Inspection of local authority arrangements for the protection of children

Surrey County Council

Inspection dates: **10-19 September 2012**
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Age group: All

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The inspection judgements and what they mean

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

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

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Surrey County Council is judged to be **adequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Surrey, the local authority and its partners should take the following action.

Immediately:

- ensure that threshold arrangements are confirmed as in place and adhered to by all key agencies for children in need and those in need of protection.

Within three months:

- the leadership of the Surrey Safeguarding Children Board (SSCB), Surrey Alliance and core partner agencies should establish a clear, joint commitment to the implementation of an integrated early help offer in order to ensure seamless support arrangements for those children not yet, or no longer, at risk of significant harm

- ensure the implementation of the existing agreement to deliver an integrated child protection initial and risk assessment unit across the local authority, Surrey Police Service and health services in the area

- ensure that recent improvements in supervision are consolidated, extended and applied consistently across all teams in order to provide reflective developmental opportunities and explicit links with annual appraisal and training plans, particularly in relation to recently recruited and newly qualified social workers

- ensure that assessments of children in need, including those in need of protection, clearly evaluate risks, needs and protective factors
- ensure that child in need and child protection plans are specific about what needs to change for the child and within what timescales
- ensure that effective consideration is given to a child's or young person's ethnicity, culture, religion, language and disability in assessments in order to inform planning and interventions.

Within six months:

- review the current risk for children who have been on child protection plans for more than 18 months to determine whether a plan is still appropriate to manage and reduce risk
- review the use of the common assessment framework for any purposes other than the assessment, planning and delivery of a multi-agency early help offer.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect, and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of five of Her Majesty's Inspectors (HMI) and an additional inspector.

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

Service information

9. The county of Surrey has approximately 246,100 children and young people under the age of 18 years. This is 21% of the total population. Children and young people from minority ethnic groups account for 12% of the total population, compared with 16% in the country as a whole. Some 4.5% of children and young people are of Asian or Asian British heritage and Surrey has a significant Gypsy, Roma and Traveller population. At the time of the inspection, there were approximately 5,500 cases open to children's social care services and 952 children were on child protection plans.

10. Early help in Surrey is provided by a range of services including 58 children's centres, augmented by two mobile children's centres serving rural areas. The council has refocused its youth services to deliver a more targeted response and has established, together with partner agencies, a family support initiative under the government's troubled families agenda.

11. Initial contacts with children's social care services are managed by the council's contact centre, and those identified as requiring further social care assessment are transferred to one of four area-based referral and assessment teams. Children and young people assessed as requiring social care support or protection then transfer to one of the council's child in need or child protection teams. An emergency duty team responds to children and young people who require support or protection out of normal office hours.

Overall effectiveness

Adequate

12. The overall effectiveness of the arrangements to protect children in Surrey is judged to be adequate. Children who are at risk of harm are protected through effective and prompt action by the county council and the police. Senior leaders within the council, well supported by elected members, have delivered significant improvements to practice and service delivery from a low base. Staffing levels have improved, resulting in children at risk of harm and most children in need receiving a timely service from children's social care. However, there remains an over-reliance on the use of locum staff and while measures to improve recruitment and retention are now being implemented, the lack of stability in the children's social care workforce means that children experience too many changes of social worker.

13. Practice is child centred and risks are identified. Children receiving social care services are seen regularly by their social workers, including alone, and there is an emphasis on understanding and responding to their views and feelings. However, assessments do not routinely evaluate the specific needs of children arising from their ethnicity, culture or religion and the extent to which they fully analyse risk and protective factors is too variable. These shortcomings have an impact on the quality of child protection and child in need plans. These often lack specific goals, and the required changes are rarely made explicit for parents and children. While most child protection plans end appropriately at a time that is right for the child, a small number of children have remained on plans for long periods when no longer at risk of significant harm.

14. While there is a wide range of early help provision, including children's centres and a targeted service for young people, the integration of early help within a comprehensive needs framework is not well developed. The common assessment framework (CAF) and team around the child (TAC) processes are not fully understood and embedded across the partnership. This deficit combines with a widespread lack of understanding and acceptance of social care thresholds and creates a culture in which some professionals in partner agencies see social care as the response to problems that could be resolved through properly coordinated early help. The CAF has been re-launched and there is a high level of support available to professionals to help them in using the CAF. Senior leaders in the council are aware of the challenges and are implementing an early help strategy. However, the full impact of these factors remains to be seen and it is still evident that too many children are referred to social care when the thresholds are not met. This imposes an undue burden on the council's contact centre and referral and assessment teams.

