Inspection of Herefordshire local authority children's services

Inspection dates: 18 to 29 July 2022

Lead inspector: Lisa Summers, Her Majesty's Inspector

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

Children and young people in Herefordshire are not protected from harm. Protective responses are too often delayed and are not sufficiently robust. Fundamental areas of social work practice are weak. Assessments across the service are poor. They fail to identify children's needs or effectively assess carers' abilities to provide safe and secure homes. Plans do not ensure children are safer or have their needs met, and for too many children the security of permanence is not achieved soon enough. Drift and delays are endemic, compounded by continuous staff turnover, weak guidance and a lack of management grip. Senior leaders were aware of many, but not all, of the inadequacies and the impact on children until this inspection.

The quality and impact of social work practice has significantly deteriorated since the last judgement inspection in June 2018. Insufficient scrutiny and focus by the council meant that deficits in practice were not realised until the highly publicised court judgement in April 2021. This was despite focused visits in January and December 2019 identifying recurring themes of poor practice. In July 2021, a focused visit noted further deterioration in the quality of services, resulting in priority action being required in a number of areas.

Minimal improvements have made little difference to children's experiences. This is amplified by a historical lack of stable and capable senior management, under-developed partnerships, and a limited ability to secure accurate data. Despite significant financial investment, there remains insufficient capacity across the

workforce to support a timely and appropriate response to children. The heavy reliance on agency workers makes the service unstable and fragile. Despite recent developments, leaders do not sufficiently ensure that social workers are readily available and responsive to children and families who need their help. Many improvement plans are still in development or very new and untested, resulting in insufficient prioritisation of critical areas of practice.

What needs to improve?

- Corporate responsibility for the help and protection of children and those in care and care leavers, so this is prioritised and embedded across the council and partnerships.
- The sufficiency and stability of staff across the workforce, including sufficient numbers of foster carers, so children receive a timely response to having their needs identified and met across the service.
- The timely and robust identification and multi-agency response to children and young people who are at risk of harm, including, but not limited to, the response to pre-birth children and babies, 16- and 17-year-olds who present as homeless, children living in private fostering arrangements and children who go missing from home and care.
- The quality of practice including assessments, plans, planning and purposeful visits that are responsive to risk and need.
- Timely and effective multi-agency arrangements to ensure children are protected and enter care when required.
- Monitoring and tracking to prevent drift and delay. This includes the monitoring and tracking of children in the Public law Outline (PLO), permanence planning, children subject to deprivation of liberty orders and those placed in unregistered children's homes.
- The availability of support and services to meet children and young people's needs, including timely access to therapeutic interventions, access to dentistry, life-story work, emotional and mental health support, help for young people to support transitions into independence and sufficient suitable accommodation.
- Management oversight and grip across the service to include clear structures and service pathways, and regular and effective supervision.
- Performance and quality assurance arrangements to support and test service improvements.

The experiences and progress of children who need help and protection: inadequate

1. There are widespread and serious failures which leave children harmed or at risk of harm. Services for children needing help and protection are fragmented and chaotic. The lack of a stable and responsive workforce means that children do not receive the right support at the right time. Too many children do not

have a consistent social worker to rely on. The churn in social workers and managers means that decisions made are not always appropriate or followed through. Overall, there is a lack of agreed systems and practice to assess risks and manage concerns. Poor decision-making, poor understanding of risk and ineffective management oversight leave children at risk of harm.

2. Some children do not receive the right help at the right time. The interface between early help and the multi-agency safeguarding hub (MASH) is not sufficiently robust. Concerns are directly allocated to early help without screening, resulting in some children 'bouncing' between early help and statutory services, delaying their needs being met. Once a family support worker is allocated, families benefit from the help and support they receive and some children's lives improve. The early help offer is limited and, in particular, services to address domestic abuse, substance misuse or mental health are lacking.

3. Insufficient social work capacity in the MASH results in an inconsistent response to concerns. Managers depend on partners to identify the level of risk rather than using their own professional curiosity and analytical skills to inform next steps. This means that for some children risk of harm is not identified soon enough. The quality of screening is not consistently robust, as children's histories are not always considered and important information is therefore not used to analyse the level of risk and potential harm.

