children's records that they have been seen or the extent of direct work that has been undertaken with children.

6. The current arrangements within the MASH are not fully collaborative. Domestic abuse notifications are not triaged prior to them arriving in the MASH, which places additional burden upon the MASH manager. Police notifications classed as medium or standard risk (other than domestic abuse) are reviewed by police development officers appropriately and on a daily basis. However, there is no social care oversight of these cases, and, currently, there are no agreed timescales for ensuring that all notifications are reviewed. The consequence of this is that any risks to children might not be identified in a timely way, or they might be missed entirely. When alerted to this deficit, the local authority responded immediately to ensure thorough and timely management oversight of such cases.

7. Multi-agency risk assessment conferences (MARAC) are effective in identifying risks to adults and children. Information is relevant and specific. The quality of action plans is good, addressing risks by identifying actions for relevant agencies.

8. An effective out-of-hours emergency duty service (EDS) provides timely and appropriate responses to children and families. Information sharing, contact with daytime services and access to the electronic database enables EDS staff to make informed decisions and take any immediate actions to protect or help children.

9. Some children and family assessments are thorough, child centred and robust, and result in the provision of services and evident progress for children. However, this is not consistent. In poorer assessments, and particularly where neglect is a long-standing issue, social workers do not routinely consider historic concerns and their analysis can be over-

optimistic. Children are not routinely spoken to alone by social workers as part of their own assessments, and so subsequent plans are not informed by a child's view of their lived experience. In some cases, assessments are overly focused on the needs of adults.

10. Social workers across this service have high caseloads. In addition, and because of delays in transferring to other teams, they are also holding a mixed caseload. This means that social workers are struggling with competing demands and are prioritising their work with child protection and court cases taking precedence. In best case examples seen, social workers are tenacious and responsive. Evidence showed that there is effective child-centred practice that improves children's circumstances, but this is not consistent for all children.

11. The quality of services and practice for children in need is poor in many cases. Responses to their needs are too slow and lack the focus required to make meaningful changes to their situations. Current arrangements do not provide effective oversight, and while senior managers have developed an action plan to improve this situation, they do not ensure that all children in need are receiving the services they need in a timely way or that they their needs are prevented from escalating.

12. The local authority has invested in graded care profile training to support social workers in dealing with cases of neglect. Despite staff speaking positively about this, no evidence of this training was seen being used with individual children.

13. Initial child protection conferences are held in a timely way. There is good multi-agency attendance, which ensures a holistic contribution to the child's plan. The quality of child protection plans is too variable and is poor in some cases. The plans for some children result in good multi-agency support that improves their circumstances and achieves sustainable change. Weaker plans lack sufficient details for families to see clearly what services are going to be offered, who will provide them, their responsibilities and the timescale for them to take particular actions. This makes it difficult for families to understand what needs to change and by when.

14. Children in need and children subject to child protection plans do not always receive timely visits. Over half of children who are the subject of a child protection plan are not visited the locally defined minimum amount or visited enough times to meet their needs in line with their plans. Children are not always seen alone when social workers visit. This means that children are not always able to develop meaningful and trusting relationships with their social workers. Further social workers do not always have a sufficiently full understanding of children's current

circumstances to mitigate risk and to effectively progress the child's plan.

15. Fewer children are the subject of repeated referrals to children's social care and fewer children are subject to repeat child protection plans. This means that, for some children, intervention is effective and their improved outcomes are sustained.

16. Some children benefit from good direct work by social workers they know and trust, but this is not a consistent feature of social work practice. Children in this service experience too many changes of managers and social workers.

17. Management oversight of frontline practice is not consistently effective. It is not evident in all cases and does not provide the robust challenge and direction needed to urgently progress plans and avoid drift and delay. Social workers do not receive regular supervision, and when it does take place, it does not provide the necessary support and direction to ensure that all children's cases progress without delay.

