Herefordshire Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 29 April 2014 – 21 May 2014

Report published: 30 June 2014

The overall judgement is **requires improvement** There are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.		
1. Children who need help and protection		**Requires improvement**
2. Children looked after and achieving permanence		**Requires improvement**
	2.1 Adoption performance	**Good**
	2.2 Experiences and progress of care leavers	**Requires improvement**
3. Leadership, management and governance		**Requires improvement**
The effectiveness of the Local Safeguarding Children Board (LSCB) **requires improvement** The LSCB is not yet demonstrating the characteristics of good.		

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Contents

Section 1: the local authority

Summary of key findings

This local authority requires improvement and is not yet good because

1. Services for safeguarding children and young people in Herefordshire have only recently improved since they were judged to be inadequate in the Ofsted inspection of child protection in 2012. No widespread or serious failures were identified by this inspection that currently left children being harmed or at risk of harm. However, progress to improve how children are safeguarded has been slow and many improvements are very recent. Too many of the areas for development from the inspection in 2012 continue to be areas that require improvement.

2. Services for looked after children have not improved since they were judged to be good in 2012 and some of the work has got worse because many staff have left and the local authority has found it difficult to recruit experienced permanent social workers and managers. This has meant that many looked after children have experienced too many changes of workers and some have not received good quality support or been able to form relationships with their social workers.

3. In 2013 children's services in Herefordshire experienced many difficulties, such as high numbers of referrals, high caseloads for social workers, many social workers and managers moving jobs and poor electronic recording systems. As a result children and their families often received services that were not good enough.

4. Staffing remains fragile and a major challenge to maintaining improvements in the quality of work. More permanent social work and management staff have been recruited and many of the high number of agency staff who are being employed are on long term contracts. The use of agency social work staff is beginning to reduce from the September 2013 high of 50%.

5. During 2013 the local authority and other agencies joined together to form a multi-agency safeguarding hub to receive contacts and referrals about children and to decide what action needed to be taken. At first this did not function properly, but from the beginning of 2014 it has improved and now assesses the needs of children and families well; it is better managed and improves how staff from different agencies share information. However, the service is still at an early stage of development.

6. The authority's children's services have developed electronic systems to record details about children and families to allow managers and other agencies to understand what services are needed and how well they work. However, the information they contain is not accurate enough and managers often are not able to get the information that they need.

7. Herefordshire has a relatively small number of children and families from diverse ethnic and cultural backgrounds. Few services have been developed in the area tailored to their needs. The diverse cultural and ethnic needs of many children and families who are known to children's social care services are not properly assessed or met.

8. Child protection conferences are not well managed and child protection plans made at conference are too vague. Most agencies attend conferences, but few children are invited. People who attend conferences often do not get the reports or minutes quickly enough.

The local authority has the following strengths

9. From the beginning of 2014 the quality of social work and operational management has significantly improved and the morale of staff has risen.

10. Children and their families are able to receive a wide range of early help to prevent any difficulties that they experience from getting worse.

11. Children in need of protection are identified and assessed well. Many more children have been helped through child protection plans than in previous years, and not many are subject to a second or subsequent plan.

12. Most children who are looked after live in stable and supportive foster placements or in high standard residential accommodation that is in or close to Herefordshire. They are supported well by their carers and are helped to maintain positive contact with their families where this is best for them.

13. Where children cannot live with their families, adoption is promptly considered and court proceedings are rapidly completed so that the children can quickly settle into new permanent families. People interested in adopting children are well prepared and supported throughout and following the adoption process.

14. Local authority councillors and senior managers show commitment to improving services for children and families and have secured extensive financial and staffing resources. They have worked closely with partner agencies to improve how staff work together to prioritise the needs of children and young people in the area. The senior staff team in children's social care services is now established and increasingly has gained the confidence and commitment of staff.

15. Social work caseloads are now more manageable because an external agency has been temporarily brought in, until July 2014, to finish off work with some children and families. This has given space for the authority's social work teams to improve their work.

What does the local authority need to improve?

Priority and immediate action

16. There are no areas of priority action.

Areas for improvement

17. Ensure that caseloads in children in need and looked after children's teams remain manageable and reduce caseloads within the Children with Disabilities service so that all social workers have sufficient time to provide children with the level of service they require.

18. Ensure that the electronic case and performance management system in children's social care provides accurate performance information.

19. Ensure that audit and performance management is robustly and routinely undertaken by managers across children's services and is effectively used to develop services and to improve the quality of practice.

20. Ensure that consistent and high quality formal supervision of social care staff is provided and that all staff have regular supervision that provides reflection and challenge.

21. Ensure that regular case file audits and re-audits within social work teams are undertaken and are used to identify areas of strength and development and to measure the effectiveness of actions taken to improve performance.

22. Ensure that thresholds for access to children's services are understood and consistently applied by local authority staff and partner agencies, so that children and families get the right help at the right time.

23. Ensure that the independent reviewing officers effectively structure and manage child protection conferences and develop specific and measurable child protection plans. Ensure that there is effective leadership, practice, quality assurance and capacity within the Independent Reviewing Officer service.

24. Ensure that all children with a disability known to children's services are rigorously assessed to ensure that their needs are met and that the local authority is fulfilling its statutory functions.

25. Ensure that information about children who go missing is effectively shared and robustly analysed between partner agencies.

26. Ensure that the partner agencies and the community are aware of the need to notify children's social care services of private fostering arrangements.

27. Ensure that the Emergency Duty Team effectively supports young people held in police custody out of hours and that appropriate alternative

accommodation is available to prevent young people being held in police custody overnight.

28. Fully utilise Family Group Conferences to inform care planning, particularly where care proceedings are being considered.

29. Ensure that diversity issues and the ethnic and cultural identity of children and their families are thoroughly assessed and addressed.

30. Implement and monitor a robust system for making timely decisions to ensure there are no delays in accommodating children when they need to be looked after.

31. Ensure that plans for permanency are made and clearly recorded at children's second looked after review in line with national guidance.

32. Develop specific assessment methods to inform decisions about whether siblings should be permanently placed together or apart. Record assessments and decisions in detail to reflect the significance of the decision being made.

33. Ensure that regular analysis and reporting from the advocacy service provides an accurate account of emerging themes.

34. Ensure that the virtual school develops and implements a strategy to narrow the gap in attainment between looked after children and all other children in Herefordshire.

35. Ensure that all looked after children and young people make consistently good or better progress at every stage of their education and close the attainment gap between looked after children and all children in Herefordshire.

36. Ensure effective joint working with the police and youth offending services to routinely record and analyse information about looked after children engaged in offending behaviour.

37. Develop and implement working arrangements with local Child and Adolescent Mental Health Service providers to enable better access to treatment for looked after children.

38. Ensure that the children in care council is effective, is representative of the range of looked after children and has membership of the council's corporate parenting group.

39. Ensure all local authority elected members understand and effectively undertake their role as a corporate parent.

40. Refresh and re-launch the recruitment strategy to increase the number of adopters for children with complex needs and for larger sibling groups.

41. Ensure that all pathway plans are up to date, are of good quality, are based on a robust analysis of need, with clear and agreed goals and are regularly reviewed.

42. Ensure that all care leavers receive a copy of their health records.

43. Ensure that all looked after children and care leavers understand their rights, responsibilities and entitlements and receive the guidance, support and resources to realise them.