4. Timely and proportionate action is taken to respond to children's urgent needs outside of normal office hours.

5. Action to protect children is not taken soon enough. Too many strategy meetings are delayed, sometimes for several days, leaving children in situations of unassessed risk and ongoing harm. Police availability is often the cause of delays, compounded by insufficient co-location or partnership resources in the MASH. Police and senior managers took immediate action to remedy this during the inspection. The quality of strategy meetings is not consistently robust in considering a family's history. Multi-agency safety planning is largely absent, leaving risks to be managed by social workers during subsequent enquiries. Too many children experience further delay in progressing to initial child protection conferences, leaving them without the necessary multi-agency plans to keep them safer.

6. Most assessments, including child protection enquiries, are poor. Many lack focus on the relevant issues and do not consider children's histories. Multi-agency information is not routinely sought and there is a lack of consideration of the impact of long-term neglect and domestic abuse on children. Children who are highly vulnerable, specifically under-ones and unborns, do not receive a robust response to ensure their safety. Children's needs are not sufficiently understood to inform decisions on next steps or what actions are needed to help them. Consequently, work with children and families is often closed too soon or children experience repeated referrals as their needs remain unmet.

7. There is significant variability in social work practice across and within teams for children who need help and protection. Changes in workers and managers lead

to drift and delay for too many children. For some children, critical meetings to progress plans, such as strategy meetings and child in need meetings, are not being held. Inspectors identified a significant number of children, including those with a disability, where risk had not been adequately managed. Senior managers were notified of inspectors' concerns and took appropriate action.

8. Most plans and planning are weak and do not ensure that children are sufficiently protected and that their lives improve. Most plans are too generic and do not relate to the identified risks for the child. Some centre around adults and tasks to be completed, without defining the outcomes to be achieved for children or timescales to work towards. Although children in need reviews and core groups are mostly regular and well attended, these overly focus on reviewing actions and tasks. The impact of the plan and what is improving, or not, in children's lives is unclear. Some plans end prematurely, despite ongoing concerns and work not completed, leaving children at risk of further harm.

9. Most children are seen regularly, but not always by their allocated social worker and not always at a frequency that reflects the level of risk or changes in circumstances. Some children are seen by duty workers, as many workers live a distance from Herefordshire and are not office-based. Many children experience multiple changes in social worker, which hinders the development of trusting relationships. Some children in need are benefiting from some, more recent, purposeful direct work. Skilled workers in the edge of care home team (ECHo) provide effective support to prevent family breakdown and provide help for carers. Capacity in this service is, however, limited and not all social workers understand the pathways to access the service.

10. When children receive support from the exploitation team, the work is effective. Risk management meetings are valuable multi-agency forums to understand concerns, share intelligence and progress appropriate planning, including disruption activities. Keep-safe workers are tenacious in building positive relationships with children, enabling children to explore and understand the risks they face. This is helping children to think differently, and some risks are therefore reducing. Pathways and the interface between this service and the main social work teams are not clearly defined. As a result, the quality of co-working is largely dependent on relationships between workers, leading to some children receiving a disjointed service.

11. The response to children who have been missing and to homeless 16- and 17-year-olds is weak. Most return home interviews carried out by social workers with children who go missing from home and care are poor. They do not routinely explore why children go missing or help children to stay safe. There is a lack of analysis of children's histories of going missing to add to intelligence already known, to support effective planning. Services for 16- and 17-year-olds who are homeless are under-developed and there is no clear strategy in place. Sixteen- and 17-year-olds who present as homeless are not made aware of their rights and entitlements to make informed choices about their future. Accommodation decisions are not informed by assessments of their circumstances or needs. Children living in private fostering arrangements are not always identified by social workers in Herefordshire.

12. Leaders have a clear oversight of children missing education and those electively home educated. Systems used to track and record are robust. When a referral is made, information is shared and appropriate actions are taken. These systems incorporate checks against a range of information sources and the local authority is tenacious in its efforts to secure information regarding the whereabouts of the child.

