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Dear Catherine

Monitoring visit of Worcestershire children's services

This letter summarises the findings of the monitoring visit to Worcestershire children's services on 12 and 13 September 2017. This was the second monitoring visit since the local authority was judged inadequate in November 2016. The visit was carried out by Her Majesty's Inspectors, Dominic Stevens and Brenda McInerney.

The local authority has taken steps to tackle the serious weaknesses and is now beginning to make progress to improve services for children and young people.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on children whose cases were open to the contact and referral service, known as the Family Front Door (FFD). Additionally, inspectors reviewed the quality of social work practice in the assessment service. The progress of the local authority was reviewed against its improvement plan targets, to assess the distance travelled.

The visit considered a range of evidence, including electronic case records, child and parent telephone conversations and meetings with social workers and team managers. Inspectors also spoke to senior leaders and managers, including the local authority's chief executive, the leader of the council and the cabinet member with responsibility for children and families.

Overview

The local authority has been working hard to improve services to children since Ofsted inspectors conducted a monitoring visit in May 2017. At that time, inspectors concluded that insufficient progress had been made since services were judged to be inadequate in November 2016.

The director of children's services and her senior team know where services need to be better. They have the backing of the chief executive, wider council and political leaders to tackle these challenges. Many of the actions taken by the local authority are quite recent, and some are too new to have yet had a significant impact on

improving services. Significant weaknesses remain, for example, in the quality of services to children who go missing, in the electronic systems to support managers in the FFD and in the consistent focus within assessments and plans on the lived experience of children.

However, the local authority has achieved some tangible improvements. A well-focused improvement plan and significant investment in additional staffing have supported these improvements. The local authority has prioritised engaging the workforce in understanding the improvements needed for children in Worcestershire. Social workers and team managers spoke to the inspectors about the positive impact of recent audits and the role of the principal social worker to support their practice.

When referrals about children's safety and welfare are made to the FFD, the multi-agency team receives and considers such concerns, and initial decisions about levels of risk and need are made much more quickly than previously. Threshold decision-making about children's levels of need is more consistent. As a result, the services received by most children are better matched to their needs, supported by an improving application of the threshold for early help services. These improvements have been helped by a very recent, but significant, improvement in the attendance of health professionals at child protection strategy discussions and by more timely completion of assessments by social workers.

Findings and evaluation of progress

The local authority's priority improvement plan for July to September 2017 is succinct and well focused. It has been used effectively to drive and measure progress against key priorities, in particular, improving both the pace and quality of the work of the FFD. The local authority has tackled successfully a significant backlog of work in the FFD that inspectors, who visited in May 2017, found was delaying children being seen and receiving services. Tight oversight of initial decisions about children's levels of need and the services and further assessments that they may require is resulting in decisions being made more quickly, mostly within 24 hours. When, in a small number of cases, decision-making does take longer than 24 hours, these children's cases are reviewed daily by team managers to prevent drift and to make sure that no child who requires an urgent visit from a social worker is left waiting. This is a notable improvement on the situation that inspectors found in May 2017. At that time, children, including those with immediate safeguarding needs, were waiting for up to two weeks for decisions to be made. The local authority has achieved this improvement through significant investment in additional staffing. The recent permanent addition of two extra team managers and two more social workers is helping to improve the speed of social work and management decision-making in the FFD.

A generally helpful and clear 'Multi-agency levels of need' document, published in June 2017, has been used as the basis for a number of briefing sessions for staff. Inappropriate and inconsistent decision-making seen at the time of the last inspection and at May's monitoring visit has improved. In the majority of children's cases looked at by inspectors in the FFD, more recent decision-making was timely and appropriately matched to need. However, in a small number of those cases seen

by inspectors, decision-making remains poor. Although none of these children were left at immediate risk of significant harm as a result of poor decision-making, this is not good enough. In one case seen by inspectors, the risks to a young child were only recognised after multiple referrals were made to the FFD by family members.

In almost all children's cases seen by inspectors, the issue of parents' and older children's consent to referrals and to information sharing between agencies is both appropriately considered and recorded. This is a significant improvement. The local authority has also taken an important step forward to engage health agencies to fulfil their statutory expectation of attending all child protection strategy discussions. Health agencies' attendance, which fell as low as 44% in July of this year, has been 100% since the start of September, when an agreement was reached to ensure their consistent attendance. This is a very recent improvement. It is important that it is sustained and that work also continues to improve the attendance of other relevant agencies, such as schools.

A sharp focus on the timeliness of assessments has resulted in a significant improvement at the point of this monitoring visit. Alongside this improvement, there has been a shift to a much more even spread of completion timescales across the 45-day period. This means that children are more likely to have their needs understood and to receive services more quickly and within a timescale that is proportionate to the urgency of their needs.

Electronic case management and performance management systems for the FFD are not fit for purpose. They do not provide sufficient 'real-time' information to support fully effective management oversight and workflow management. For example, it is not easily possible to know how many children's referrals are being worked on by the FFD at any one time or, until they go beyond 24 hours, what stage each individual child's case has progressed to. The local authority has improvements to the electronic system included in its work plan and needs to progress these at the earliest opportunity.

The local authority has a standard that all children will be seen by a social worker within five days of a referral being made. Senior managers are monitoring performance against this standard and, at the time of the monitoring visit, the majority of visits were being achieved within this timeframe. This is a notable improvement. The local authority also has an expectation that the most vulnerable children, those who may be at risk of significant harm, are seen within one day. However, there is not yet a mechanism for recording this performance. This lack of oversight makes it difficult for managers to know which children's cases may most need their oversight or direction. It also results in senior leaders and managers not having a full picture of the effectiveness of frontline practice. The local authority is aware of these weaknesses and is working towards solutions, but these are not yet in place. The reduction in social workers' average caseloads, combined with a significant increase in management time, resulting from increased staffing in the FFD mitigates the risks arising from these systemic shortcomings but is not a sufficient long-term solution.

Work to ensure that children who are at risk as a result of going missing is poor. Despite a recommendation at the time of the inspection to improve management oversight, performance information and practice in this area, performance is declining. There is no management oversight of missing notifications received by the FFD. As a result, the risks to children who go missing, including children missing overnight, are not adequately assessed. In July 2017, only 61% of children received a return home interview after going missing, and only 24% received their interview within 72 hours of their return. This means that children's feedback about the 'push and pull factors' that influence their running away is not being consistently collected to help plan to keep them safe in the future. This is reduced performance compared with that at April 2017, at which time all children received an interview and 68% of these interviews were within 72 hours. Furthermore, children who go missing are not being offered return home interviews carried out by an independent person, as required by statutory guidance.

The local authority has prioritised improving social workers' focus on the child. Progress against this aspiration is mixed. Inspectors saw some examples of assessments that are very child-focused and in which the voices of children are clearly articulated and driving analysis and planning. However, an equal number had too strong a focus on the needs of adults at the expense of fully exploring and understanding children's wishes and feelings. A new template for recording home visits to children is supporting social workers to focus on the voice of the child and to improve their analysis, but this development is too recent to have had a significant impact. While some children attend child protection case conferences, this is not promoted strongly enough. Although there is an advocacy service for children, most staff are not aware of it and advocacy has been used for children at only a very few conferences since April 2017.

I should like to take this opportunity to thank you and your staff for your positive engagement with this monitoring visit. While services for children in Worcestershire require much further progress, I am pleased to report the progress that has been made and to be able to acknowledge the 'whole-council' commitment to improving services. I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Dominic Stevens
Her Majesty's Inspector