15. The SSCB meets its statutory requirements but its effectiveness in providing leadership and developing partnership-wide understanding and ownership of the broader safeguarding agenda has been too variable. The board, under the leadership of the current independent chair, has recognised the deficiencies and is beginning to have an impact, evident in increased challenge to agencies, the improved attendance at meetings of key partners and the securing of a jointly funded quality assurance post for the board. The SSCB has established four area safeguarding boards which are becoming increasingly influential in their localities and the shadow clinical commissioning groups (CCGs) are demonstrating commitment to the safeguarding and child protection agenda. While these developments are important and signal the right direction of travel, it remains the case that too much is seen as the council's business and key documents such as the thresholds framework relate solely to social care.

16. There are well developed performance management and quality assurance structures within the council, with regular reporting of performance to senior leaders and elected members. In addition to the measurement and analysis of performance indicators, the council uses thematic audits to examine the quality aspects of practice such as supervision. There is routine use of service user surveys to gauge satisfaction with services provided. However, while all of these activities combine to give the council a good understanding of its strengths and areas for development, the performance management and quality assurance framework is not yet consistently robust in driving improvement in the quality of work and the effectiveness of practice to improve outcomes for children, young people and families.

17. The council has taken action to improve the quality of supervision provided to social workers and there is evident progress since an audit in February 2012. However, the improvements have not been across the board, with some staff files indicating infrequent supervision, limited discussion of development needs and learning opportunities and the lack of reflective discussion and challenge. Supervision records for some newly qualified social workers indicated that they were undertaking work above their current level of development. In a small number of cases, staff supervision records do not show what action was taken in response to newly qualified social workers reporting feelings of being overwhelmed.

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

Adequate

18. The effectiveness of help and protection provided to children, young people and their families and carers is adequate. Effective action is taken to protect children at risk of harm and there are examples of parents and

children benefitting from some early help provision, for example through children's centres. However, despite some progress over the last 18 months, challenges remain in the implementation of a consistent and cohesive early help offer across the county. A draft interim early help strategy has been developed and early help is now an identified priority for improvement within the council's Children, Schools and Families Strategy 2012-2017. Systems to collate information on early help and to evaluate its effectiveness are being established to inform the Joint Strategic Needs Analysis. However, there is currently no evidence of early help preventing children entering statutory services.

19. The use of the CAF and the development of multi-agency TAC working are still not consistently embedded across and within agencies. Much work to develop effective partnership working continues through the CAF coordinators and champions, but only a minority of completed CAFs result in multi-agency team around the child meetings and some key partner agencies are not yet fully engaging in the early help agenda.

20. Among cases seen by inspectors there are good examples of effective early help leading to improved outcomes, for example through children's centre outreach work and the Early Support Service. CAF numbers do show an increase this year, but in too many cases it is being used primarily as a referral form rather than to provide an holistic assessment and response to children's needs. The quality of CAFs is too variable, ranging from good to inadequate.

21. The number of children referred to children's social care from other agencies and the public has increased substantially in recent years. Partner agencies understand the importance of referring children about whom they have concerns and know how to do this. They are less clear about appropriate thresholds and as a result a significant proportion of contacts do not require any further action from children's social care. Contact and referral processes are effective and appropriate in screening these cases and robust in identifying those cases where children may be at risk and further child protection enquiries are indicated. Children who might be at risk of immediate harm receive a prompt and when required robust response. In other cases the timeliness of responses and completion of assessments is less assured but no children were found to have been left at unacceptable risk as a result of these delays.

22. Assessments consistently identify and address risk but the degree to which this is analysed is too variable. In some cases seen, risk was clearly and comprehensively evaluated but in others the assessment was overly descriptive and so of limited help in determining where and how interventions need to be focused. Where children are subject to child protection or children in need plans it is not always evident from reports and records of reviews what the current assessment of risk is.