13. When children's lives do not improve, escalation into pre-proceedings is not always timely. Once in pre-proceedings, there is further drift and delay in ensuring that essential actions are taken to ensure that children are protected. Letters to parents do not fully inform them of the reasons for the concerns, what actions they need to take and to what timescales. There is much variability in practice and inconsistent decision-making. Some children are in pre-proceedings who do not need to be, whereas proceedings are not initiated for others where levels of concern are high. Mechanisms to monitor and review children in pre-proceedings are very new and it is too soon to see their impact.

The experiences and progress of children in care and care leavers: inadequate

14. There are widespread and serious failures for children in care and care leavers in Herefordshire. Too many children experience unnecessary delays in achieving permanence, which result in their welfare not being safeguarded and promoted.

15. Some children do not come into care at the right time, despite their situations significantly deteriorating. Poor management oversight and social work practice, along with delays in allocation of work and a lack of placements, result in some children remaining in situations of harm for too long.

16. Assessments are mostly weak and do not identify children's needs. Most plans and planning for children in care and care leavers are poor. Plans are too generic and often do not focus on individual children or young people, and insufficiently reflect what is needed to improve outcomes. Too many children are not engaged in their reviews, to shape important decisions about their lives. Critical work to support children's well-being and an understanding of their lives, including therapeutic support and life-story work, is not undertaken.

17. Some children make good progress. Children living with long-term foster carers live with their brothers and sisters when appropriate. These children have improved experiences due to the quality of care and support they receive from their carers. Children's voices are heard, and they are safe and settled. Many are matched with their carers in their long-term home. Unaccompanied asylum-seeking children are mostly placed with carers at distance from Herefordshire so they can live in communities that reflect their cultural background, where they make progress.

18. Children are seen regularly, but experience too many changes of social workers, which impacts on the quality of their relationships. Children told inspectors that they were angry with the local authority as they do not feel

listened to, valued or heard. When decisions are made on their behalf they are not acted on.

19. There are delays in achieving permanence for some children. Capacity issues in the fostering service impact on the timeliness and completion of assessments for special guardianship orders (SGO). Most carer assessments are weak and fail to identify if carers can meet children's needs and provide a safe, stable and loving long-term home. Required checks to ensure homes are safe are not always completed prior to children moving in with connected carers.

20. For a very small number of children, critical decisions to discharge them from care are not well considered. Poor assessments to explore if parents can provide adequate support and care for their children result in a small number of children being exposed to further harm when they are returned home. As a result, some children then return to local authority care.

21. Serious concerns for children and young people's safety are not always identified. Strategy discussions for children in care often lack immediate safety planning, and enquiries do not fully explore all concerns in the context of children's histories. For many of these children, risk is not reduced, and children and young people experience further harm.

22. Children and young people's health needs are not sufficiently well supported. Too many children wait too long to see a dentist. There are insufficient services, and a lack of clear pathways for children in care and care leavers to access timely emotional and mental health support. Care leavers are advised to seek and secure help from other professionals without the assistance of personal advisers (PAs). Young people are not given their health histories, so they do not have the essential information they need as they move to adulthood.

23. There is insufficient management oversight of children living in unregistered children's homes and for children subject to deprivation of liberty orders. During the inspection, the local authority provided three different sets of information about which children were living in unregistered children's homes or with unapproved carers. For some children, their needs are not thoroughly assessed to ensure they receive the correct support to manage recognised trauma. This manifests in worrying behaviours such as children going missing and, for some, this ultimately leads to applications for deprivation of liberty orders. There is an absence of robust senior management oversight to review these unlawful placements and to understand children's progress to ensure their welfare is safeguarded.

24. There are not enough foster carers and fostering staff to meet the demands of the service. Staff turnover, vacancies, sickness and temporary appointments result in a lack of continuity, consistency and support for children, staff and foster carers. The quality of assessments of foster carers is variable. As a result, decisions that support stability and long-term permanence for children are delayed. The procedures for approving exemptions, changes to approvals and extending connected carers temporary approvals lack rigour and independent oversight. This fails to promote the safety and well-being of children.