44. Ensure that learning from complaints and representations from children and young people, parents and carers and service users is systematically collated and analysed and is used to improve service delivery and development.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted and an additional inspector (AI).

The inspection team

Lead inspector: Pietro Battista

Team inspectors: Shirley Bailey, Brenda McLaughlin, Susan Myers, Lynn Radley, Judith Nelson, Lisa Williams (AI) and Steven Gauntley.

Information about this local authority area[2]

Children living in this area

- Approximately 36,000 children and young people under the age of 18 years live in Herefordshire. This is 19% of the total population in the area.
- Approximately 10% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 10.5% (the national average is 19.2%)
  - in secondary schools is 9% (the national average is 16.3%).
- Children and young people from minority ethnic groups account for 6.3% of all children living in the area, compared with 20.2% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are White other (1.62%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 6% (the national average is 18.1%)
  - in secondary schools is 4.3% (the national average is 13.6%).

Child protection in this area

- At 31 March 2014, 1,269 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,444 at 31 March 2013.
- At 31 March 2014, 237 children and young people were the subject of a child protection plan. This is an increase from 208 at 31 March 2013.
- At 31 March 2014, four children lived in a privately arranged fostering placement. This is an increase from two at 31 March 2013.

Children looked after in this area

- At 31 March 2014, 242 children are being looked after by the local authority (a rate of 67.24 per 10,000 children). This is an increase from 216 (60 per 10,000 children) at 31 March 2013. Of this number:
  - 65 (27%) live outside the local authority area
  - 14 live in residential children's homes, of whom 92.86% live out of the authority area

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- None live in residential special schools[3]
- 148 live with foster families, of whom 11.5% live out of the authority area
- 11 live with parents, of whom one is living out of the authority area
- There are no unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 17 adoptions
  - nine children became subjects of special guardianship orders
  - 95 children have ceased to be looked after, of whom three subsequently returned to be looked after
  - 19 children and young people have ceased to be looked after and moved on to independent living
  - No children and young people have ceased to be looked after and are now living in houses of multiple occupations.

Other Ofsted inspections

- The local authority does not operate children's homes.
- The previous inspection of Herefordshire's arrangements for the protection of children was in October 2012. The local authority was judged to be inadequate.
- The previous inspection of Herefordshire's services for looked after children was in October 2010. The local authority was judged to be good.
- The previous inspection of Herefordshire's fostering services was in March 2013. The local authority was judged to be adequate.
- The previous inspection of Herefordshire's adoption services was in July 2011. The local authority was judged to be good.
- The previous inspection of Herefordshire's services for private fostering was in March 2009. The local authority was judged to be inadequate.

Other information about this area

- The Director of Children's Services has been in post since January 2012.
- The chair of the LSCB has been in post since February 2012.

[3] These are residential special schools that look after children for fewer than 295 days.

Inspection judgements about the local authority

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

45. Children and their families who need early help are able to access a wide range of services that offer support to prevent their problems escalating. The recent reconfiguration of early help services into a more holistic family support service for children and young people up to 19 years of age is enhanced by co-location with children's social care teams.

46. The stability of the workforce in Families First enables children to build relationships with workers and to make positive changes in their lives; for example, to improve school attendance and to improve relationships at home. In the majority of cases seen, age-appropriate direct work with children was undertaken and used to inform case planning. Preventive work with children and young people is appropriately targeted to those at risk of becoming looked after. A large proportion of these children are subject to child protection plans or have recently been removed from such plans.

47. The Common Assessment Framework (CAF) is embedded across the county and its use is slowly increasing. At the time of the inspection there were 950 active CAFs. A further 400 CAFs had been completed and were waiting to be closed. Practitioners engaged in CAFs understand their roles and staff from many partner agencies take on the role of the lead professional. Information sharing at monthly Multi Agency Meetings (MAGS) ensures that children receive additional support when they need it from a range of agencies.

48. The Multi-Agency Safeguarding Hub (MASH) has contributed to the recent improvement in multi-agency information sharing across the partnership. This enables partners to better identify children in need of help and protection. Currently the local authority and Herefordshire's Safeguarding Children's Board (HSCB) are reviewing their thresholds for services as they are not being consistently applied by staff across partner agencies, resulting in some inappropriate referrals to children's social care services.

49. Since January 2014, decisions by managers on contacts and referrals in the MASH are timely and in the majority of cases are appropriate with clear case direction. The process for managing referrals has been clear and most decisions to take action are made within 24 hours. Referrals that meet the threshold for an assessment are allocated to social workers promptly.

50. Assessments of children's needs by social workers in the MASH are prompt in the majority of cases, and most assessments result in the delivery of appropriate services. However, in a small number of cases, assessments focused primarily on mothers and failed to sufficiently consider adult males in the households. A few assessments were overly optimistic about what can be achieved by some families, leading to re-referrals and delay in understanding

the children's experiences. In some cases, inconsistent use of chronologies and recording resulted in key information not being effectively used to inform the analysis.

51. In nearly all cases seen by inspectors, assessments did not demonstrate any meaningful consideration of the religious, ethnic or cultural needs of children or their families. Planning is not informed by the child's diverse needs and children and their families are often treated as having the same needs.

52. Neglect was a major factor in most cases seen by inspectors. Recent improvements in early help services have enabled early recognition of signs of neglect in families and more timely work to tackle the causes. However, in a few cases where management oversight was poor, delay in recognising the impact of chronic neglect on children resulted in an approach that was too focused on the needs of adults or on the presenting incident. The local authority's own audits identify the need to improve the quality of assessment for children and young people who suffer neglect. Staff are beginning to be trained in a variety of methods to measure the impact of neglect.

53. Since January 2014 management oversight of casework has become more robust. This has resulted in some improvement in practice and in the timeliness of work undertaken with children and families. However, inspectors saw many cases where the standards of social work assessment, support and case planning and management oversight were inadequate throughout 2013. This was confirmed by audits undertaken by the local authority, LSCB and partners in that period.

54. Since January 2014 referrals that meet the threshold for a child protection enquiry have been appropriately undertaken by suitably qualified social workers. Child protection strategy discussions that include relevant partner agencies are timely. Follow-up strategy meetings are fully recorded and result in well coordinated arrangements to protect children. No cases were seen of children and families being subjected to child protection investigations unnecessarily and none where children were left at risk of harm. Two cases were brought to the attention of children's social care services by inspectors where necessary child protection enquires had not been undertaken. Appropriate immediate action was taken to ensure that the children were safe.

55. The majority of child protection case conferences are appropriately held within timescales, are quorate and have good multi-agency attendance by partners. This results in the timely progression of child protection plans by core groups. However, conferences observed were poorly managed and meetings were too long and unfocused. Lack of capacity in administrative support for conferences results in unacceptable delays in distributing invitations to meetings, minutes and plans. In one case a parent reported receiving the conference minutes and child protection plan at the review conference six months later.

56. Outline plans made at initial child protection conferences are not sufficiently specific and measurable. They are too long and lack clarity on actions and timescales. However, most core groups are developing more robust child protection plans. Core groups are regularly held and are well attended by a range of agencies. Children subject to child protection plans are seen regularly and are seen alone where appropriate.

57. The local authority has taken decisive action to reduce social work caseloads to a manageable level. Caseloads have reduced from an average of over 30 in October 2013 to an average of 18 at the time of the inspection. This has been achieved by commissioning an external agency social work team to complete some work, provisionally until July 2014. The impact has been positive on staff morale and now social workers have time to spend with children which enables them to improve the quality of direct work with children and families. Improvements in practice are evident, particularly in the last three months, but have yet to be sustained.

58. Management oversight of social work practice and clarity of managers' decision making and direction in cases has begun to improve slowly. However management decisions and the reasons were not recorded well enough in the majority of cases. Supervision of social work staff is improving in regularity, but remains inconsistent in its quality. The local authority has recognised this and has recently provided supervision training to managers.

59. Children and their families have experienced frequent changes in social workers, often at short notice. For example, in two cases seen there had been eight different social workers in a two year period. This negatively affects the development of meaningful relationships with their social workers and has led to drift and delay. Where relationships with social workers have been sustained, inspectors saw examples of effective work leading to good outcomes for those children.

60. Inspectors reviewed 11 cases where children were living in households where there are concerns about parental mental health, domestic abuse and substance abuse. Similar significant improvement was evident from January 2014, with good child-focused direct work and assessment using research-based analysis and risk assessment. Collaborative partnerships working with the Drug & Alcohol Services, the adult mental health service and police in these cases resulted in timely intervention and better outcomes for those families.

61. The Multi-Agency Risk Assessment Conference (MARAC) is well established to consider children in families where domestic violence is known, with good representation and input from partner agencies. Inspectors saw evidence of appropriate communication between the police and children's social care services through the MARAC with strong links to the Multi-Agency Public Protection arrangements.

62. Arrangements for identifying and tracking individual young people who are missing from home are now managed and progressed well by the MASH team. A return interview takes place within 48 hours by staff from the early help service. Interviews are recorded and address issues of safety and vulnerability to sexual exploitation. However, information from return interviews is not routinely collated or analysed to understand trends, and is not shared with the police to enable them to develop local intelligence.

63. Effective work is undertaken to identify and respond to individual young people at risk of child sexual exploitation. In most cases seen, strategy meetings and child protection conferences were held where it was appropriate to do so.

64. Children who are missing from care, particularly those children placed in the area by another authority, do not receive a consistent response. Data on the number and type of incident is not robustly maintained or analysed. The number of reported missing episodes of looked after children is rising, as are the number of children who go missing three or more times in a 90-day period. The lack of a robust multi-agency approach means that for most children this is being managed on a case-by-case basis without consistent collaborative information sharing.

65. At the time of the inspection 17 children were missing from education. Clear protocols are in place between schools, the fair access panel and children's social care services. As a result, children missing from education receive a consistent response and any children not found within 14 days are referred to the MASH and are appropriately assessed. There are currently 100 children home educated, who are subject of robust safeguarding consideration.

66. The eligibility criteria for children with disabilities (CWD) lacks clarity and this means that children who have a disability are not always appropriately identified. Some children in receipt of respite care who meet the criteria are not currently being reviewed by the Independent Reviewing service. In one case, a young person in a joint-funded placement had not been reviewed by the local authority for five years. Inspectors reviewed all the current children with disabilities where there were child protection concerns, and recent risk assessments are robust. However, in one case child protection concerns had not been properly considered in 2013, and the local authority acknowledged this.

67. Few children are enabled or encouraged to attend child protection conferences. Advocates are available for children over ten who do effectively represent their views, although this support is not extended to representation at core groups. The voice of younger children is not independently represented as there is no advocacy service offered to children under ten years old.

68. Arrangements to identify and support children who are privately fostered are underdeveloped and issues identified in previous inspections of Herefordshire's private fostering have not been fully addressed. During the inspection the local authority reported they were aware of seven private fostering arrangements. All four cases seen by inspectors had a private fostering assessment and appropriate visits had been undertaken. There is an on-line private fostering training module and a poster campaign in schools and children's centres, but little evidence that awareness raising initiatives are having any impact.

69. Arrangements for managing and responding to allegations of abuse or mistreatment of children by professionals and carers, through the Local Authority Designated Officer (LADO) have recently been reviewed. All cases seen by inspectors were responded to appropriately. Outcomes of referrals to the LADO are reported to the Local Safeguarding Children Board.

70. The Emergency Duty Team (EDT) for children is commissioned from a neighbouring authority. Effective systems are in place which ensure good communication between the EDT and the social work teams and access to electronic case files. However, arrangements for young people detained in police custody needing alternative accommodation out of office hours are poor. There is no local authority emergency accommodation for children held by the police. The EDT do not always sufficiently explore all options, resulting in young people being detained in police cells overnight unnecessarily. This was identified in previous inspection by HMIC in September 2013 and has not been resolved.

The experiences and progress of children looked after and achieving permanence requires improvement

71. For children where family breakdown is likely, intensive support services provided by the early help team work well and improve outcomes for the majority of children. Targeted youth support working in partnership with social workers also provides help for those at risk of becoming looked after. Edge of care services are located within the children in need service. The placement panel provides routine oversight, case guidance and monitoring of edge of care work.

72. Where legal processes are required to secure a safe future for children improvements have, in most cases, resulted in effective use of the public law outline (PLO) and legal planning meetings. However, in four cases out of six seen children did not become looked after promptly enough as a result of delay in taking assertive action prior to 2014.

73. Family Group Conferences (FGC's) are not used to inform legal planning. The service is under-resourced and poorly developed, and generally staff in children's services are unaware of the benefits that FGC's bring to effective care planning. Early identification of children requiring permanence is

achieved by adoption managers' routine attendance at legal planning meetings.

74. The development of the court team over the last year is positive, and where children need the protection of legal orders work is timely and delays are the exception. Nearly all cases are completed within 30 weeks and performance in the timeliness of court proceedings continues to improve. The Judiciary and CAFCASS report that Herefordshire is raising its practice standards, although they acknowledge that some social work court reports are still insufficiently analytical.

75. Where looked after children are returned to their families, reunification plans are not consistently robust. In three cases out of the 15 seen work was well planned and structured to support children's return home. However, in others children returned home in an unplanned way, without planned support, and in one case a young person moved in and out of care several times in a short period.

76. Enabling children to maintain positive contact with their families is a priority in care planning, and social workers take a flexible approach to ensure that children benefit from and enjoy contact. When contact is being planned or reviewed children's views are sought and taken into account. They are able to influence how often they see their relatives and for how long. Resourcing supervision of contact remains a challenge for the local authority, and recent improvements include the provision of additional staffing and an in-house manager to oversee and co-ordinate arrangements.

77. The vast majority of the 65 children who are placed outside of Herefordshire are not disadvantaged and their needs are currently met. 42 are placed in adjoining authorities. Children are only placed at distance to meet their individual, specific needs, for example to be with family members or because of complex disabilities. Social workers visit children regularly and routine monitoring of provider standards is undertaken by a contracting team. A young person living out of the area reports very good care, access to specialist help and high levels of satisfaction with the support that they receive.

78. Permanence plans are not always made as promptly as they should be. Managers acknowledge that these plans are not always made at the second review and can be significantly delayed. A small number of plans were seen which were not prompt or focused where young people were accommodated on an emergency basis.