23. In nearly all cases seen where children were the subject of a child protection or children in need plan, there was evidence of regular activity aimed at improving their wellbeing. The effectiveness of this help varied but in most cases there was evidence that outcomes for children had improved as a result of the intervention. In some cases, however, the child protection plan was not leading to improved outcomes or reducing risk. Difficulties in forming constructive working relationships with resistant parents, sometimes compounded by a lack of consistency of key worker, contribute to this ineffectiveness in these cases. There is appropriate escalation and use of legal steps to protect children where parents do not make necessary changes within a timescale that meets the child's needs.

24. Most parents spoken to during the inspection were positive about the help they had received and the difference it had made for their children. A wide range of targeted services supports families with lower levels of need and parents told inspectors that they have benefitted from them. However, these services are not always fully coordinated through, for example, a multi-agency team around the child. As a result help provided does not routinely respond to the full range of a child's and family's needs. A minority of parents receiving statutory services did not feel they had been effectively helped or that they had fully understood the purpose of the help offered. Some did not understand what was required to remove the need for a child protection plan. Most child protection plans seen were too lengthy and not specific enough to assist parents to develop this understanding. The extent to which children and young people understand the reasons for the help they are receiving, or feel they have been effectively helped, is not clear as this is not consistently recorded.

25. The ethnicity of children and families is not always accurately recorded and assessments and plans were highly variable in the degree to which they identified and addressed needs arising from ethnicity, culture and religion. Some good and sensitive work was seen, for example, in responding to the needs of Gypsy and Roma children but often needs are not identified and when they are there is little evidence of them being addressed. Children with complex needs and disabilities are benefiting from early support and team around the child approaches but few disabled children have multi-agency child protection plans. The local authority has recognised this and is examining the reasons, though they are not yet fully understood. Nevertheless, inspectors saw no cases where children with disabilities were left at risk of significant harm.

26. A lack of sharing by health services of live birth data hinders children's centres' capacity to target vulnerable families effectively. Across agencies, early help professionals report that there are difficulties in accessing some services. Some professionals in universal services report that they do not know the range of services available and this constrains their ability to bring together effective teams around the child. There is no current

collated information to assist this, but the CAF coordinators are now providing a useful signposting service when supporting the production of CAFs.

27. Where children are the subject of child protection or children in need plans most key agencies participate in case planning processes with examples seen of work that was well co-ordinated. The effective engagement of adult mental health, substance misuse services and child and adolescent mental health services (CAMHS) is much less consistent and largely dependent on the practice of individual workers. Communication and information sharing is effective in most cases although some examples were seen where significant information should have been shared earlier. Where children in need cases are assessed as appropriate for stepping down into less targeted provision, arrangements for ensuring on-going co-ordinated support without social care leadership or involvement are not well established.

28. A significant proportion of referrals to social care progress to strategy discussions and section 47 enquiries. In most cases this escalation is appropriate, but inspectors saw some cases that could have been managed safely through an initial assessment, which would have been a less intrusive experience for the child and their family. A relatively high proportion of children are assessed as requiring child protection plans for emotional abuse. In cases of emotional abuse seen by inspectors, while children were clearly in need of support and help it was often unclear how it had been determined that the threshold of significant harm or risk of significant harm for a child protection plan under this category was met. As a consequence the nature of the harm being experienced by the child and how this might be reduced was not clearly established. With these exceptions, decisions to make children the subject of child protection plans are appropriate although in some cases seen children are remaining on child protection plans when it is unclear whether the threshold criteria continue to apply. Often the views of partner agencies had been overly influential in the decision to retain the plan in these cases.

The quality of practice

Adequate

29. The quality of practice is adequate. The application of thresholds for accessing social care services through the contact centre and assessment teams of the local authority is inconsistent. While child protection referrals are consistently recognised and acted upon, social care also acts on other referrals that do not identify substantive levels of concern for children. Despite recent revision to the thresholds and eligibility criteria for children in need, too many referrals are taken where children fall below the level at which a social care assessment is required. Many referrals from partner agencies are descriptive, lacking significant information and failing to

identify the level of concern clearly enough. This contributes to an undue burden on children's social care assessment teams. For example, the police service sends 15-20,000 undifferentiated notifications of contact with children and families to the contact centre each year, all of which require screening and risk assessment. Partners have recognised that better communication and risk management arrangements are needed. Children's social care, police and health have agreed to implement more effective triage arrangements through an integrated child protection initial and risk assessment unit, but this remains to be established.