25. The local authority has ensured there are recruitment strategies in place through a regional adoption agency (Adoption Central England), which are effective in attracting sufficient adopters. There is appropriate focus given to those who may be able to care for brothers and sisters, children with complex health needs and for older children. Recruitment continued throughout the COVID-19 pandemic, although there was a dip in placements due to court delays. The council's permanence hub team has significant experience in the field of adoption and a good understanding of the adoption process. They are actively involved in family finding and transition plans. They work in close partnership with the regional adoption agency to track and progress children at all stages of the adoption process. As a result, timescales for children achieving permanence and placement stability are good, with no disruptions over the last 12 months.

26. The virtual school is ambitious in ensuring that most children and young people in the care system make good educational progress at school or other provisions. Most achieve well relative to their starting points, but the impact of the pandemic is unclear at this time. Frequent changes of social worker and placement moves compound this issue and further negatively impact on attainment. Personal education plans (PEPs) are reviewed regularly. There is some variability in the detail recorded by social workers, despite the training provided by the virtual school, as well as in the quality and ambition in setting children's targets. Leaders promote good attendance but the number of exclusions from school for children in care or children with a social worker have risen this academic year. Too many care leavers are not in education, training or employment and they are not supported or encouraged to access these opportunities. This limits their capacity to become successful adults.

27. The local authority's offer to care leavers is weak, and lacks aspiration and the necessary resources to provide an effective service. Capacity issues means that not all young people are allocated a PA soon enough, and do not have the opportunity to form relationships with them before their 18th birthdays. Once relationships are established, some young people receive basic help. Care leavers with specific vulnerabilities, such as those in custody, have limited assistance and, in particular, for those who are parents or due to become parents there is an absence of tailored work to support them to become successful mothers and fathers. Other young people choose not to engage with their PAs due to having already experienced several changes of workers and fractured relationships. Young people aged over 21 have to request support, despite some having high levels of need. If support is not asked for, they are closed, with insufficient effort to try and engage them. This hinders young people's preparation and support with transitions to adulthood.

28. Young people have a lack of sufficient accommodation choice. Most young people live in suitable homes, but a small number are homeless or continue to live in bed and breakfast accommodation. Some live at a distance to their support networks and are not provided with the funds or assistance to ensure they are able to maintain relationships with family and friends.

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

29. Leaders and managers fail to safeguard and protect children in Herefordshire. Children's services was last inspected in June 2018 and judged to be requires improvement to be good. Since that time, the quality and impact of social work practice has significantly deteriorated. The court judgement in April 2021 identified considerable weaknesses in services for children, leading to a non-statutory improvement notice from the Department for Education. Significant numbers of staff at all levels started to leave the authority, including, in April 2021, the director of children's services (DCS) and the vast majority of the senior management team. A new chief executive officer took up post in May 2021 and worked with the improvement adviser to establish the improvement board in June 2021 and secure substantial council investment to stabilise the service. Strategic priorities were focused on crisis management to secure the day-to-day running of the service in a climate of increasing demand and significant staff turnover, along with establishing an accurate baseline of quality of practice.

30. Extensive auditing, commissioned by the new chief executive in 2021 exposed substantial weaknesses across all services, systems, and structures. Senior leaders have invested significant time and effort to ensure that the council and leaders fully understand the magnitude of these shortfalls. Further weaknesses were identified during the inspection that leaders were not aware of. In October 2021, the interim director resigned and the current DCS was quickly appointed following a short period as the improvement director. Very recently, two permanent service directors have started in post. A permanent leadership team is now secured but it is too soon to see the impact of these appointments.

31. The pace of improvement is too slow. Despite recent efforts and plans to address the significant and serious weaknesses in the service, improvements for children have not been realised. The improvement board has not been able to have the necessary impact. It is hindered in developing a workable plan because of inaccurate and unavailable data, challenges in securing additional strategic capacity to support improvement and acquiring the necessary support from partners. This has been compounded by continued high turnover of staff at all levels, and a historical lack of a stable and capable team of senior managers.