18. The quality of help and protection offered to children by the disabled children's team is a strength. Strong and effective work with partner agencies results in effective support to children and their families. Workers know the children they are working with very well and they ensure that children's views are evident in their reviews and assessments. Assessments are updated regularly and provide a good analysis of the needs of children.

19. When children live in households where multiple risks are present, these risks are identified well. However, this identification of risk is not then routinely followed up by well-coordinated and focused intervention, with the result that there are delays in progress for children. Often, there is too much focus on single issues, rather than understanding how risks relate to each other and then formulating an overarching plan to address this. The impact on children who are living in such circumstances is not well understood by senior managers, and assertive and timely action is not always well coordinated to improve their circumstances.

20. Work with families is not always consistently child-centred. Following an initial public law outline (PLO) meeting, in some cases the significance of what happens to a child is lost as the focus shifts on to the adults. Some letters before proceedings are too long and do not assist parents to understand what they need to prioritise and how they are going to be supported to change. Some children experience drift and delay at this stage, and review PLO meetings are not taking place in a timely way.

21. For children at risk of exploitation, effective multi-agency working results in risks being identified and appropriately assessed. Robust risk assessments result in children being supported at the right thresholds to mitigate risk. Where concerns increase and where it is appropriate, children come into care without delay to ensure that they are safeguarded.

22. Child sexual exploitation and other child exploitation is effectively managed. Timely information sharing between professionals enables effective mapping to take place, identifying potential adults of concern and other children at risk of exploitation. Appropriate support and information is provided to parents and carers to enable them to develop a better understanding of child exploitation and the key role that they play in safety planning.

23. The local authority's designated officer ensures that prompt and effective action is taken when allegations are made against professionals or persons in positions of trust. Position of trust meetings are timely and well attended, ensuring that appropriate actions are taken to effectively safeguard children.

24. For children who go missing from home or care, return home interviews are completed in a timely manner. The recordings of discussions with children lack analysis, with the result that it is not always clear how the information gathered informs safety planning for children. The local authority is aware of this deficit and has taken action to improve the way that staff can record their findings that supports more effective analysis and data collection.

25. There has been concerted work to get children who have been reported missing from education back into school. Schools report any concerns promptly and officers follow up cases effectively, working in partnership with other agencies and local authority teams. Officers keep detailed records of their work and cross-check any emerging concerns with social care colleagues.

26. Local authority officers know which pupils are being electively home educated. The elective home education officer works effectively with families to make checks on the quality of education that pupils receive. Any safeguarding concerns are promptly acted on.

27. The arrangements for children in private foster care are not well managed. Children do not receive a timely and responsive assessment of their needs or of their carers' abilities to meet their needs. Not all required checks are carried out and not all children have been seen in a timely way. The local authority responded immediately to concerns

raised by inspectors for the very few children living in these arrangements and has taken appropriate steps.

The experiences and progress of children in care and care leavers requires improvement

28. Appropriate decisions are made when children need to come into care. When risks increase, and children are no longer able to live safely at home, the local authority is making increasingly good use of its legal powers to safeguard and protect children.

29. Decisions for children to become looked after are not always based on up-to-date assessments. Assessments are not routinely updated to reflect changes in a child's circumstances and needs. Historical concerns are not always fully considered, and this means that some children whose circumstances had not changed should have come into care sooner. Better assessments take good account of historical concerns effectively, using research and analysis to inform planning.

30. When children and young people become accommodated under s20 Children Act 1989, the initial decision-making is appropriate. The planning that follows is not always sufficiently robust or purposeful, and, as a result, several children have remained subject to these arrangements for too long. This has resulted in prolonged drift in progressing their care.

31. As a consequence of a recent court judgement, it was recommended that the local authority should review all cases where children were subject of s20 Children Act 1989 arrangements. As a result, a targeted and effective action plan has led to more recent assertive decision-making and the progression of plans for some children.

32. Children's care plans are of variable quality. Some are specific and clear, while others are overly long. In these plans, outcomes are not measurable and actions and timescales are recorded as 'ongoing'. In some cases, this has contributed to drift and delay for children.