30. Social work practitioners and managers provide expertise within the contact centre and evaluate cases where there are concerns about a child. However a number of cases progressing from the contact centre to referral and assessment teams were subsequently assessed not to meet social care threshold criteria. This variability causes delays in the offer of early help for children and contributes to the uncertainty about thresholds that is evident in discussions with partner agencies and professionals. While a number of agencies expressed a view that social care thresholds are too high, this is not shared by inspectors. Recent efforts to provide informal social work advice to partner agencies have been positively welcomed by partners and have led to a better understanding of children's needs and prompt access to appropriate help.

31. Where there are clear indicators that a child is or may be at risk, initial decision making and action in both the contact centre and referral and assessment teams are appropriate and timely. However, in some cases, there was escalation to section 47 enquiries when it was not clear that the threshold was met and a child in need response might have been more appropriate. Of those children who do proceed to section 47 enquiries, only 40% are made the subject of an initial child protection conference. This means that a high proportion of children referred receive an unduly intrusive intervention. There is effective communication between daytime and out of hours services, and requests for action from daytime services receive an appropriate response from the out of hours service.

32. All child protection enquiries are conducted by qualified social workers and overseen by operational managers. Strategy discussions and meetings between social care, police and other agencies are well managed and documented. These provide an effective planning mechanism to inform any necessary enquiries and interventions. While such enquiries are conducted within appropriate timescales, most initial child protection conferences are not held in a timely way. Reports to child protection conferences identify and clearly evidence risks, but the analysis and evaluation of those risks and other vulnerability factors are not always fully developed. In consequence, some child protection plans are too vague, lacking specific goals and actions that enable parents to know what needs to change. Although there is good multi-agency participation in most child protection conferences and core groups, in some cases seen,

key participants such as health professionals including those from adult mental health services had not attended.

33. The overall quality of assessments is adequate. Assessments are conducted in a timely way with children being seen and regularly seen alone. There is much evidence that social workers develop effective professional relationships with children and young people with clear efforts to elicit and incorporate their views and feelings into plans. There are good examples of social workers within the children with disability teams working hard to understand children's wishes and feelings about their needs despite the complex communication challenges involved. However, inspectors saw few examples where children who were the subject of child protection conferences had an advocate or were otherwise helped to express their views directly to the conference rather than indirectly through the social worker's report.

34. Review child protection conferences and core groups are generally timely and sensitively conducted. Not all agencies involved with families attend or provide a report to these meetings, leading to a partial picture of the circumstances of the child and family. Most plans are extensive but they are often not specific enough about the objectives required to protect the child. Plans are often unnecessarily detailed, with expectations that do not relate directly to the protection of the child. Not all reports to conference are shared with parents and children far enough in advance. While many parents and carers understand and welcome the support, some remain unclear about the purpose of the plan and what their responsibilities are.

35. Management oversight of social work practice through supervision is variable. In almost all cases tracked there is evidence on case files of regular managerial direction through formal and ad hoc supervision. However, formal supervision does not always focus sufficiently on required outcomes within defined timescales. The quality of staff supervision files varies greatly across localities and teams. There have been improvements since an audit in February 2012 and inspectors saw some good examples of regular supervision with good support and development for practitioners. However, this is not consistent and in one team almost all supervision files were inadequate, with long gaps in recorded supervision. These records demonstrated insufficient focus on induction, training and development, and a lack of reflective discussion.

Leadership and governance

Adequate

36. The judgment for leadership and governance is adequate. Following the finding of significant shortcomings in children's social care by an inspection in 2008, incoming senior leaders in the county council prioritised the improvement of child protection services. Front line social care budgets have been protected and in some cases increased by elected members to ensure that these improvements are sustained. The council has increased practitioner and first line manager staffing levels and is now beginning to implement measures such as the introduction of a social work career grade to improve recruitment and retention. However, the impact of this has yet to emerge and there remain significant numbers of vacant posts. These are covered by locum staff, which ensures that there are sufficient practitioners and first-line managers to deliver services and that children known to social care are seen and spoken to regularly by their social workers. However, the continuing high level of temporary staff has an adverse impact on workforce stability as well as budgets.