32. Recently, there have been some small areas of progress from a significantly low base. Work is focused on building some of the infrastructures and systems to enable improvement. This includes more accessible and more accurate data, developing the functionality of electronic case recording systems and reducing caseloads. The local authority recognises that multi-agency governance arrangements are weak. The Children in Care Council, 'Your voice matters', reported that they are not heard, not responded to and promises made are not adhered to. Following external reviews, work is ongoing to support the corporate parenting board and children and young people's scrutiny to improve its functioning.

33. Critical systems to protect children and secure their long-term well-being have not been adequately prioritised. For example, the tracking and oversight of children in pre-proceedings is very new and the systems to progress timely permanence are still in development. There is insufficient management grip and oversight across most areas of social work practice. This includes oversight of children with specific vulnerabilities, those living in unregistered children's homes and those children subject to deprivation of liberty orders.

34. Although improvement plans have been refreshed, governance is clearer and work streams are recently established, many plans are still in development and it is too soon to assess their impact. Improvement planning requires further strengthening to provide strategic cohesion and detailed operational plans, with clear timescales to inject pace, prioritisation and accountability.

35. Senior managers' line of sight of frontline practice is not sufficiently robust. This is due to a previous absence of performance data and an over-reliance on self-reporting by previous managers, without this being tested. Throughout this inspection, senior managers and leaders have been open and honest about the challenges faced and weaknesses in practice, identifying appropriate actions as the inspection identified further concerns. They reported that services for children were inadequate. Many, but not all, deficits had been identified but the detail of what this means for children was not fully appreciated until this inspection.

36. Relationships with partner agencies are underdeveloped. This is in part due to the churn of senior managers and ineffective multi-agency arrangements. Operationally, agencies are not working together effectively. There is much more to do to ensure a collective responsibility across the partnership for the improvement of services to children and families. The judiciary and schools report a loss of confidence in children's services, which indicates the depth of work required to improve services.

37. The council has failed to retain and recruit foster carers to meet demand. Strategies put in place to stabilise and increase the capacity of the council's in-house fostering service are insufficient. Sufficiency is a significant challenge due to the geography of Herefordshire and the reputational damage of continual negative media reporting. Senior managers recognise that their sufficiency strategy is not underpinned by recent profiling that sets out local needs and is, therefore, out of date. A wholescale commissioning strategy is in development.

38. A lack of a stable workforce at all levels means that children experience multiple changes in worker. Inconsistent management oversight and direction significantly impacts on children's progress and experiences. To manage increased demand and churn, senior managers secured a swift, extensive and necessary expansion across the workforce to reduce pressures and caseloads. A high number of agency workers and dedicated project teams are in post, which makes the service highly fragile. Many locum workers live at a distance, impacting on their ability to be available and responsive to children. Although recruitment and retention of social workers has been a long-standing challenge,

the local authority offer to recruit and retain staff is not fully operational. Despite significant financial investment by the council to assist the transformation of children's services, corporate support is not strong enough to realise their high recruitment aspirations.

39. Performance reporting is improving from a very low base. Data is now more timely and accessible but not broad enough to monitor all areas of the service. Data is not used in sufficient depth to identify areas for further scrutiny, to understand children's experiences. Although auditing is routinely completed by dedicated auditors, there is an inconsistent approach to how it is carried out. Practice deficits are not always identified, particularly in understanding the impact for children. When recommendations are made, these are not routinely actioned to improve children's circumstances. Themes from audits have only been used very recently to inform the service's practice priorities.

40. There are capacity issues across most services. Although caseloads have recently reduced, the range and complexity of the work are highly demanding. This, coupled with an electronic case file recording system that is time-consuming, impacts on social workers' ability to keep records up to date. Some basic documents, including records of child protection visits, reviews and core groups, are missing from some children's files. Although work has recently started to address this, it means that children are not able to access their records and understand why critical decisions have been made about their lives.

41. Inspectors met with many dedicated and committed social workers and managers who are trying to do their best for their children. The vast majority of children's social care staff still work virtually, with poor guidance, lack of consistent management oversight and irregular and often weak supervision. Many social workers feel frustrated about their work in a turbulent environment and the lack of structure. This does not support service cohesion or a shared culture that places children at the centre of decision-making and practice. Staff report that senior managers' visibility is poor. During this inspection, plans to move back to office-based working were accelerated.

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