Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

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Nigel Minns
Strategic Director of People Group
Warwickshire County Council
Market Square
Warwick
CV34 4RR

Dear Mr Minns

Focused visit to Warwickshire children's services

This letter summarises the findings of a focused visit to Warwickshire children's services on 17 July 2018. 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 those subject to a child protection plan.

Inspectors looked at a range of evidence, including case discussions with social workers. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

The local authority has been able to demonstrate some progress in the delivery of social work services since the last inspection, with a new approach to working with children in need through a recognised model of working with families. This is beginning to have an impact on outcomes and ensuring that families receive good-quality, targeted direct work. A focus on reducing the numbers of agency staff, along with recruitment of a significant number of social workers, has been successful. However, this has not yet achieved the desired goal of reducing caseloads to the local authority's target of 15 per worker. Pressure to manage overly high caseloads remains evident. Inappropriately allocating work to managers constrains capacity for effective managerial oversight and increases the risk of drift and delay in meeting children's needs.

Children in need and child protection plans are appropriately focused on issues of risk and what needs to change to improve outcomes for children. Where risk increases, The Public Law Outline (PLO) process and applications to the Court to intervene are used well. Young people's voices are evidenced in case recording, but reviewing officers do not see children regularly before conferences to seek the children's views. Further work is required with partners to ensure that children at risk of missing education receive support and intervention. A quality assurance process is embedded but does not sufficiently focus on the quality of practice to support improvements in children's outcomes.

What needs to improve in this area of social work practice

- Ensure children are allocated a frontline social worker, that there are sufficient numbers of social workers to undertake all casework and that this work is not allocated to managers.

- Work with partners to identify those children who are at risk of missing from education and ensure that those children receive appropriate support and intervention to reduce further periods of absence.

- Supervision of cases should be reflective and analytical in order to assist the allocated worker to think about complex issues and different approaches in seeking better outcomes for children.

- Work with managers and independent reviewing officers to enable them to better understand the management of risk and the thresholds for child protection and children in need interventions.

- Independent reviewing officers should meet with young people before conferences to ascertain their views and explain the child protection process and the purpose of a child protection plan.

- Ensure that the audit process focuses on the quality of practice and how practice can support children's outcomes to improve.

Findings

- The local authority has responded positively to many of the recommendations of the last inspection. This includes a significant reduction in the use of agency staff, more consistent recording of the child's voice and an increase in referrals for and use of advocacy. Senior leaders and managers have improved their understanding of their service. Performance is managed through appropriate use of data and, since the last inspection, managers have ensured that a new information system is more fully integrated, and that staff are able to use it successfully. This has further improved data quality and managers' understanding of practice.

- Caseloads are too high and, although reduced since the last inspection, remain in the mid-twenties. The local authority is making some progress towards its stated target of 15 cases per social worker, but has yet to achieve this. Agreement to recruit extra numbers of social workers to increase overall capacity has been successful, with a number of new social workers due to start in September. This will assist in reducing caseloads further, although the staffing profile will be weighted by a high ratio of relatively inexperienced social workers. Senior managers recognise this and have taken action to support staff by creating additional teams to undertake specialist assessments and direct work. The practice of allocating some work, albeit on a temporary basis, to team managers is inappropriate, although there have been no significant deficits in the quality of services to children and families in these instances. This practice has, however, reduced frontline managerial capacity and oversight and increases the risk of drift and delay in meeting children's needs. Senior managers are aware that this practice is not acceptable and have indicated that these cases will be allocated to frontline social workers by September.

- Work with children in need has been enhanced through the development of a new targeted support service. This service is providing a range of effective direct work interventions, including parenting programmes, drug and alcohol interventions and awareness of the impact of domestic abuse on children. This work results in positive outcomes for children and their families. Family support workers and social workers are able to articulate how intervention had made a difference, leading to cases being stepped down to early help or closing. This evidence is well recorded, and workers know the families they work with well.

- Thresholds for work with children in need are appropriate. Children in need plans are detailed, with clear action points that have a focus on the help required to make a difference. Plans are regularly reviewed, and progress is recorded, ensuring that the plan is updated. In a few cases, children in need plans were not placed on the information system on a timely basis, limiting their effectiveness as a working tool.

- When progress has been made, decisions to step down to early help or close are made at an appropriate point. Where concerns have increased, decisions are being made to increase support, and, where necessary, step up to a child protection process.

- The local authority has seen a significant rise, up to 20%, in the numbers of children subject to a child protection plan in the last 12 months. Senior managers have undertaken work to understand the reasons for this, and have identified that, in a few instances, a child in need plan would have been the more appropriate response. Inspectors also found that, in most cases, the threshold for child protection was met but that, in a small number of cases, the local authority should have implemented a child in need plan. These cases evidenced too great a caution in decision-making and an element of professional uncertainty about the management of risk among frontline managers and conference chairs.

- Child protection conferences are held in a timely way, with good attendance by partners in most cases. In some instances, child and adolescent mental health services (CAMHS) were absent from conferences and core groups. Waiting lists for direct services from CAMHS are too long and their absence from key meetings means that some children do not benefit from their specialist professional input at important stages in their lives.

- There is little evidence that independent reviewing officers effectively engage with children, and they do not routinely speak to children prior to child protection conferences. However, children's voices are well represented in social workers' reports to conference and there are some examples of good practice where social workers use descriptive tools to explain child protection plans to younger children.

- Child protection plans are comprehensive in identifying risk and the work to be done with families to help them understand the impact that parents' behaviour has on their children. Conference chairs escalate issues of concern when necessary and this includes when there is delay in actions being completed. Senior managers have responded appropriately and taken remedial action. In a small number of cases where young people are missing from education for lengthy periods, not enough is being done by social workers, conference chairs and education partners to ensure that non-attendance is minimised and the right support offered. Where progress is not being made in a child's plan, or risk is increasing, the local authority appropriately escalates their intervention, for example by initiating the PLO process and, if necessary, care proceedings to ensure that children are safe.

- Core groups are held regularly and used to monitor and progress the child protection plan. In most cases, there is appropriate partnership attendance and efforts are made to engage parents and carers to implement the plan and make progress. As a result, parents are better able to understand the impact on children of their behaviour, and this helps to reduce risk and ensure better outcomes for children and families.

- Supervision of staff is regular, but the quality is not consistently good. Better examples of supervision included some analysis and reflection on children's progress and the difference that social work is making. Poorer examples merely noted events and action to be taken. This means that staff, particularly those who are newly qualified or relatively inexperienced, are not always benefiting from considered discussion of casework and being able to reflect on what is good practice.

- The local authority has an established quality assurance process with regular case auditing and thematic activity. Audits are hampered in their effectiveness by the audit template not being sufficiently focused on the quality of social work practice. Too many questions allow for a tick box approach and auditors are not always asking and answering qualitative questions, such as 'if there is a plan, is it the

right plan?' This weakness is compounded by auditors not answering many sections in sufficient depth and on occasion not responding at all. The practice of moderating audits to ensure consistency of overall judgement is positive but as yet has limited impact. A lack of clear expectations and a baseline for what is good practice means that the moderation process is not yet driving improvements as it needs to.

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