Inspection of local authority arrangements for the protection of children

Suffolk County Council

Inspection dates: **3-12 June 2013**
Lead inspector **Debbie Barazetti-Scott HMI**

Age group: All

Website: www.ofsted.gov.uk

Further copies of this report are obtainable from the local authority or at www.ofsted.gov.uk

Contents

Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Suffolk 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 Suffolk, the local authority and its partners should take the following action.

Immediately:

- ensure decisions taken to initiate assessments in the access team are taken within acceptable timescales and that the timeliness of assessments is accurately monitored
- ensure that caseloads of all social workers and senior practitioners are brought within the Local Authorities own guidelines
- ensure that all staff receive supervision that is regular, reflective, challenging and is used effectively to improve the quality of social work practice
- take action to accelerate progress in recruiting sufficient numbers of qualified social work staff to manage the workload.

Within three months:

- ensure that decisions and actions taken on all cases where children have a child in need or child protection plan are monitored by managers and acted upon in a timely way

- ensure that the views and experiences of children and young people are routinely collected and that where appropriate these are used to inform case planning and are fully reflected in recording and assessments

- ensure that information collated as part of assessment activity is thorough, correctly recorded, takes account of historical information and is rigorously analysed to understand and reflect risks and protective factors in relation to children

- ensure that professionals working with children and adults in Suffolk are clear about how to access social work advice and consultation.

- embed the consistent use of quality assurance systems and performance management within front line teams to ensure effective front line practice

- ensure that the quality assurance of the LSCB and senior managers in the LA effectively impact on the quality of child protection services in Suffolk.

Within six months:

- develop effective systems across integrated service teams and specialist teams to obtain, record and collate the wishes and views of children and young people about the service they are receiving, including complaints, and use these to influence the development of services

- ensure that all children's plans are specific, measurable, and regularly reviewed, in order that timely interventions are based on understanding of current risk and need, and improving outcomes for children

- ensure that children's identity and cultural needs are fully incorporated within assessments and reflected in their plans

- ensure that children and young people are actively supported to contribute to their case conferences, have access to an independent advocacy service and are encouraged to attend where appropriate

- develop skills and confidence in partner agencies to take on lead professional role for CAF's, to ensure that plans are developed and delivered by those most able to contribute to meeting children's needs

- develop the skills of child protection chairs to enhance their role in the quality assurance of reports to conference and the quality and timeliness of child protection planning, intervention and impact.

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 focussed 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), and two seconded inspectors.

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

Service information

9. Suffolk has approximately 167,600 children and young people under the age of 19 years. This is 22.9% of the total population. The proportion entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for 8.1% of the total population, compared with 21.9% in the country as a whole. There is however some significant diversity in deprivation and ethnicity across the county with, for example some areas of significant child poverty and deprivation in parts of Ipswich and Lowestoft. The largest minority ethnic groups is white other. This category includes Americans (many of whom live on airbases) and other Europeans. The proportion of pupils with English as an additional language is below the national figure.

10. The organisational structure through which services for children and families are provided in Suffolk was redesigned and implemented in July 2011: referred to as the New Operating Model (NOM).There are four core elements. Contacts and referrals from the public and agencies are dealt with by a central contact team, Customer First. Once an enquiry has been screened and relevant information gathered, an integrated access team

provides a single point of entry for all service requests. It is planned that this will become a Multi-Agency Safeguarding Hub (MASH) early in 2014. Multi-agency integrated teams provide early help and intervention for children and young people who need additional, targeted support. These teams include community health staff; health visitors, school nurses and learning disability nurses who have transferred from the primary care trust into the County Council. Specialist teams deliver statutory services for children and young people with higher levels of need including those in need of protection and for Looked After Children. In addition there are universal and community services providing open access to all children and young people.

11. Integrated teams and specialist teams are age banded from 0-11 and 12+ and organised into seven localities with coterminous boundaries. In most localities integrated and specialist teams are co-located. There are also county-wide teams including services for disabled children, children with additional needs and their carers, a County Asylum & Private Fostering Team, Family Group Conferencing and a Family Assessment and Support Team (FAST) supporting families with children at risk of coming into care.

Overall effectiveness

Adequate

12. The overall effectiveness of local authority arrangements to protect children in Suffolk is **adequate**. Significant changes made to the configuration of services just before the last inspection in August 2011 have been consolidated and are now established. The council and its partners have a sound understanding of the strengths of their services and the areas for further development and these are progressively being implemented. No systematic failures leading to children failing to be protected were identified within this inspection.

13. Appropriate priorities for action are developed and shared by key strategic leaders, however overall scrutiny of the performance of child protection services in Suffolk by senior managers and the LSCB has not been sufficiently robust. There has been a period of significant change across the leadership in Suffolk in the past two years, with the appointment of a new Chief Executive in October 2011 and the current Director of Children's Services (DCS) taking up post in February 2013. Whilst oversight of the implementation and continued progress was made in implementing the NOM by two interim DCS', not all objectives have yet been achieved. This is recognised and the LSCB have agreed to oversee the further development of the NOM across the partnership and monitor progress as part of their strategic leadership of the Early Help Strategy. This and other recent developments including the establishment of a dedicated education and children's services committee indicate more informed challenge and support is now being provided by senior managers and elected members.

14. A wide range of family support and early intervention services are in place, including 48 children's centres. These are appropriately placed to deliver effective services to most children in need of help. Across the partnership there is increased use of the common assessment framework (CAF), which has improved the coordination of activity. However professionals in universal services do not always feel they have the confidence or expertise to act as a lead professional. Social work assessments and direct work with children are usually undertaken to a standard which is at least adequate, although the quality of practice is too variable with some inadequate and some good examples seen by inspectors.

15. In the access team decisions are made by a suitably qualified social worker the same day as the information is received from the Customer First team. If children are considered to be at risk of harm they are referred to the relevant locality team to undertake strategy discussions with the police. Where children do not meet the threshold for child protection intervention there can be delays in acting on decisions for several days, and in a few cases, weeks, before being transferred to

locality teams for assessments to begin. During the inspection, this practice was reviewed, and a process of management review of any cases awaiting a decision regarding assessment for three days has commenced, to ensure formal assessments are started in a timely manner.

16. Professionals working with children not open to children's services are not always clear how to access social work advice on whether a referral to children's social care is warranted. In some instances, professionals who make a referral do not receive timely feedback explaining what actions are being taken in response to their concerns.

17. Children and young people subject to child protection plans are visited and seen regularly. Children and young people are appropriately protected through multi-agency plans and activity, with child protection conferences well attended by relevant professionals. However the quality of written plans, for children in need of protection; children in need and children requiring early help require improvement. Although some good examples were seen, too many lack focus on the key factors of risk and protection and do not set measurable outcomes. The role of child protection chairs in quality assuring reports to child protection conferences and monitoring child protection plans is underdeveloped.

18. There is a lack of consistency in case management across the County. Most teams are adequately resourced to undertake their role in helping and protecting children. There are, however, some areas of high demand, where the majority of social workers have too many cases and managers are not exercising sufficiently rigorous management oversight. Some staff in these teams say that they are feeling overwhelmed. In many cases seen by inspectors, supervision was irregular, with little evidence of challenge or reflection. In some teams inspectors found gaps in information recorded, weak assessments which did not clearly identify risk and protective factors, and plans which were not focused sufficiently on meeting children's identified needs.

19. The views of children and their parents are captured within the majority of individual cases in the integrated teams, and there are examples of how case planning has included these views. Within specialist services, most cases have a factual record of diverse cultural and ethnic detail, but it is not always evident how this is considered as part of case planning and assessment. The views of children and parents are not routinely reflected within assessments or individual plans. There is little evidence of the views of service users being collated and used to shape service development, and the advocacy service is not routinely used to support children in contributing to child protection meetings.

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

Adequate

20. The effectiveness of help and protection provided to children, young people and their families and carers is **adequate**. The local authority deploys a wide range of services to help and support families at an early stage. There is increasing evidence to show that preventative services generally work well together to protect children, young people and families from risk of harm, at all stages of vulnerability.

21. Children's centres are a key resource in offering early and targeted universal support to families with children under 5. Most are actively involved in outreach work. However engagement with identified vulnerable groups is low across the county. Three children's centres have been judged by Ofsted to be inadequate. Although senior leaders have responded by taking decisive and robust action to address those weaknesses, they cannot yet be assured that potentially vulnerable children are being consistently engaged and supported by these services.

22. The configuration of community health services, children's centres and integrated 0-11 and 12+ teams under a single line management arrangement in each locality is increasingly effective in coordinating support for vulnerable children at an early stage. The integrated teams are instrumental in effecting transfer processes to and from specialist teams. Parents affected by issues such as homelessness, mental ill health, substance use, unemployment or with a history of offending were seen to have benefitted from direct work with the staff both from the integrated teams and specialist agencies. Examples seen demonstrated that help was well targeted to meet their needs and improved their parenting abilities.

23. With robust referral pathways and a CAF coordinator in each locality providing specialist support and training for staff, the use of the CAF is increasing. Schools and other partners report that CAF and Team Around the Child (TAC) processes have helped to improve information sharing and partnership working. Most are very positive about the impact of multiagency work. In particular, the team around the child, at all levels, has been effective in meeting needs and reducing risks. For example resulting in fewer fixed term exclusions, improved school attendance and stability in the home. In one school, vulnerable young men have been engaged in positive activities leading to a reduction in anti-social behaviour.

24. Some initial CAF assessments are incomplete, with little emphasis on assessing the needs of the child or young person. Although most seen by inspectors had delivery plans, action planning was not always child centred, outcome focused or measurable. Planning for improvement often

lacked precision, leading in some cases to delays in ensuring effective intervention to families. Where help had been most effective, this was linked to delivery plans where the child's needs were clearly identified, and the purpose of the plan in meeting these needs was clear. The use of detailed closure summaries in most cases seen ensures that outcomes are systematically recorded and reviewed to provide information on effectiveness.

25. Children and young people who are clearly at risk of harm are identified by both early help and children's social care services. Referrals to children's social care are timely and most professionals reported that the Customer First service and Access Team arrangements worked well. Underpinned by clear guidance, good communication between integrated and specialist services ensures that where there is a transfer of responsibility between teams there is a continuity of care. There is a good understanding of thresholds across these services and most children and families are receiving an appropriate level of support.

26. Most children who are the subject of a child in need or child protection plan are helped and protected by the support that is provided. However in some cases seen intervention is not sufficiently focussed on reducing risk in a timely way, and poor quality assessments have impacted on the effectiveness of child protection plans, leading to drift and delay.

27. Multi agency risk assessment conferences (MARAC) meetings are well attended by a wide range of professionals who share information effectively. This enables the identification of perpetrators and their links with families to be tracked, resulting in robust multi-agency risk management plans for children who are at risk from domestic abuse. Suffolk also has a well developed and coordinated, multi agency approach to identifying and protecting young people identified as being at risk of sexual exploitation. A clear commitment from partner agencies to this work is evident from the newly embedded LSCB strategy to identify young people at risk. The multi agency 'make a change' team delivers a training programme to professionals and provides direct work with young people at risk of sexual exploitation to help keep them safe.

28. Integrated services are able to demonstrate high levels of service user satisfaction based on the evidence of children and parents' voices, and feedback obtained electronically. Most parents spoken to by inspectors were positive about the help and support provided and, in the case of those whose children were the subject of a child protection plan, appeared to understand the reason for the plan and what was expected of them. However the local authority' systems for obtaining feedback from parents/carers and children and young people across specialist services are underdeveloped.

29. The local authority has some good processes and initiatives to respond to the challenge of diversity in its services, for example a targeted community drop in at a children's centre has been effective in engaging Roma families. However casework practice is not consistent. Whilst most case records reflect the ethnicity of the child for example, the consideration of wider equality and diversity issues are not well documented in the majority of assessments and plans.

30. There is effective intervention to provide early help and protection for children and young people with a disability, and good examples of child centred assessments and plans were seen in the disabled children's team. The County Asylum and Private Fostering Team are knowledgeable and thorough in assessing and meeting the needs of children and young people and provide effective help and support. There is ready access to interpreters across the county, and the CAF form is available in eight different languages.

31. There are good practice guidelines for the assessment and housing of young people who are homeless. Where it is necessary to use bed and breakfast accommodation to address immediate needs, properties that comply with guidelines on safe practice are used. The pressure on accommodation in some areas of the county has been recognised and commissioning processes have been successful in acquiring additional accommodation, but despite reductions in the use of bed and breakfast too many young people are still accommodated in this way.

32. The local authority and it's partners are committed to proactively identifying areas of specific need, such as the increasing number of babies born countywide with foetal alcohol or drug withdrawal problems. The 'positive choices' project is targeted at women who have previously had children removed from their care, offering specific intervention to help them recognise the needs of subsequent children and helping them to keep subsequent children safe.

33. Partnership work with voluntary sector organisations is an important factor in achieving good outcomes for children and young people. Suffolk Family Focus is actively harnessing the strengths of various community based voluntary organisations in order to make a significant impact on families identified as eligible for the national 'troubled families' programme. It is still too early to assess the impact of this activity.

The quality of practice

Adequate

34. The quality of practice is **adequate**. Decision making on contacts and referrals is timely and the recording of decisions made is consistently accompanied by a clear rationale and action plan. Universal services make appropriate referrals, but although there is a process in place, some

professionals report delays in getting a response following a contact or referral. This means that referrers are not always clear what action is being taken to assess a child's needs. All notifications of domestic abuse are screened and risk assessed by the police, and these are passed to the access team in a timely way, supported by the co-location arrangements. Where referrals reach the threshold for child protection, these are responded to promptly.

35. Child protection investigations are always undertaken by qualified social workers and these are mostly well coordinated, robust and provide an effective response to safeguarding children. Whilst strategy discussions are consistently taking place, and are timely, they are not always recorded effectively.

36. In some cases where children do not meet the threshold for a child protection response, inspectors saw unnecessary delay in reaching decisions about whether further assessment was needed. In some examples this was between 7-21 days. This means that children in need of help can experience delays in transfer to the assessment and intervention teams and in the provision of services to meet their needs. The local authority has now taken immediate action to introduce a more rigorous monitoring system to prevent this happening in future. There is a direct access point for professionals to seek advice and consultation from the Child and Adolescent Mental Health Service (CAMHS), and this was reported to have improved accessibility to the service. Professionals who wish to consult with a social worker are usually able to do so, although not all professionals spoken to were clear about how to make contact with social workers.

37. Children are seen regularly and are seen alone when age appropriate. Whilst the local authority's most recent questionnaire to children subject to child protection processes mostly reported children and young people felt listened to and their views are considered and represented, this is not consistently reflected in case recording or at assessment and planning stages. Although there is a dedicated advocacy service, children who are subject to child protection processes are not always advised of how this could help them. The local authority has recognised this area for development and have recently identified the need for workers to promote the use of advocacy services more effectively for children involved in child protection and child in need processes.

38. The reported timeliness of initial assessments and core assessments has improved. However a number of assessments seen by inspectors were incomplete, and the quality overall was too variable. Although in some teams a quality assurance tool is used by managers to assess and comment on assessment reports, this is not used consistently, and some reports are signed off by managers although the assessment may be incomplete or of poor quality. Some very good examples were seen, with

pre-birth assessments in particular being of consistently high quality, resulting in plans which effectively protected children. In others however, risk and protective factors were not clearly identified and analysed. Although when spoken to many social workers were able to clearly articulate their analysis, the absence of good quality recorded assessments inhibits joint working and effective management oversight.

39. Chronologies seen on some case files were not always up to date and in many cases did not sufficiently distinguish between every day activity and significant events. They were not effectively used by workers as a tool for considering historical risks as part of planning intervention. In some cases this contributed to delays in escalating cases to child protection conferences or to court proceedings.

40. Whilst children are adequately protected during investigations, case records do not always demonstrate how children will be kept safe until the initial child protection conference is able to construct a plan. Electronic case files reflect regular management oversight in most cases seen, however the impact of this scrutiny is inconsistent and does not always prevent drift in arrangements for children. Recording of management oversight does not consistently explain the rationale for decisions being made and follow up of actions agreed is not always evident.

41. There is insufficient consideration of individual contingency planning for children and young people in some plans, with most recording that legal advice will be sought, which may not be appropriate in all cases. Although some children in need and protection plans are comprehensive, too many are not sufficiently outcome focused, specific or measurable, and they do not always enable parents to understand expectations or the consequences of not meeting these.

42. Information sharing between partner agencies is adequate overall and partnership working is mostly effective in ensuring actions on plans are achieved. The use of discharge planning meetings between hospital midwifery services and social care teams is well embedded and facilitates effective planning for babies being discharged from hospital. Core groups and case conferences are generally timely and well attended by partner agencies. Case conference chairs are committed and recognise the need to continue to develop the service, however their current role in quality assurance is limited. They do not always reflect to managers on the quality of reports or the way child protection plans have been developed. Although there are plans in place to expand this element of their role, these are not yet implemented.

43. The out of hours service offers a satisfactory level of support to children and their families. Actions taken or interventions made with families out of hours are recorded on the ICS system and are passed to social workers in a timely manner.

Leadership and governance

Adequate

44. Leadership and governance is adequate. Appropriate priorities for action are developed and shared by key strategic leaders. The Children and Young People's Directorate Plan 2012-2013 is part of a family of plans including 'transforming Suffolk' and the Suffolk Health and Well-Being Strategy. There are clear links from strategic priorities through to individual service plans. The 2012 review of the CYPP demonstrates adequate progress across all four of the identified priorities.

45. In July 2011 Suffolk introduced their integrated service delivery model (New Operating Model, NOM).The integrated service delivery model based upon early intervention focused on more consistent and efficient delivery of services by coordinating early help, and reducing the demand for child protection interventions. The model initially demonstrated improvements, however the distribution of resources across the county and the integration of a range of agencies also created some challenges. These challenges are being addressed through a review process including the findings of a Peer Review undertaken in March 2012. Recommendations included the need to develop outcome based measures which would provide key performance indicators for the success of the NOM. The action plan following the review uses more in depth performance and quality assurance processes instigated by the performance and quality assurance board. For example the board has begun to map the effectiveness of individual services through a process of team health checks, and has developed action plans to improve effectiveness for each team. However progress in implementing comprehensive team health checks has been too slow and not targeted in areas of greatest need.

46. The performance and quality assurance board produce bi-monthly reports which demonstrate progress and both quantitative and qualitative areas for action. For example; in considering the timeliness of completion of initial assessments, identifying the need to review transfer processes in escalating or de-escalating casework, improving the quality of feedback from children, young people, parents and carers, and considering issues in respect of recruitment and selection.

47. Although council leaders have a good understanding of the challenges facing children and young people's services, and demonstrate their knowledge of local issues with regard to child protection, they are not doing enough to ensure they are being effectively addressed in a timely way. They receive regular updates on performance and current issues through meetings with the DCS and senior staff. A new dedicated education, children and young people's scrutiny committee has been established to ensure closer scrutiny of performance.

48. The independent chair of the LSCB demonstrates effective leadership in driving the work of the LSCB ensuring a clear focus on priorities for safeguarding children and young people in Suffolk. Attendance at meetings and sub groups is generally very good. The work of the board clearly demonstrates effective challenge of performance and learning through the use of multi-agency case file audits and through the 'learning template' which considers significant case issues through partnership reviews and action planning. The decision by the new DCS to take forward the further development of integrated service delivery under the 'umbrella' of the LSCB as an integral part of the multi-agency Early Help Strategy is welcomed to ensure that there is a clear multi agency focus to drive improvement.

49. Effective commissioning arrangements are in place across all services. Commissioners have a clear understanding of the challenges, priorities and areas for development. Performance management is integral to the commissioning of services and the good practice guide for commissioning, procurement, grants and contract management sets out clear expectations including the safeguarding of children and young people. Priorities include early intervention, preventative services and joint commissioning. Commissioning of services is informed by feedback from children and young people, for example in shaping the provision of short breaks services.

50. The DCS uses the e-CYPress as a tool to communicate with staff and partners about updates to service delivery and challenges. Within the document is a section on equality information where the council has publicised its objectives to reflect their commitment to equality. This includes, eliminating unlawful discrimination, harassment and victimisation, advancing equality and fostering good relations between communities tackling prejudice and promoting understanding. The work done by the council to combat homophobia has been recognised by Stonewall, rating it fifteenth out of forty local authorities.

51. Recent work undertaken to ensure sufficient numbers of qualified and experienced staff are available to meet the demands of the NOM have been only partially successful. There are a high number of social workers currently in post with less than 2 years' experience. There has been a pattern of newly qualified staff gaining experience in their first two years in Suffolk and then leaving the county. The local authority is aware that retention of staff is critical to building up their experienced workforce, and has strategies in place, including renumeration packages to address this. Recruitment and leadership development programmes are in place and the specific challenge for front line teams is recognised, however these actions are not addressing the issues of too high caseloads in some teams. The annual workforce analysis for children's services identifies specific equality themes and the need to ensure that the workforce better reflects the communities in Suffolk.

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