33. Where appropriate, children and young people who are unable to return to their birth families are being supported to live with connected persons. Family group conferences are used well to facilitate the exploration of family-based solutions.

34. The local authority is succeeding in ensuring that brothers and sisters are placed together where possible and where it is appropriate. Good assessments inform contact plans, and any changes to contact

arrangements meet the needs of the children and support family relationships.

35. Children are actively encouraged to attend their reviews, and advocacy is used appropriately. Children are routinely seen alone. In most cases, recording of visits is thorough. Social workers know children well and are able to clearly articulate their needs, identify risks and vulnerabilities and describe their personalities. However, this knowledge is not always fully reflected in case records. Views of parents and other family members are well recorded and are reflected in children's care planning.

36. Despite this good work, the quality and progress of care planning is compromised for some children because of too many changes in social worker. This also means that it is difficult for children to build trusting relationships with their social workers.

37. Children's views are well recorded within review minutes. Child-centred letters are written to children by independent reviewing officers (IROs), informing them of outcomes and decisions of their reviews, and this helps children understand what is happening. IRO visits to children are not always recorded on their case files, and so the IRO footprint is not consistently evident. IRO scrutiny and challenge to progressing plans and addressing drift is not always sufficiently robust.

38. Children seen are in appropriate placements, and are having their needs met, with the majority developing well and their outcomes improving. The process for supporting stability of placements is effective and help is available early to prevent concerns from escalating further. Access to Herefordshire intensive placement support service therapeutic support is a strength. Case records do not demonstrate that matching takes place at the point of children coming into care, and for some children permanence is not achieved within their timescales.

39. The authority's arrangements for delegating authority to carers is not sufficiently clear and has not been for some time, despite the issue being raised by young people previously. This is an important issue for young people and means that some foster carers are still unable to make appropriate day-to-day decisions on their behalf. Senior managers have acknowledged this and have agreed to take immediate action to remedy the situation.

40. Foster carers go through an appropriate approval process and receive the right range of training to meet the needs of children placed with them. The local authority is struggling to provide a sufficient number of foster families, and in particular those that meet the needs of sibling groups and teenagers.

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41. Too many children do not have life-story work completed and this means that carers do not have a comprehensive and accessible account of a child’s life history to enable them to fully support children.

42. Educational outcomes for children in care are variable across the local authority. The attainment of key stage 4 children in care has been in line with, or above, national levels for the last two years. The attainment of children in care in key stages 1 and 2 has been variable for the last two years. The local authority is aware of this variability and is committed to raising standards further. The electronic system that has been introduced to record children’s outcomes does not provide the virtual school with sufficiently detailed information about the children’s attainment and progress. As a result, it is not yet possible to fully track outcomes and respond accordingly to any identified issues or trends.

43. The virtual school headteacher has a clear view of the strengths and priorities of the local authority provision. The virtual school does not have sufficiently detailed information about the attainment of children in care, and schools report that children in care achieve mixed levels of progress. Targets within personal education plans are not specific or measurable enough to allow professionals to make an accurate judgement about the progress of children in care. This is particularly the case for looked after children and care leavers in secondary and 16–19 provision. Personal education plans do include the views and feelings of children in care.

44. For the majority of children for whom the permanence decision is adoption, adoption is achieved in a timely manner. Family finding and matching are strong areas of practice. Families are carefully matched to children, and information sharing is good. Introductions are well managed, with input from the adoption social worker as well as the child’s social worker.

45. Arrangements for adoptive families to access post-adoption support are good, enabling help and support to be available without delay. The service keeps in touch with adopters, sending out emails and flyers to invite them to tailored training and social events. All adopters have access to a play therapist based in the service if children require this type of support. This is good practice.

46. Care leavers have timely effective pathway plans that address their needs. Plans are individual, aspirational and reflect young people’s hopes for the future. Young people clearly contribute to their plans and they focus on what is important to them. Care leavers have trusted relationships with their personal assistants.

47. While young people at 18 years old have a meeting with the child looked after nurse, not all young people have access to their health

information. Inspectors identified this as an important issue for young people and the local authority has agreed to take this forward as an area for immediate improvement.

48. Skilled work with unaccompanied asylum-seeking children takes place. The diverse needs of these young people are well understood, and it is recognised that their needs cannot always be met within the Herefordshire area. Out-of-county placements are sourced and meet children's cultural religious and inclusion needs. Staff proactively seek to further develop their skills in this area to appropriately support young people.

49. Young people in care and care leavers are positive about their engagement with senior managers and the corporate parenting board. They spoke positively about the recent council 'take over day' in November, which also included other agencies.

50. Care leavers live in good-quality placements and accommodation, including supported living and staying put arrangements. Care leavers are aware of the advocacy service, although they feel that their voices are not always heard or taken account of. Access to mental health services for care leavers is difficult, and to date there is no strategy to improve this situation. Care leavers know about their entitlement to services and they receive good support to access information, legal rights, and the benefits and financial help that they can receive.

The impact of leaders on social work practice with children and families is inadequate

51. The last year has been extremely challenging for leaders and managers. A very specific set of circumstances occurred from September last year that included restrictions on the range of functions some senior managers have been able to undertake and challenging personal circumstances that have resulted in a leadership team with constrained capacity, lack of stability and, in some areas, poor performance.

52. A number of areas for improvement from the last inspection in 2014 still require attention and this is a concern. These include caseloads that are too large, ineffective quality assurance and performance management and continuing difficulties in recruiting good-quality social work staff and managers.

53. Senior leaders have sought and are receiving support from colleagues within the social care sector who lead children's social care effectively in the sector, but it is too early to evaluate this.

54. Leaders and managers have not been effective in overseeing and ensuring that social work practice flourishes. Their lack of grip and direction has resulted in a service where some decision-making is very poor, some staff do not receive supervision and workforce capacity is not at the level required to provide a good-quality service for children and families.

55. Social workers from various teams are prevented from providing the quality of service they know is required because of excessive caseloads and ineffective deployment of staff. This is further hampered by a lack of robust, clear and timely management oversight and case direction. Senior leaders acknowledge this and now have the early stages of an improvement strategy in place. However, it is too early to see any impact.

56. Too many children in need of help and protection and children in care are receiving a poor service. Practice is not consistently child focused. Planning for children is not always sufficiently robust or purposeful and this is compounded by management oversight that is not effective in addressing this. As a result, some children experience unnecessary drift and delay and their circumstances do not improve in a timely way.

57. Staff in some teams feel a strong disconnect from their senior managers, which is inhibiting improvement. If improvements are to be made securely, this needs immediate attention.

58. Sufficiency planning lacks effective strategic direction and future needs are not articulated clearly. This is compounded by the current commissioning strategy not being underpinned by a comprehensive assessment of future needs.

59. Senior managers acknowledge that their current performance and management information data is underdeveloped and does not provide sufficient accurate detail to support their understanding of what is happening in their service. This requires immediate and robust attention.

60. Quality assurance processes are undertaken routinely, but they are rendered ineffective because of a lack of follow-through on issues of concern. This is a missed opportunity to improve the quality of social-work practice and a failure of managers.

61. Leaders and managers are aware of deficits in practice and service provision, but currently there is a lack of timely action planning to remedy this. Inspectors have seen evidence of their capacity to

implement improvements in the children with disabilities service and in the care leavers and 16-plus team. The management team's response to s20 Children Act 1989 cases has also been effective.

62. Furthermore, the council has made a recent significant financial investment to support the development and improvement of children's social care services. This is supported by a recent appointment to the senior management team of an assistant director who brings a renewed focus to long-standing issues. The director of children's services is aware of the need to take robust and immediate measures to strengthen his management team and there is very recent evidence of assertive action.

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