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Chris Baird  
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Dear Chris Baird

### **Focused visit to Herefordshire local authority children's services**

This letter summarises the findings of a focused visit to Herefordshire children's services on 18 December 2019. The inspectors were Peter McEntee, Her Majesty's Inspector, and Pauline Higham, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for children in need and children subject to a child protection plan. This included elements of contextual safeguarding, particularly those issues relating to peer-on-peer abuse. Inspectors looked at a range of evidence, including case discussions with social workers and team managers. They also looked at local authority performance management and quality assurance information and children's case records.

### **Overview**

The local authority has made little progress in improving the quality of practice for children in need and those subject to a child protection plan since the last inspection. There remain areas of concern identified at the last inspection in relation to children in need and child protection services that have not been resolved. Despite ongoing investment by senior leaders, children in need and child protection social work services remain challenged by vacancies as well as turnover of staff and ongoing difficulties in attracting experienced staff. Supervision of staff is inconsistent in quality and, when considering casework, does not provide good enough guidance or an overview of progress. While no child was seen to be left at significant risk and without intervention, child protection plans are not sufficiently focused on the links between parents' actions and the impact on the child, making it more difficult for parents to understand their responsibilities. There are gaps in the recording of both

core groups and children in need meetings, resulting in slower progress in meeting children's and family's needs. There is better work in the children with disabilities team; plans for children are more focused on their needs and there is more consistent guidance and reflection from supervising managers.

A quality assurance framework is in place and is providing accurate information to the local authority in relation to practice standards and compliance. However, actions to correct issues found in audit activity are not completed quickly enough. The local authority has improved its understanding and overview of contextual safeguarding in relation to peer-on-peer abuse and has assured itself that schools recognise this issue and work with social care services to minimise risk.

### **What needs to improve in this area of social work practice**

- The frequency and quality of supervision offered to staff.
- The prioritisation of family support work for those children and families most in need of this service.
- How child protection plans are written in order to ensure that children are clearly identified as the focus of actions to reduce risk.
- Support for newly qualified social work staff, including a review of case holding expectations and responsibilities.
- Timeliness of actions taken in order to address deficits identified in case audit activity.

### **Findings**

- Despite strategic and financial interventions to improve staff stability and managerial capacity and to ensure better quality practice, Herefordshire has made little progress in improving the quality of practice for children in need and those subject to a child protection plan since the last full inspection. Areas of concern identified at the last full inspection in relation to children in need and child protection services have not been resolved.
- Senior managers have taken steps to better understand the quality of services and what needs to be done to improve services in Herefordshire. There has been good use of assistance from other local authorities to identify both good and poor practice and an updated self-assessment is open about the issues faced by the local authority. There is a clear understanding of the need to further invest in services, and the political and financial commitment to do so. As a result, senior managers have plans to reconfigure services, including the introduction of an edge-of-care service and a re-focused child in need service. A recruitment and retention strategy has been put in place and greater stability of staff has been

secured, including a permanent senior staff group. However, it remains difficult to attract permanent social work staff with experience to Herefordshire.

- The current court and child protection service that works with the large majority of children in need and those on a child protection plan is struggling to provide consistently good services to children and families. These teams are under pressure from too many staff changes, including changes in team managers, and a fourth head of service in 18 months. A third of staff are agency staff, and turnover is high, with a large number of inexperienced and newly qualified staff. This has had a significant impact on the ability of senior managers to ensure a consistent quality of practice in these teams.
- There are significant gaps in the frequency of recorded supervision, and, in too many instances, social workers are unable to refer to clear guidance on how cases should progress and by when. In some instances, supervision on cases is not evidenced for many months. In some cases, there is evidence of drift and delay in progression of plans, which is compounded by a lack of supervision and poor handover of cases, particularly when staff have left with little notice.
- Both children in need (CIN) and child protection work is supported by a family support service working in social work teams. This work is valued and provides additional skills in parenting assessments and a range of direct work with families. However, there are waiting lists of up to four months for both family group conferences and allocation of work to family support staff. In some instances, such waits for intervention fail to take into account the priority of the case and actively impede the possibility of progress in cases, leading to delays in achieving key goals in plans.
- In both children in need and child protection cases, risk to children is clearly identified, and no child was seen to be left at significant risk and without intervention. However, issues of neglect are not always recognised quickly enough, and the graded care profile to help identify neglect and poor parenting is not being used consistently to help measure progress. In a few cases, thresholds were not correctly applied, and some children were subject to child protection plans when it would have been more appropriate for them to have been subject to CIN plans.
- Child protection reviews are timely and well attended by multi-agency professionals. However, child protection plans are often too parent-orientated and focused on what they must do. This is not linked to the impact on the child or to how matters will be made better for the child as a result of the plans. For some parents, this will mean a disconnect between their actions and the impact they have on children. Children are barely mentioned in some plans, and are not the focus. In some cases, there are gaps in core group recording. This means that it is difficult to evidence progress, and, as a result, some children stay on child protection plans longer than necessary.

- There have been some very recent improvements in the recording of CIN plans and CIN planning meetings, but this is from a low base, and, in a number of cases, CIN meetings have not been entered into the record in a timely way. In these instances, this absence has not been identified by managers quickly enough, and, as a result, some families have waited longer than they should for the right help.
- In the children with disabilities team, CIN plans are better tailored and responsive to children's needs. Packages of support are appropriate to needs identified, and social workers are quick to ensure these are adapted if children's needs change, or in response to crisis. Children's and carers' views are consistently recorded and influence planning. Social workers know the children well and are skilled at communication with children; they use a variety of different methods and apply observational skills to ascertain children's well-being. Supervision is qualitatively better in this team, is well recorded and includes elements of reflection that help to ensure timely progress.
- The caseloads of newly qualified social workers with a year or less of experience show little evidence of protection. This is in relation to absolute numbers: one new social worker has been in post for only eight weeks and has 19 cases. It is also in relation to types of case allocated. Several newly qualified social workers were seen to have complex cases in care proceedings and on child protection plans. Expectations of and responsibilities put on these staff are too great, and there is risk that they will have a poor experience of Herefordshire local authority and the support it offers. The consequent risk is that these social workers will not stay, and this will exacerbate current staffing difficulties.
- A quality assurance framework is in place and is providing accurate information to the local authority in relation to practice standards and compliance. Case audit activity is supplemented by thematic deep dive audits, and a learning tracker is helping the local authority to close the loop that connects the impact of audit activity and subsequent learning. The local authority accepts that there is more to be done in this area of its work. In particular, staff have been slow to address actions identified by audits. For example, the response to a CIN deep dive audit shows that a month after the target date for completion, only 31% of cases had all actions completed. This is concerning as it means that deficits identified are not being remedied in a timely way.
- There has been a significant strategic focus by the local authority since the last inspection on contextual safeguarding, and, in particular, peer-on-peer abuse and ensuring that there are appropriate responses to risk in this area. The local authority has worked closely with schools to ensure that all have policies and procedures that both help to identify peer-on-peer abuse concerns and help to limit risks. The local authority has ensured that these issues have been the subject of practice reviews, including through a recent multi-agency spotlight review on peer-on-peer abuse. The local authority has also undertaken audit activity in relation to service responses, including looking at school safety

planning. The responses of children's services indicate that thresholds for services are appropriate and that schools are using the multi-agency hub to appropriately refer concerns. They are also using both social care staff and education officers to discuss issues and plan further work with children and families.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Peter McEntee  
**Her Majesty's Inspector**