79. Care plans are reviewed in a timely way and the views of children and young people are sought and are included. An advocacy service is available and either a young person or their carer can make a referral. The number of times advocacy is used for children looked after appears high at 116 in the last year; no analysis has been undertaken to determine how effective the

service is or what issues it helps to address. In addition young people report there can be a long wait to see an advocate.

80. Independent Reviewing Officers (IROs) routinely see children prior to their review and very occasionally between review dates. Where plans for permanence are not made promptly enough or use of the PLO is prolonged, IROs do not always challenge practice. Some reviews are chaired well by IROs, who are sensitive to the needs and emotions of children and family members. Managers acknowledge that substantial work is required to fully implement the requirements of the IRO handbook. The quality assurance role of IROs is underdeveloped and currently the IRO team does not have sufficient capacity to progress and develop its work as swiftly as it needs to. The drive and leadership required to ensure the IRO service becomes fully effective is not evident.

81. For some brothers and sisters with permanence plans a specialist therapist within the adoption team provides good quality assessments of whether they should live together or separately. For other children, placement planning meetings make these decisions and the minutes seen were poorly recorded and did not reflect the significance of the decisions made. Where children achieve permanence through long-term fostering the match to their carer is thoroughly considered at Placement Panel. Matching reports are good and the significance of the event is marked by a letter and certificate for the child from the Head of Service.

82. The vast majority of children live in good quality, stable foster care and appropriate use of Independent Fostering Agencies ensures that there is sufficient placement choice. Placement stability is good, with only 7% of children having three or more placement moves in a year in 2012–13 compared to a national average of 11%. Children seen understand why they are in care and what their care plans mean for them. They all say that they feel safe at home and school. Whilst children make meaningful and positive relationships with their carers, often they experience many changes in social worker without any warning or reason being given. Further, they are not always made aware of and sure of their rights and entitlements.

83. Performance in securing permanent arrangements for children through the use of special guardianship (SGO) is good. In 2012–13, 21% of children left care through SGO compared to statistical neighbours at 9%. Currently 65 children are subject to special guardianship and a full review of their placements and support plans is taking place. Plans are well advanced to implement a kinship and special guardians' unit to centralise and improve standards of support.

84. The local authority meets its duty to ensure that there are sufficient suitable placements to meet children's needs through the use of in-house and purchased placements. A well-planned sufficiency strategy is in place and future projections of need are realistic. Placement costs are benchmarked

against both neighbouring authorities and national averages. Managers have appropriate plans to increase their in-house provision and demonstrate success through an additional 14 carers in the last year. Kinship care is routinely used, underpinned by appropriate assessments, and numbers are steadily increasing.

85. Family-finding strategies for children who require permanence through long-term fostering are effective and are informed by a detailed knowledge of children's needs**.** Placement support is good and meets the child's and carer's needs. Fostering files are clear and well-maintained. Training for carers is good, wide-ranging and easily accessible. Children receive effective individual support when needed from a specific family support worker who is a member of the fostering team. Delegation of day-to-day authority to enable foster carers to make decisions about children is clear. Foster carers receive good management oversight. Routine reviews of foster carers, unannounced visits, and required reference checks are all undertaken and are recorded well in case files.

86. An experienced, independent chair of the Fostering Panel works well with the Agency Decision Maker (ADM) to ensure that safe decisions are made about the approval and review of foster carers. The panel is appropriately constituted, has a measured approach and provides robust quality assurance of the work it oversees.

87. The majority of looked after children are now making the educational progress expected of their age, taking into account their often low starting points when they enter care. In 2012/3, however, progress and attainment at Key Stage 2 dropped well below the national average for looked after children because only 5 out of 15 children achieved as expected. At Key Stage 4, most made good progress and seven out of 14 gained five or more good GCSEs, following improvement on the previous two years performance. Most of the remainder gained at least five A-G grades at the same level. The proportion achieving good grades in English and mathematics remains in line with the national average for looked after children and, therefore, the gap in attainment with all children in Herefordshire is not closing.

88. School attendance of looked after children is good. Those with a history of persistent absence prior to coming into care improve their attendance rapidly. Behaviour of looked after children at school is good and resulted in a low level of fixed-term exclusions that has fallen further this year, with 20 incidences to date. There were no permanent exclusions of looked after children in the two school years to 2013, however, one child has been excluded this year.

89. The virtual school has had a positive impact on raising the profile of looked after children, in partnership with a well-established network of designated teachers. The large majority of looked after children are in schools judged to be good or outstanding by Ofsted. Additional support has been put in place

for the 24 children already attending two local schools when they were not judged good by Ofsted. Progress in all education placements is monitored, including for the seven children receiving alternative education or less than 25 hours education for medical reasons. No looked after child was missing from education at the time of the inspection. The virtual school's active involvement in care placement planning enables suitable education to be found swiftly, in or outside the county, and most children enjoy good continuity in schooling throughout their time in care.

90. Good quality personal education plans (PEP) underpin the tracking of individual pupil attendance, behaviour, progress and attainment. Children play an active part in PEP meetings and plans are readily available to social workers and IROs to use in looked after children reviews. Nine of 12 plans seen by inspectors were good, comprehensive and meaningful for all concerned, including children and young people. Suitable attention is paid to personal and social development as well as behaviour and learning goals. However, academic target setting does not always focus sufficiently on rapidly improving the progress of children who are, or are at risk of, falling behind.

91. The virtual school's capacity to directly provide targeted support to children has been strengthened this year by retaining a proportion of the pupil premium which is delegated to schools. There is keen awareness that more needs to be done to close the attainment gap and additional education psychology support, group and individual tuition and activities to raise aspirations are underway. Children benefit from a diverse range of recreational activities and opportunities in and outside of school. The participation project within the virtual school runs popular weekly Fun Clubs and recently enabled a group of young people to make an excellent hard-hitting film about bullying, working alongside professionals in the media industry.

92. Improving the health outcomes for looked after children is appropriately prioritised. Within the last six months, very rapid improvement in the capacity to offer timely appointments for initial health assessments means that 82% of looked after children were seen promptly. General practitioners are now notified when a child becomes looked after, facilitating the prompt sharing of information if a child has an existing medical condition. Improved performance is also demonstrated, with 92% of immunisations completed and clear reasons for those not completed. Partnerships with health professionals work well to provide specific examinations and assessments that contribute to child protection processes.

93. Access to Child and Adolescent Mental Health Service (CAMHS) treatment is inconsistent. While many referrals are made to CAMHS very few looked after children and young people meet the threshold for treatment so do not receive the help requested. Managers are placing reliance on the Therapeutic Intervention Support Service due to be operational in September 2014 to fill

the gap in support for the emotional and mental wellbeing of looked after children.

94. The children in care council is underdeveloped, but the recent appointment of a dedicated participation worker as part of the virtual school has brought new direction, commitment and energy to developing the council. Over the last six to nine months a small but enthusiastic group of young people are starting to make a difference in representing looked after children and have engaged in revising the pledge, staff recruitment and the development of a website.

95. The quality of management oversight in the looked after children team is too variable. Case records demonstrate some improvements in recording manager's directions in the last few months. Managers in the fostering and adoption teams demonstrate good oversight, clearly recorded on case files. The placement panel provides an additional and beneficial layer of oversight to managing looked after children's work. The complex needs panel meets routinely and oversees and makes decisions about joint-funded placements for children requiring the highest levels of support and care.

96. Performance management across looked after children services is poor, and is not supported by effective management information. This means that strategic and operational managers do not have an accurate overview or contemporaneous knowledge of what is happening in their services. The adoption and fostering teams have compensated for this through the use of effective manual systems and benefit from an in-depth knowledge of their service.

The graded judgment for adoption performance is good

97. When children cannot live with their parents, or within their extended family, adoption is appropriately considered as a permanence option. Adoption plans were made within six months of the child coming into care for the vast majority of the 15 children who are currently waiting for adoption. For seven of those children a potential match has been identified but has not yet progressed to the adoption panel. Legal planning meetings thoroughly consider the thresholds for legal proceedings. The decision for adoption and seeking a placement order by the agency decision maker (ADM) is made in a timely way, which helps children move into their adoptive placement as quickly as possible.

98. The local authority's improving performance in relation to the Adoption Scorecard is good. Court timescales currently average 30 weeks and make a good contribution to helping children move in with their adoptive family as soon as possible once their placement orders are granted. Good performance is also demonstrated in the time it takes for children to move to their prospective adopter from coming into care. In January 2014 Herefordshire was one of only 36 authorities meeting its target in this area. Since then,

based on the local authority's unvalidated data to March 2014, performance has improved further with the time taken now standing at 15 months. This is significantly better than the current national average of 21 months and, if performance is sustained, is in line to achieve the DfE target for 2016 of 14 months.

99. When there are delays in adoption these are clear and appropriate, for example in some cases the reason for delay relates to legal processes such as an appeal against the placement order. In other cases evidence clearly demonstrates that there is continued and persistent family finding activity. The adoption team do not like to 'give up' and their commitment, combined with their expertise in family finding, means that only three children have had their plans changed away from adoption in the last year. In those cases children have remained with existing carers or moved to extended family.

100. Applicants are routinely informed during their training about the benefits for children of concurrent planning and fostering to adopt. They are encouraged to consider this during their assessment and good evidence was seen of this in Prospective Adopter Reports and panel minutes. However, no concurrent or foster to adopt placements have been made.

101. Co-location and good information sharing between the adoption and fostering teams helps social workers to build a detailed knowledge of the children who may need an adoptive family. Information gathered is used well to develop children's profiles which are circulated within the team, neighbouring authorities, the Adoption Register and more widely as the family finding process progresses.

102. Adoption service managers effectively oversee the progress of family finding for all children who are waiting for an adoptive placement. This is supported by effective (manual) management information systems. Monthly progress reports are made to adoption panel and six monthly reports to senior managers which set out progress and the local authority's performance against the adoption scorecard.

103. Rates of recruiting adopters are satisfactory and numbers have increased year on year. The authority acknowledges that more targeted recruitment is needed to better meet the needs of children who are waiting too long. Some progress has been made but continued negotiations to develop a regional approach, through the West Mercia project, has added delay.

104. Prospective adopters have good, prompt access to preparation and training. Stage 1 of the application process is completed promptly and within required timescales. The content of the training is appropriate and applicants report positively about the learning they have gained, particularly in relation to attachment issues. Stage 2 is also timely and compliant with national guidance. Assessments are thorough; reports are of good quality and increasingly analytical.

105. The adoption panel and the panel chair ensure good standards of practice, robust quality assurance of reports and constructive feedback to applicants. The panel chair provides challenge to improve assessment practice and to ensure appropriate levels of adoption support for children. A strong working relationship between the adoption panel chair and the ADM ensures that the matches between children and prospective adopters are thorough and timely.

106. Adopters spoken to said that adoption social workers are professional, approachable and very skilled in making the assessment process feel thorough, probing but not intrusive and a 'two way process'. Case files are compliant with regulations and case recording is up to date and detailed. Adoption team social workers provide good, highly-valued support to adopters throughout the process and this is evidenced in routine post-adoption order feedback. The part-time child and adolescent therapist attached to the team provides good individual support for children and families from assessment to post-adoption. One adopter said that work done with their child had made the difference between having 'a happy family and one that was just about coping'.

107. Post-adoption order support is good. The service is responsive to all parties in post-adoption arrangements. Adopters appreciate being able to access advice and more extensive support when they need it. 21 children have received adoption support in the past year, not including children who have been in receipt of financial support only. A dedicated Letterbox coordinator provides a good service to support contact with birth relatives post-adoption for 125 children. The adoption team also provides valued counselling for birth parents and, in the last year, for 22 adopted adults. Good use is made of learning from this aspect of their practice by enriching preparation of adopters and undertaking life story work with children.

The graded judgment for the experiences and progress of care leavers is requires improvement

108. The 16+ team, which provides services for older looked after young people and care leavers, is emerging from a long period of instability, management changes and a legacy of under-resourcing, well below the national average. Over the last year, clear direction from a new team manager, development of the No4 centre as a team base and centre for young people, and additional qualified staff, have all had a positive impact on the service. Staff morale is now high and a strong team ethos is developing. However, many policies, procedures and practices are new and their impact on improving outcomes for care leavers has not yet been fully demonstrated.

109. In the last six months, improvements in transition arrangements from looked after children teams to the 16+ service are helping to support young people as they progress through and out of care. All young people, including those with learning difficulties and disabilities, have named personal advisors who

provide good continuity at key stages towards independence or transition to adult services. Care leavers with learning disabilities also have a lead worker in the adult learning difficulties service to facilitate joint planning.

110. The majority of young people have a pathway plan based on an assessment of their needs. However, nine of the 12 plans seen required improvement and two were inadequate or were out of date. This was a key area for improvement at the last inspection of looked after children's services and remains so. Different planning and risk assessment tools, for example in relation to drug use or sexual exploitation, are used but do not link together coherently. A much-improved interactive electronic planning tool is being developed to address this. Young people contribute to their plans and reviews, but few plans reflect their aspirations or individual needs sufficiently. Partner agencies, who often provide key services and support to care leavers, are not routinely involved in plans.

111. The quality of plans contrasts sharply with the views that young people expressed to inspectors, which were positive about the care, support and practical help provided by the 16+ team. One young person said 'They go the extra mile for you'. Workers build trusting relationships over time through regular contact and reviews.

112. Young people are encouraged to live healthy life-styles and make informed choices about their health, relationships and behaviour. The looked after children nurse runs a weekly drop-in session at No4, with the option of a full health assessment for all aged under 18. The take-up is currently low but is improving and non-attendance is followed up. Young people have good access to youth counselling, substance misuse and sexual health services. Ten young people make regular use of the free gym membership that is available to all care leavers. Personal advisors ensure that young people have relevant identity documents, national insurance numbers and birth certificates. Only three young people currently have a copy of their full health record and action is being taken to ensure that they all do.

113. A range of suitable accommodation and housing meets the needs of young people and this includes supported housing, foyer provision and tenancies. 91% of care leavers are in suitable accommodation, which is above the national average of 88%. Young people told inspectors that they felt safe where they lived and benefited from practical support and regular contact with personal advisors and housing workers, helping them to develop independent living skills. The Staying Put policy has increased choice for those who want to remain in foster care with a level of support well matched to individual need. Eleven young people have chosen this so far, with carers trained for three more. The 16+ team works well with the youth offending service to meet the needs of young people in custody in preparation for their return to the community.

114. As a result of learning in 2013 from a local serious case review, no young people are placed in bed and breakfast accommodation. Improved partnership work and information sharing between children's social care, the housing department and key partners ensures that 16 and 17 year-olds who present as homeless and cannot return home safely are found suitable accommodation which meets their needs. However, a gap remains in specialist provision locally for the small number of highly vulnerable care leavers with complex needs and often chaotic life-styles, who are more likely to be placed out of the area at a greater distance from support networks. The local authority is exploring how to meet this need locally.

115. The virtual school supports all young people well in their initial transition into further education. A post-16 personal education plan is available, but only a few are currently in place and arrangements are informal and ad hoc. Although the majority of care leavers are engaged positively in education, training or work, 14 out of 50 aged 16 to 19 years are not. Care leavers in Herefordshire are four times more likely to be out of work, not in education or training than their peers locally. The local authority recognises that more targeted and independent information, advice and careers guidance is needed. Work experience, mentoring opportunities and two apprenticeships have been identified specifically for care leavers and are being developed as part of the local authority's New Belongings programme.

116. Care leavers attending university are well supported. Seven young people are currently on degree courses and four more have places in September 2014. The virtual school is working with foster carers, linked to a number of other new activities, to raise young people's aspirations in relation to higher education.

117. Care leavers are not always aware of their legal entitlements and this is not a routine part of pathway planning. A small, committed and active group of care leavers are supported well to raise the profile of care leavers and to champion their views within the local authority, partner agencies and with other young people. Care leavers are involved in recruitment and selection processes, support the work of the children in care council, and undertake voluntary work in the community. They are engaged in the development of a new website designed to provide helpful information and advice.

Leadership, management and governance requires improvement

118. Progress has been made in improving the quality of front-line practice since Ofsted judged the local authority as inadequate in an inspection of local authority arrangements for the protection of children in October 2012. However, until very recently this has been too slow and erratic. Many of the improvements in front line practice are as recent as January 2014.

119. Services for looked after children and care leavers have deteriorated since the child protection and children looked after inspection in 2010 which

judged the services as good. In contrast, adoption services have been maintained at a good level.

120. Following the issue of an improvement notice by the Department for Education (DfE) in February 2013 the local authority engaged in a comprehensive improvement plan which was subsequently refined and more sharply focused as a result of learning from a rigorous peer review undertaken in October 2013.

121. Despite high levels of self-knowledge and activity demonstrated at every level in the local authority, too many areas for improvement identified in the child protection inspection of 2012 have not resulted in positive progress prior to January 2014. Throughout 2013 there were significant concerns in relation to poor standards of practice and management throughout children's services which left children at risk.

122. Ensuring that the senior leadership team within the local authority has sufficient capacity and skill to lead organisational change has been a key challenge that has slowed the pace of improvement. Since the appointment of a permanent Chief Executive in March 2013 and a lead member with specific responsibility for children's services the pace of change has accelerated. Senior management capacity has been increased by separating the previously combined role of Director of Children's Services and Director of Adult Services in August 2013. Other key posts in the current children's services senior leadership were filled in October 2013 and the team in its current establishment has been fully operational since January 2014.

123. Senior leaders in the local authority, strategic partners and key elected members now demonstrate a detailed and consistent understanding of the service's strengths and weaknesses based on learning from the inspection of 2012, a rigorous Local Government Association (LGA) peer review conducted in October 2013 and reviewed in February 2014, and on-going monitoring and evaluation of its progress by the independent Improvement Board. However, progress has been hampered by the persistently poor quality of performance management information available within the children's services, from electronic case file and data systems which are still being developed. Also, many of the plans that have been developed to improve services are in draft form or have only recently been implemented, making it too early to evaluate their effectiveness.

124. Protecting children and giving them a great start in life is a key priority for the local authority and across partnerships, who now ensure that the focus on protecting children is not lost in the light of competing priorities in a time of severe financial austerity. Despite challenging reductions required in the council expenditure over the next three years, children's services as a whole has been largely protected in the savings identified for other council services and there are no plans to cut front-line social care services. Efficiency savings in other parts of the organisation, such as in business support, have

had a negative impact, for example resulting in delayed distribution of invitations and minutes of child protection conferences. This was identified in recent multi-agency audits and is being closely monitored by the senior leadership team.

125. Leadership, management and governance arrangements comply with statutory guidance and are well understood by all key stakeholders including elected members, the Chief Executive and other members of the senior management team. They discharge their individual and collective responsibilities diligently and with effect. The Chief Executive meets regularly with the Director of Children's Services (DCS), the chair of Herefordshire Safeguarding Children's Board (HSCB) and the lead member for children's services. There is mutual constructive debate and challenge within these meetings that shapes the development of children's services.

126. The local authority makes good use of its links with the LGA and is active in seeking out new opportunities to learn from good practice elsewhere. For example a group of councillors recently visited another local authority to explore how to improve their role as corporate parents.

127. The establishment of a Multi- Agency Safeguarding Hub (MASH) during early 2013 for the contact, referral and assessment service was ineffectively overseen and significant practice, management and resource issues amongst the contributing partner agencies were not recognised or resolved. A Peer review of October 2013 identified that significant urgent changes were required in relation to the consistency, timeliness, and the quality of partnership working within the MASH. This resulted in the local authority and its partners taking prompt, decisive remedial action. As a result, since December 2013, more timely and effective assessment and safeguarding of children has been supported by increasingly effective partnership working at the front door in the MASH. Since January 2014 there is evidence of appropriate management oversight of cases within the MASH in almost all cases. However, the quality and regularity of management oversight in the rest of children's services remains too variable.

128. The local authority invested in supervision training for all frontline managers in April 2014. Staff report that they receive regular formal and informal supervision. However, the use of regular formal written supervision as a tool for reflection, support and management of performance is inconsistent. In 13 of 26 supervision records seen there were gaps in the frequency of supervision and records were brief. Inspectors saw few examples of good supervision records, demonstrating appropriate challenge and support. Prompt recording of supervision is not prioritised in all teams. The Local Authority had already identified this issue prior to this inspection and an audit of supervision is planned for July 2014.

129. Staff report that senior managers are visible and supportive. The Chief Executive and elected members visited social care teams following the last

Ofsted inspection and members of the senior leadership team regularly visit teams. A staff forum has been held to consult with staff formally and to keep them apprised of developments. Another, which was planned for the time of this inspection, was postponed. Staff told inspectors that senior managers, after a period of many changes, are now making an 'emotional investment' in the authority as well as a financial investment in improving and developing their service. As a result staff express confidence and commitment to the service.

130. Almost all the areas for improvement identified in the inspection of child protection services in 2012 have been addressed, albeit at a slow pace, and some, such as the screening and prioritisation of referrals in the MASH, are now working well. However, performance monitoring and quality assurance arrangements continue to pose significant challenges, as does the number of changes of social worker experienced by children and their families. Both were identified as areas for development in that inspection.

131. Performance management is not embedded in management culture. The local authority's ability to evaluate its own performance is compromised at every stage of the child's journey due to inaccuracies and gaps in its data collection. The local authority struggled to provide prompt, accurate data to inspectors during the course of this inspection.

132. Improvements and adjustments to the authority's electronic systems were identified as an area for further improvement by the DfE following the twelve month review meeting on the 12 March 2014. There is a clear work plan to address the issues by July 2014.

133. There has been improvement since January 2014 in the accuracy of data within the MASH team which enables managers to monitor the timeliness of work. However, across the rest of the service accuracy of data remains poor. The most easily accessible and accurate data seen by inspectors were those held in the adoption and fostering teams, which is collected manually.

134. The quality of case file audits undertaken by the local authority for the purpose of this inspection was good, using a comprehensive audit tool. Findings were aspirational, and where deficits in practice had been identified appropriate plans with clear priorities had already been put in place. However, routine case auditing at a team and service level is not sufficiently established and learning from those audits that have taken place has not been used to collate themes.

135. Learning from complaints is anecdotal, and insufficiently robust. The local authority identified in October 2013 that the complaints process in relation to children's services was ineffective and required fundamental changes to ensure it is meeting statutory guidance. There are plans to transfer responsibilities to the quality assurance team in June 2014 in order to streamline the process and improve robustness of investigation and

response. The current arrangements, although improving, remain insufficiently detailed to assist analysis of themes arising from complaints. Similarly, qualitative evaluation of the impact of the advocacy service across looked after children and child protection provision is not undertaken, and there is no collation of themes to inform organisational learning.

136. The local authority acknowledges that until very recently corporate parenting was not given sufficient priority. The creation of a dedicated health and social care overview committee, supported by a permanent operational safeguarding group, has resulted in increased focus on children's services. This group has made a series of key recommendations to strengthen elected members' understanding of the role of corporate parent, including mandatory training as part of the induction process for newly elected members. This has not yet taken place. The number of cross-party councillors in the corporate parent group has been increased. This newly reconstituted group has made some progress. They have refreshed the Pledge which is now written by young people, and held events to raise awareness of children in care, including the planning of a looked after children celebration event. Many recent developments are standard practice in most local authorities and much further work is required for the local authority to achieve its goal of becoming 'good' corporate parents.

137. There has recently been substantially increased investment in the leaving care service, which was significantly under-resourced compared to statistical neighbours and national averages. This was the result of learning from a recent serious case review. Expenditure on care leavers has increased from 2% to 7% of the children's services budget this year, which is now in line with the national average. The leaving care grant has been increased and a contract for commissioned services to improve levels of support to young people with complex needs in supported accommodation is being tendered.

138. The retention and recruitment of a suitable workforce with sufficient capacity to deliver good quality services for children remains a key risk to the sustainability of improvements in practice and management of the local authority children's services. Until as recently as March 2014 caseloads were too high, in part due to increased referral rates. Attempts to address the balance by transfer of cases between teams were ineffective. This, combined with high staff turnover, caused delay and uncertainty for some children. Leaders took decisive and effective action and, in March 2014, engaged a short-term project team provided by an external agency to reduce caseloads and to ensure that children now receive a prompt and effective service. Caseloads in the Children with Disabilities team remain too high and have been compounded by an increase in children subject to child protection processes within that service as a result of improved recognition of risk.

139. A period of destabilisation and high turnover of staff followed the findings of the Ofsted inspection in 2012. The ratio of agency staff to permanent rose sharply due to a variety of factors, including positive moving on of both

permanent and agency staff who were unable to provide the standard or work required. As a result, many children have had too many changes of worker and this has negatively affected the quality and consistency of practice in the past two years. Some workers report that they have had up to three changes of manager in a year. This has begun to stabilise through securing more permanent staff and through securing suitable agency staff on longer-term contracts.

140. The local authority workforce strategy is comprehensive, realistic, and is based on a detailed analysis of local market forces. It incorporates financial and professional development incentives to make working in the authority competitive. It acknowledges the inevitability of use of interims and minimises disruption to children by the use of long-term contracts with skilled agency staff. Finance to support sustainability is agreed. The current ratio of agency to permanent staff is improving, but remains high. The local authority has recently recruited a further eight newly qualified social workers as part of a 'grow our own' initiative.

141. The local authority has developed effective strategic partnerships with the Children and Court Advisory Service (Cafcass) and the judiciary and protocols with health partners which have resulted in a substantial reduction of timescales in court proceedings to avoid delay in securing outcomes for children. Targets set under the Public Law Outline of within 26 weeks are nearly met. A member of the judiciary commented that the local authority has done 'astonishingly well' to reverse the position they were in 2009–10, when Herefordshire had nine out of ten of the longest running cases placed before courts locally to now having the fewest.

142. The Children and Families Joint Commissioning Group, with the local authority and health partners, commissions services based on the priorities of the Children and Young People's Partnership forum. The priorities are consistent across strategic groups and ensure that vulnerable children and those known to children's social care services remain at the forefront of joint commissioning arrangements. Priorities drawn from the Joint Strategic Analysis (JSNA) are recognised by the group to have insufficient detail about children, and this is being addressed through a further analysis of the needs of vulnerable children commissioned to report in June 2014. The local authority and partners are improving the targeting of services through more robust analysis of need. For example, a domestic abuse needs analysis resulted in increased services commissioned from Women's Aid and a review of the effectiveness of the CAHMS service, which has recently been completed.

143. The looked after children commissioning strategy is robust. It is based on trend analysis and an understanding of gaps in provision, and good team level knowledge of the young people known to children's services. It is informed by best practice considerations, statutory requirements and case law.

144. Within local authority commissioned services recent consultation with service users and other interested stakeholders have enabled young people and their carers to be actively involved in the drawing up of service specifications and evaluation panels, ensuring that the tendering process is fully inclusive and relevant to the needs of specific groups. Monitoring of contracts across services that are commissioned is informed by unannounced visits to providers, user feedback and short-term evaluation of impact based on case studies which, whilst appropriate and informative, is insufficiently robust.

145. Current services commissioned are relevant to the local authority's statutory duties. Stakeholder events with third sector providers and private business have been held to promote development of alternative funding to maintain services which, whilst helpful and enriching to children's lives, do not meet the threshold for statutory intervention. Events were well attended but it is too early to measure effectiveness.

146. Commissioning of short breaks for children with disabilities to move from a medical model of respite care has been too slow. The identified service in place since January 2014 has so far recruited only one carer and received two referrals neither of which was suitable. Currently, therefore, there is insufficient choice and flexibility of provision available to support disabled children and their families.

147. The local authority has not effectively addressed the diverse needs of the children and families that its supports at either a strategic level or when assessing or meeting the diverse needs of individual children. Strategic planning is hampered by poor information collection and by the relatively small number, but wide range, of families from cultural and ethnically diverse groups. This also poses a challenge for staff to gain knowledge and experience to understand and engage with children and young people from diverse backgrounds. However, inspectors saw two good examples of careful and sensitive work that took into account children's individual identity needs.

What the inspection judgements mean: the local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

Section 2: The effectiveness of the Local Safeguarding Children Board (LSCB)

The effectiveness of the LSCB requires improvement

Priority and immediate action

148. There are no areas for priority or immediate action.

Areas for improvement

149. Ensure that governance arrangements between the LSCB and the Improvement Board are clarified.

150. Ensure that LSCB policies and procedures are up to date and incorporate issues specific to Herefordshire.

151. Ensure that the LSCB receives accurate and relevant performance information from its partners to enable it to assure itself on the quality of safeguarding work.

152. Ensure that the work of the LSCB operational groups is manageable and prioritised.

153. Ensure that learning from multi-agency case audits is actioned and the impact is reviewed through repeat audits.

154. Ensure that robust strategies and intelligence in relation to specific vulnerable groups are developed and implemented, in particular missing children and those at risk of child sexual exploitation.

155. Ensure that multi-agency safeguarding training is sufficient, taken up by partners and is robustly evaluated.

156. Ensure that the LSCB business unit is effectively able to support the work of the LSCB.

Key strengths and weaknesses of the LSCB

157. Governance arrangements between the LSCB and the local authority are well established, with the LSCB chair regularly meeting with the Director of Children's Services and Chief Executive Officer, to ensure that the authority is fulfilling its safeguarding responsibilities. The LSCB Chair is a member of the Children and Young People's Partnership, which helps to ensure that safeguarding children is appropriately considered in the wider context of services for children and families and is incorporated into the Children and Young People's Plan. Whilst the LSCB Chair has made presentations on safeguarding children to the Health and Wellbeing Board, safeguarding of children is not clearly prioritised by this board.

158. The LSCB complies with its statutory responsibilities. The LSCB minutes and the last published annual report provide sufficient account of the challenges faced by the Board and its partners in developing and promoting safeguarding issues and of the activity of the board. The 2013–14 report has not yet been completed. The board and its sub-groups have developed detailed actions plans which are specific and measurable. However, the extensive range of practice, policy and procedural issues that need to be addressed, revised or updated poses a significant challenge to partners on how well, quickly or systematically actions that have been agreed are progressed.

159. The terms of reference for the LSCB are clear, as are the roles and responsibilities of the Chair and board members. The role of the LSCB Chair is sufficiently independent. However the respective roles of the Improvement Board and the LSCB are not sufficiently clear, with no protocol established between them. The LSCB is described by members as 'reporting to' the Improvement Board and, particularly in the period following the last Ofsted inspection 2012, aspects of the LSCB work programme were established by the Improvement Board plan. Engagement by the LSCB in the Improvement Board has strengthened and enhanced the profile of the LSCB and secured commitment from senior officers from partner agencies. However, as the LSCB increases its effectiveness its lead statutory role in safeguarding children needs to be realigned with that of the Improvement Board.

160. The LSCB has received reports on the range of early help provision in the area, and in April 2014 began to consider proposed changes to early help services and to explore its governance role in relation to these. However, this is very recent and the Board has exerted little influence in the development or targeting of early help services or in the evaluation of the effectiveness of early help services in preventing the need for safeguarding children or children being subject to repeat plans of protection. The LSCB has appropriately maintained an overview of the safeguarding of looked after children, including those placed outside the area, and has challenged children's services to report to the Board on the effectiveness of these services.

161. The LSCB has focused appropriately on performance management, primarily through enhancing the role of its Quality Assurance sub-group, which has undertaken regular multi-agency audits of safeguarding practice. An extensive programme of themed audits has been scheduled, focused on key practice issues. However, repeat audits of the same themes, to ascertain whether actions resulting from the learning have improved practice, have not been achieved due to the extensive and overambitious work programme for this sub-group. One repeat audit on child protection conferences did not demonstrate significant improvements in the areas identified by the previous audit. The sub-committee also considers performance information from partner agencies, and is particularly dependent on data from the local authority children's services. Partners recognise that repeated inaccuracies in

performance data provided by children's services severely undermine their ability to robustly analyse safeguarding practice. The Board and its partners have continually challenged the local authority to provide accurate data. The LSCB and its sub-groups and partners had not identified the issues of concern in relation to practice in the Multi-agency Safeguarding Hub (MASH) as it was becoming established in 2013, which were identified by the Peer Review. The LSCB now more rigorously monitors the effectiveness of the MASH through an LSCB governance group.

162. The LSCB has responded to developments in child sexual exploitation through a case discussion group and working group tasked to develop local plans. A new sexual exploitation and trafficking strategic group was established in March 2014 to review local policies and to develop a new action plan, intelligence and information sharing. A new operational group is to be established to consider individual cases and themes arising from these. Similarly, strategic planning for missing children is underdeveloped. Whilst the LSCB uses the West Mercia Police joint protocol, this was last reviewed in 2011, is outdated and does not include local issues. The LSCB developed a missing children action plan in 2013. Whilst work with individual children who are vulnerable, at risk of going missing or of sexual exploitation is appropriate, this is not yet well supported by strategic oversight and intelligence sharing and is not sufficiently joined up.

163. The Child Death Overview Panel and the Joint Case Review Sub-Group are well-established, well-represented by partner agencies and robustly consider detailed information. One Serious Case Review has been recently completed and several single and multi-agency reviews have been appropriately undertaken, with learning shared at the Board and with partner agencies. Due consideration has been given to joining these groups with similar groups in neighbouring authorities, as the work programmes are low, commensurate with the size of the area, but the LSCB has decided to retain locally focused groups.

164. Safeguarding is appropriately prioritised by partner agencies and this is confirmed through the safeguarding audits that agencies completed in 2013, under Section 11 of the Children Act 2004. Partners from all agencies are well-represented at the right level on the Board and its sub-groups. Strong commitment and enthusiasm to work collaboratively to improve safeguarding services is now evident. The LSCB has implemented a range of safeguarding policies and procedures, many based on regionally agreed policies. However, few have been reviewed and updated to incorporate local and national emerging issues, and an LSCB policies and procedures sub-group has now been tasked to undertake this.

165. Board members recognise the need to engage with children, young people, families and the community to secure their views to influence the development of its work and safeguarding practice. However, little progress has been made in obtaining the views of children and their families who have

contact with safeguarding services. Several lay members have been appointed to the LSCB to represent the views of the community and are actively engaged in the LSCB and its sub-groups. The voluntary sector is extensively and well engaged in the work of the Board, which is currently considering how to ensure that third sector organisations in the area take responsibility for safeguarding children.

166. The LSCB is appropriately funded by contributions from member agencies. A significant proportion of funding is used to maintain the LSCB business unit that facilitates the operation of the Board. However, the business unit has a significant challenge in meeting the widespread demand of the ambitious LSCB work programme and supporting the LSCB and its operational groups. The business unit also supports the Adult Safeguarding Board in the area, whose business has significantly expanded. As a result, the business unit has struggled to effectively support both boards and this has been exacerbated by staff and role changes in the unit. The local authority and both boards are currently considering how to reconfigure and resource the unit.

167. The LSCB has an established multi-agency training programme, which underpins safeguarding training provided within individual partner agencies. This has recently been revised and commissioned from an external provider following the departure of the LSCB training officer. Significant effort has been put into developing e-learning for partners. However, there has been low take-up or completion of e-learning. For example, e-learning on leadership for representatives engaging in the work of the LSCB has had poor take-up, with the exception of voluntary sector representatives, even though there are increasing numbers of new representatives on LSCB groups. Evaluation of the quality and impact of training on improving practice and the experience of children is significantly underdeveloped. This is primarily based on basic feedback from training participants through short questionnaires, which are not effectively used to ensure the quality, content or relevance of training or to enable the strategic development of multi-agency training. A number of awareness raising seminars have been delivered on behalf of the board, for example on learning from case reviews. These have been well received and enhanced awareness and understanding of safeguarding issues across partners.

What the inspection judgements mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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