37. The focus of both the council and the SSCB on improving children's social care has contributed to a lack of focus on the development and implementation of partnership working in some key areas of wider safeguarding and early help provision. For example, multi-agency triage for referrals, including those generated by the police, is only now being developed. In consequence, social care receives a high volume of referrals to its contact centre, many of which do not reach the thresholds for social care intervention. Similarly, there has been a lack of attention and strategic development in relation to early help and CAF and TAC processes are under-developed. While there is an early help strategy and systems and structures are now in place, the extent to which they are understood and used is variable and the consistent engagement of partner agencies remains uncertain. Some practitioners in partner agencies still see the CAF as cumbersome and not their business, and this perception is enhanced by confusion about its continuing use as a referral tool for access to resources. The thresholds document was produced by social care managers in consultation with partner agencies, but relates solely to social care provision and this contributes to the lack of understanding of thresholds across the partnership.

38. Formal reporting arrangements and accountabilities at senior levels are clear. The council's chief executive, the lead member for children's services and the council leader all receive performance and other reports on child protection and safeguarding as a matter of routine. There are regular and frequent meetings between senior officers and senior elected members at which performance is reviewed and the director and deputy director of children's services held to account. The chair of SSCB meets

routinely with senior officers and there is evidence of strong challenge as well as support.

39. The SSCB meets the minimum requirements of Working Together and the Local Safeguarding Board Regulations. As the independent chair and partner agencies recognise, its size and structure have impaired its ability to exercise effective leadership across the partnership. As a result, it has not had sufficient influence to ensure the timely delivery of key objectives such as the development by the Surrey Alliance (the children's trust) of a co-ordinated early help offer. The SSCB has also recognised the need to ensure a more efficient and effective set of arrangements for aligning with multi-agency risk assessment conferences (MARAC) and multi-agency public protection arrangements (MAPPA). It acknowledges the need to ensure that the health sub-group of the SSCB has an impact across the whole partnership and not just within the health community. The current independent chair has begun the process of improvement with new posts and a leaner organisational framework being developed to support a much-needed acceleration in the pace of change. The attendance of key partners at board and sub-group meetings has improved. However, the impact of recent improvements and plans has yet to be fully realised in the quality and consistency of provision.

40. Detailed performance management and quality assurance structures include routine weekly and monthly reporting at different levels up to and including elected members. These provide performance information, and analysis of this has been used to monitor compliance and identify trends. This routine performance management is supported by periodic deep dives and thematic audits focusing on quality, for example an examination of supervision in January 2012. Managers at all levels regularly carry out case file audits, in some cases supported by senior elected members. Issues arising from audits are followed up immediately at individual level and learning is aggregated to inform training and policy development. However, the performance management and quality assurance framework is not consistently robust in driving improvement in the quality of work and the effectiveness of practice. For example, the council's supervision file audit in January found some significant weaknesses which were still in evidence during this inspection. Recognition of poor performance in the timeliness of initial child protection conferences has led to some improvement, but this performance indicator remains worse than that of similar local authorities and the national average.

41. Most social workers and family support workers express positive regard for their managers and describe an organisational culture that is open, child centred and founded on trust. There is ready access to ad hoc support as well as regular formal supervision which considers their personal and professional well-being and development in addition to casework. Some staff, however, find that their supervision does not help them reflect on analysis of cases, tending to be functional. Poor performance has been

tackled robustly and a number of staff and managers have been made subject of performance plans, with appropriate monitoring and review of progress against improvement objectives. Caseloads are reported by social workers as manageable.

42. The views of children, young people and parents are routinely sought and the council has been successful in securing a high rate of return of service user questionnaires through quarterly surveys. Learning from these includes the key message that skilled intervention from a consistent social worker over time is a significant factor for families. However, the use of this learning in developing services is not apparent in strategy documents and service developments. Complaints are analysed and findings aggregated to enable learning, for example about the sharing and recording of personal data. While learning is disseminated through briefing notes, and where appropriate triggers practice reviews to see if changes are needed, it is not clear from reports how learning from complaints has influenced strategic developments and service design and review. However, there is some evidence that individual and team-level learning has occurred. Arrangements are in place to ensure that learning from serious case reviews is shared through localised briefings under the auspices of the local safeguarding groups. Inspectors saw evidence that a range of agencies had received briefings about the identification in a serious case review of missed opportunities for the use of inspection reports of other local authorities.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate