Worcestershire County Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 24 October 2016 to 17 November 2016

Report published: 24 January 2017

Children's services in Worcestershire are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Inadequate
3. Leadership, management and governance		Inadequate

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

There are widespread and serious failures in the services provided to children in Worcestershire who need help and protection and children looked after. Services for care leavers are inadequate, because young people leaving care do not consistently receive the necessary support to make a successful transition to adulthood. Services for children in need of adoption require improvement. Elected members and senior leaders have not taken sufficient action to ensure the protection of vulnerable children. This corporate failure leaves children in Worcestershire at continued risk of significant harm.

Following a local government association peer review, the chief executive established a safeguarding improvement board. This board has not provided sufficient focus to tackle poor practice, and there has continued to be a lack of management oversight of children's services. Senior leaders were unaware of the critical issues that were identified by inspectors during the inspection.

Inconsistent leadership and an insufficient number of staff at all levels have contributed to a fundamental weakness in practice. The challenge to recruit good-quality, permanent social workers and managers across the service has adversely affected the ability to drive improvements and embed good practice. In recent months, a new senior leadership team, including the lead member, director of children's services (DCS), independent chair of the Local Safeguarding Children Board (LSCB) and assistant directors for safeguarding and provider services, has taken up post. These leaders are starting to provide the much-needed focus and drive, and partner agencies and staff express confidence in the ambitious leadership team.

Thresholds across the service and at every point of the child's journey are being applied inconsistently. This is a critical area of concern. Management oversight at every level, including that of independent reviewing officers (IROs) and child protection chairs, lacks rigour and does not lead to practice improvement. Caseloads of social workers, IROs, child protection chairs and personal advisers, although decreasing, remain too large. This is a significant contributory factor to the poor-quality service that some children receive.

Too many children have been left in situations of escalating risk without becoming looked after. Many child protection strategy meetings do not involve all relevant agencies, to allow a thorough discussion of the risks to children. As a result, children who require protection from harm and who need urgent improvement in their lives are left in situations of actual and escalating risk of significant harm. Children are, however, well supported by the out-of-hours service, where assessments, return home interviews and overall decisions are effective.

Not enough children are seen alone by their social workers. Children's views are not fully considered, taken into account or acted on. Too few children are supported to participate fully in their child protection conferences.

The quality of assessments and planning for all children is a significant weakness.

Plans are not outcome focused and do not set out how the child's needs should be met. Pre-birth assessments are undertaken too late. Permanence is not consistently progressed for children who cannot return home. The local authority has yet to review the arrangements for all children who are looked after under a voluntary arrangement, to be certain that all arrangements are appropriate and necessary.

Many children, including those who have complex needs, are successfully adopted. The tenacity of the adoption service, which identifies children early and secures adopters, is making a positive difference to children who have a plan for adoption. Fostering for adoption is not routinely used or considered, and not all children looked after are supported to understand their identity through effective life-story work.

Too many care leavers are living in accommodation that is not appropriate for their needs. Almost half of care leavers are not in employment, education or training (NEET), and pathway planning is poor. The local authority cannot be sure that care leavers have sufficient awareness of their rights and entitlements. At the time of the inspection, the local authority had not signed up to the charter for care leavers. More needs to be done to ensure that the health needs of children looked after and care leavers are fully understood and met. Furthermore, young people need to understand their health history as they leave care.

Pathways to early help services are unclear, and the local authority does not understand the quality and impact of early help assessments and plans undertaken by partner agencies. Performance data is not reliable, and learning from audits and complaints is not effective in identifying and addressing training needs. The corporate parenting board is yet to demonstrate an impact on improving outcomes for children. Strategic oversight of children at risk of sexual exploitation is not sufficiently robust. Recently, the local authority has improved its response to missing children. This work, while positive, has not yet resulted in improved outcomes for children at risk of exploitation. Ineffective management and operational arrangements result in a poor service for children living in private fostering arrangements and for unaccompanied asylum-seeking children.

During the inspection and following its findings, strong political support was demonstrated for change, with a determined commitment to provide the required additional resources. The pace of change has recently been accelerated, with the reconfiguration of services at the 'family front door', children being offered return home interviews following episodes of missing, the implementation of the 'connecting families' programme and the setting up of a strategic workforce board. These changes have led to some very early improvements in the services that children receive. However, services remain fragile, and it is too early to see any sustained impact on outcomes for children.

Contents

The local authority

Information about this local authority area

Previous Ofsted inspections

- The local authority operates 10 children's homes. All were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was in March 2012. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for safeguarding and children looked after was in October 2010. The local authority was judged to be inadequate.

Local leadership

- The DCS has been in post since June 2016.
- The DCS is also responsible for community services.
- The nominated elected member has been responsible for children's services since May 2016.
- The chair of the LSCB has been in post since April 2016.

Children living in this area

- Approximately 115,250 children and young people under the age of 18 years live in Worcestershire. This is 20% of the total population in the area.
- Approximately 14.5% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 12.3% (the national average is 15.2%)
  - in secondary schools is 10.7% (the national average is 14.1%).
- Children and young people from minority ethnic groups account for 8% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Pakistani and White other.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 8.2% (the national average is 20.1%)
  - in secondary schools is 5.5% (the national average is 15.7%).

Child protection in this area

- At 31 March 2016, 3,767 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,942 at 31 March 2015.
- At 23 October 2016, 354 children and young people were the subject of a child protection plan. This is a decrease from 473 at 31 March 2016.
- At 1 October 2016, 24 children lived in a privately arranged fostering placement. This is an increase from nine at 31 March 2016.
- Since the last inspection, three serious incident notifications have been submitted to Ofsted and three serious case reviews (SCRs) have been completed. None was underway at the time of the inspection. The local authority is contributing to four SCRs in other local authorities.

Children looked after in this area

- At 23 October 2016, 710 children were being looked after by the local authority (a rate of 62 per 10,000 children). This is an increase from 694 (60 per 10,000 children) at 31 March 2016. Of this number:
  - 142 live outside the local authority area
  - 73 live in residential children's homes, of whom 37 live out of the authority area
  - 512 live with foster families, of whom 81 live out of the authority area
  - 49 live with parents, of whom 10 live out of the authority area
  - 33 children are unaccompanied asylum-seeking children.

Recommendations

1. Ensure that elected members and senior leaders meet their statutory responsibilities and duties to the children of Worcestershire by improving all children's services.

2. Implement the workforce strategy as swiftly as possible to improve workforce stability and capacity.

3. Ensure that children's services staff and the wider partnership understand and consistently apply the 'level of needs' at every stage of the child's journey, including in the early help pathway.

4. Strengthen children's voices by ensuring that children are seen, and seen alone, that their views are fully considered and taken into account, that they are supported to contribute to their plans and that their wishes are acted on, when appropriate.

5. Ensure that the management oversight and performance information relating to children who are at risk or vulnerable to child sexual exploitation and missing are accurate, and lead to improved safeguarding practice.

6. Complete a thorough review of all children subject to section 20 accommodation, to ensure that their arrangements are appropriate in all cases.

7. The local authority should assure itself that decisions made to close the cases of the cohort of children in need that were recently reviewed are both appropriate and in the children's best interests.

8. Improve the quality of assessments and plans for all children, including permanence plans. Ensure that children progress through robust reviews and effective oversight.

9. Ensure that strategy discussions include all relevant agencies and robust contingency arrangements, so that children are safeguarded while child protection enquiries are undertaken.

10. Improve the timeliness of health assessments for children looked after to ensure that their needs are fully understood and met.

11. Ensure that social workers and managers fully understand and exercise their responsibilities to unaccompanied asylum-seeking children.

12. Review the response to privately fostered children, to ensure that assessments of carers are completed and agreed, and that children are visited within required timescales.

13. Improve the service to care leavers by ensuring that there is a sufficient range of support and services available to all care leavers.

14. Ensure that effective performance management and quality assurance drive improvements and consistency in the quality of practice, including findings from complaints and training.

Summary for children and young people

- At the time of the inspection, senior leaders and managers in Worcestershire did not know about all the things that they needed to do to make sure that children were safe and helped properly.
- Managers have started to make some changes, but, as there is still plenty to do, Ofsted has judged the services to children as not being good enough, and the services need to improve as soon as possible.
- Social workers are taking too much time to find out about what it is that children and their families need help with. Senior managers know this and are now trying to make sure that, in future, children, young people and families receive the right help sooner.
- Some children and young people who need support from social workers are not made safe or helped quickly enough. Sometimes, what should happen for children is decided before children are able to say what they want to happen. Managers need to make sure that they make the right decisions quickly, to keep children and young people safe.
- When children and young people come into care, it can take too long to work out where they should live in the future. This means that some children and young people who should live with a new family do not become part of such a family quickly enough.
- Children and young people looked after do not always perform as well as they could at school. Teachers and social workers need to talk to each other more effectively to make sure that children do as well as they can. People who work with children and young people usually ask them how they are and listen to their views. They also need to make sure that these views lead to things changing for the better. Managers also need to make sure that the views of children and young people help to improve services.
- Young people who leave care when they are old enough do not always receive the help that they need to live on their own. Some do not have a safe place to live, and many are not helped enough to ensure that they can go to college, engage in training or find a job.

The experiences and progress of children who need help and protection	Inadequate

Summary

Services to children in need of help and protection in Worcestershire are inadequate. Children wait too long for their needs and risks to be recognised. Consequently, children who require protection from harm and need urgent improvements in their lives are left in situations of actual and escalating risk of significant harm.

Pathways to early help services are unclear. The local authority does not have sufficient oversight of the overall early help offer to all children.

The thresholds of need are not understood by social workers or partners. Children's services are receiving a continuing high volume of inappropriate referrals to the 'family front door'. Repeat referrals are too high. Too many children experience a continuous cycle of assessments, and some assessments are unnecessary. Not all assessments result in the right outcome for children.

Too many assessments lack important information, such as parental background and children's views. Social workers do not always consider the impact of previous assessments or interventions. As a result, too many children are exposed to a 'start again' pattern of social work. A thread of weak management oversight and direction across children's services results in a lack of robust challenge or support to social workers.

Chronic drift and delay are present for too many children at every level of need, including children who need statutory assessments, child protection enquiries, initial child protection conferences, children in need and children subject to protection plans. This leaves children exposed to unacceptable levels of risk without the necessary protection and with their basic needs unmet for too long.

The response to child sexual exploitation is not thorough enough. Social workers are not always using the risk assessment tools, and children identified as being at a higher risk of exploitation are not diligently tracked by managers and partners to assess the effectiveness of their work. Following a recent management focus, more children are now interviewed following 'missing' episodes, providing more children with the opportunity to express their views.

Social workers are not assessing the arrangements for privately fostered children quickly enough to establish their suitability and safety.

Inspection findings

15. Partner agencies do not understand the early help pathway for children and families. Consequently, the 'family front door' is receiving a high volume of inappropriate referrals. Leaders and managers are unable to demonstrate the prevalence and impact of any early help provided to children through partner agencies that are the lead professionals. This is a significant shortfall in the local authority's understanding of the entire range and effectiveness of early help services. (Recommendation)

16. A pilot early help service, 'Connecting families', operating in one district of the county, benefits families by tackling complex needs quickly and reducing the need for statutory intervention. This approach, which joins early help services up more cohesively, is being introduced incrementally across the county and is attracting wide strategic support from partner agencies. Its broader, long-term impact remains to be demonstrated.

17. Some children benefit from the local authority's own commissioned early help services. These offer effective targeted interventions. Families report improvements in outcomes, with very few families being re-referred at six months after the conclusion of the work. A comprehensive performance dashboard captures the impact of this work, including the involvement of the 'Troubled families' programme, which is closely aligned.

18. The local authority has recently sought to improve its initial response to concerns by forming a new, single 'front door' to manage all contacts and referrals. However, the initial screening and contact officers, who are not qualified social workers, are making the majority of decisions about contacts. Social worker and management oversight of these important decisions about contacts and referrals is inadequate. Inspectors identified some poor decisions, one of which had left a child at continuing risk of serious harm. In this matter, the local authority had to take urgent legal action to protect this child. (Recommendation)

19. The local authority offers advice to partners by holding 'quality conversations'. The intention is to clarify thresholds, and this practice is not yet embedded. Referring agencies do not routinely use the recently reissued 'levels of need' guide to inform their referrals. Consent to share information from parents and carers is rarely recorded, and written management decisions overriding consent, when necessary, are not evident.

20. A third of social workers in the initial response teams hold caseloads of over 30 children. This is too great and has a negative impact on the quality of social work practice. Community social workers, who were previously based in schools, complete brief assessments to address the high volume of work and workflow. This practice has resulted in confusion for social workers and managers. Inspectors saw assessments that often did not address concerns, lacked analysis and did not result in purposeful interventions. The local

authority has acknowledged that high numbers of children have been subject to repeat brief assessments through this practice, and has assured inspectors that this poor practice has ceased.

21. Daily domestic abuse, 'missing' and child sexual exploitation triage meetings are held in the multi-agency 'family front door'. These meetings make sure that the majority of incoming notifications and referrals receive an immediate multi-agency response. However, thresholds are not always applied consistently. No central record is made of decisions and actions. This weakens accountability and the measurement of the impact of subsequent risk-reduction activities.

22. Many child protection strategy meetings do not involve all relevant agencies, to inform a thorough 'live' discussion of the presenting risks to children who are identified as at risk of significant harm. Actions arising from the meetings are commonly not specific enough. The local authority's own data shows that 25% of children are not seen promptly during child protection enquiries. This means that the local authority cannot assure itself that all children are safe at this time. Enquiries take too long, and joint police and social work activity is not always well coordinated. In some cases, the police hold evidential interviews with children without a social worker's involvement. Accounts of these interviews are not held on children's social work records. This means that important evidence is not always recorded on the child's history. Thus, the necessary protective action is not always taken. (Recommendation)

23. Management attention to addressing significant delays in completing child protection enquiries is inadequate. Too many initial child protection conferences are delayed. During the period between the enquiries and the initial child protection conference, children are left at significant risk for too long without rigorous interim safety plans. There is also an unrealistic and disproportionate emphasis on written agreements with family members, to protect children from further contact with dangerous adults. These are serious shortcomings in the frontline safeguarding service. (Recommendation)

24. The out-of-hours emergency duty service is well resourced, and is led by an established team manager and experienced social workers. Handovers and information sharing with daytime social workers are prompt and well recorded. Responses to children who go missing and child protection episodes arising overnight or at weekends are timely, thorough and clearly documented.

25. Many assessments focus predominantly on presenting concerns, devoting little attention to parental histories. This lack of attention means that the vulnerabilities of parents and their effect on parenting capacity are poorly understood. Extended families are mentioned in some assessments, but these family members are not involved early enough when they might be able to provide important information about their family members or offer them support. Parents who are not living at the family home are not always adequately consulted, and their involvement and impact on children's lives are unexplored. Pre-birth assessments are completed too late during pregnancies,

when there are known concerns and potential risks to unborn children. In some instances, the delay is caused by late notifications. However, a sense of urgency and timeliness is lacking when notifications are received. Key-event chronologies are not regularly used to help social workers to develop a long-term overview of successive assessments, plans and interventions, some of which often fail to achieve sustained changes and improvements for children. (Recommendation)

26. Local authority data show poor compliance by social workers in seeing children alone and seeing them in accordance with the timescales agreed in their plans. Subsequently, records of children's views are limited, and case records do not effectively capture the child's lived experience. Some social workers carry out valuable and effective direct work with children, but this is not widespread.

27. Too many children in need and child protection plans are weak. The objectives of work with children on statutory plans are not always clear. Some recently closed plans featured carefully defined objectives and well-coordinated multi-agency work, achieving demonstrable improvements in parenting skills. Happier children, enjoying time at home and school, are highlighted as positive outcomes in these cases. However, this more positive practice was not widely prevalent and many plans drifted for too long. Core group meetings do not consistently develop outline child protection plans into detailed, specific plans, and they are not systematically measuring progress against plan recommendations. Professional relationships between team managers and child protection conference chairs are not constructive, weakening quality assurance and practice improvement. (Recommendation)

28. The reasons for recent sharp rises and subsequent marked decline in the number of children who are on child protection plans are not analysed or understood. (Recommendation)

29. Children and families are poorly prepared and ill equipped to participate in child protection conferences. The local authority has a very limited number of advocates to assist children to engage fully in their meetings. (Recommendation)

30. Children experiencing sexual exploitation, or who are at known to be at higher risk of exploitation, are not carefully and regularly reviewed at multi-agency meetings, to evaluate the impact of risk-reduction work. Management oversight of social workers' assessments and ongoing work with children who are exposed to sexual exploitation are not rigorous. This is partially due to the poor implementation and application of risk assessment tools. The local authority has recently reviewed its response to children who go missing from home. An increased number of children are now provided with an interview. This is starting to support an increased understanding of the risks and vulnerabilities of these children, although this has not yet resulted in children receiving additional support. However, too many interviews are completed long after children have returned home, and there is no uniform threshold understanding on which

missing children should be prioritised for return home interviews. Consequently, not all children at risk are spoken to, despite recent focused senior management attention. (Recommendation)

31. Child sexual exploitation intervention workers, commissioned by a partner agency to engage with up to 40 young people over a 12-month period, carry out direct work with children. The longer-term status of this service is uncertain, as there is no commissioning plan to secure the continuance of the project after March 2017. Effective mapping and disruption activity, including prosecutions and harbouring and abduction notices, have interrupted and prevented the further sexual exploitation of some children. The local authority and partners have undertaken some countywide awareness raising and targeted work with priority groups, including taxi drivers and hotels.

32. Strong multi-agency risk assessment conferences (MARAC) and strategic and operational arrangements effectively identify children who are exposed to serious, continuing domestic abuse. Responses to children who are living in households affected by medium and higher levels of exposure to domestic abuse are well planned and thorough. Social workers prepare well for MARAC meetings, and the follow up of agency actions is rigorous and comprehensive. Children's services are also consistently represented at multi-agency public protection panel arrangements meetings. Careful early safety planning and multi-agency monitoring of high-risk offenders occur for adults who are due for release from custody or subject to licence.

33. The local authority has identified that children's exposure to domestic abuse is the most common risk when they are living in families also affected by parental substance misuse and mental health difficulties, known as the 'toxic trio'. Despite this, repeat referrals, assessments and plans frequently feature continuing domestic abuse. (Recommendation)

34. The local authority has not identified a lead practitioner to develop expertise and offer advice concerning families affected by female genital mutilation. One of two recent referrals of suspected female genital mutilation was managed less effectively, indicating that revised policies and procedures, reflecting statutory guidance, have not yet resulted in consistently strong operational responses.

35. Local authority arrangements for considering allegations or concerns about paid employees or volunteers working with children are rigorous and effective. High levels of engagement are apparent across the professional network. Records of meetings and clarity of actions and recommendations are of a consistently high standard. Considerable training and awareness raising have been undertaken by the designated officer, alongside the Worcestershire Safeguarding Children's Board training officer.

36. Children in private fostering arrangements receive a poor service. Neither assessments of the suitability of adult carers, nor initial or subsequent visits to children, are completed within required timescales. (Recommendation)

37. The homeless intervention team carries out thorough joint social work and housing assessments of 16- and 17-year-old young people when there is a risk of a family breakdown. Tenacious and effective interventions, supported by clear management oversight and direction, secure appropriate solutions. These include a carefully brokered reunification home, when achievable, which affords continuing support to prevent further episodes of homelessness.

38. Effective governance arrangements, accountable through the 'Safer communities' board, enable the local authority to meet its statutory requirements concerning 'Prevent' and 'Channel' panel duties. An increased number of referrals from a broad spectrum of agencies are considered by a well-attended monthly 'Channel' panel. This indicates a growing awareness across the local authority partnerships of the potential threat to young people from radical and extremist influences. However, there has been a delay in ensuring that all social workers receive awareness training. This is recognised by leaders, and appropriate programmes are underway to address this shortfall.

39. Clearly defined and well-established arrangements are in place to identify and intervene quickly for children who are missing education and not receiving suitable educational provision. Immediate action is taken, including appropriate escalation to children's social care services, when safeguarding concerns arise. Good procedures and practices ensure that children who are home educated are visited and offered further support through a range of resources that are signposted by the local authority to enhance further the learning experiences of this group of children.

The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

There are serious and widespread concerns for children looked after, because children have been left in situations of escalating risk for too long before decisive action has been taken to secure their welfare. Drift and delay are evident throughout services to children looked after. These delays are widespread, including in initiating the Public Law Outline (PLO), the completion of assessments and applications to court, and there is untimely care and permanence planning.

Children who have a plan of adoption receive an improved service, and they are matched and placed with their adopters swiftly and with the necessary support. Too many 16- and 17-year-old children looked after are not being provided with the level of support and stability that they need to reduce their risks.

Care planning is a significant weakness. Care plans are neither outcome focused nor seek to meet the full range of a child's needs. IROs' and managers' oversight of care planning is poor. Permanence is not consistently progressed for children who cannot return home.

Increasingly, children are being looked after by foster carers within the local authority area, as a result of a successful marketing campaign. Gaps remain in the provision of sufficient placements for children over 12 years and large family groups. The local authority is making use of a range of purchased placements to reduce this gap.

Children looked after do not achieve well in education, and their attainment gaps are still too wide compared with all other children in the county.

Many children, including those who have complex needs, are successfully adopted. Fostering for adoption is not embedded. Delays in health assessments are, in some cases, leading to late adoption medicals and delays in gaining placement orders, for a small number of children. There are delays in accessing post-adoption support, although many families are benefiting from the adoption support fund.

Care leavers do not consistently receive the support that they need to make a successful transition to adulthood, and the support to some is very poor. Too many care leavers are living in accommodation that is not appropriate to their needs, including bed and breakfast. Almost half of care leavers are NEET. Pathway planning is poor.

Inspection findings

40. Too many children have been left in situations of escalating risk without becoming looked after. For a number of children, this has resulted in their experiencing further harm.

41. Poor practice through the PLO, with slow progress of actions, is contributing to drift and delay for children. The PLO tracker is not fit for purpose and does not enable managers to maintain a clear oversight of work with children and their families. Very recent improvements in the understanding and application of pre-proceedings work is starting to lead to more timely action, to respond to risks for children and progress key actions.

42. The judiciary confirms that the quality of written and oral evidence to court is, in the majority of cases, sufficient to enable courts to reach appropriate decisions for children. However, the quality of parenting assessments is very poor and, in some cases, has led to delays in court proceedings, due to the courts and the children's guardians, the Children and Family Court Advisory and Support Service (Cafcass), requesting further work. The local authority has detailed plans in place to address these weaknesses. The timeliness of court proceedings at the start of 2016–17 was 33 weeks. Effective joint working between the local authority, Cafcass and the courts has led to a reduction in the timescales of care proceedings. Quarter 2 performance now stands at 27 weeks, which is below the national average of 29 weeks.

43. Social workers take the time to come to know well the children with whom they work, and children's views are consistently sought. However, their views are not routinely used to inform plans, and social workers do not always understand the lived experiences of children looked after. The local authority cannot be confident that children know about their rights and entitlements. Children who spoke with inspectors, including those from the Children in Care Council (CiCC), were not aware of the local authority's responsibilities to children looked after, and they were unable to explain how they could complain.

44. Children looked after have access to an advocacy service and an independent visitor service. However, this resource is insufficient for the numbers of children who are looked after.

45. The social work identification of children looked after who are at risk of misusing drugs, of sexual exploitation and of going missing is not sufficiently timely or effective for a large number of children. Consequently, risk management planning is not well evidenced in most cases, and there is some delay in taking action to respond to risk. Not all 'missing' episodes are followed

up with an offer of a return home interview and, when one is offered, it is often not undertaken within 72 hours. (Recommendation)

46. Children's health needs are not appropriately met. There are delays in completing health assessments for children looked after. These delays include the completion of adoption medicals, which, for some children, has resulted in delays in securing permanence. Managers are fully aware of this issue. They have not been successful in tackling this gap in provision. (Recommendation)

47. Children looked after can access appropriate services to meet their emotional and mental health needs, including the provision of advice and support when they are misusing alcohol or substances. Children and adolescent mental health services (CAMHS) have developed a specific pathway to ensure that children looked after receive timely consideration of their needs. The integrated service for children looked after and adopted children's health and well-being service (ISL) carers have an improved understanding of the attachment needs of children. This work includes the positive 'Green fingers' project, which successfully improves the health and well-being of children and their carers through outdoor activities.

48. Children looked after do not achieve well in education. The attainment gap between children looked after and all other children in the county is widening. In 2014–15, children at key stage 1 did not perform well, and there was a decline in performance from the previous year and a widening attainment gap. At key stage 2, there was some improvement in mathematics and a reduction in the achievement gap. Unvalidated data for 2015–16 is not showing improvement on these outcomes. However, of the 50 children looked after who were eligible to take GCSEs in 2015, 16% achieved five GCSEs at A* to C including English and mathematics, which was better than the performance of statistical neighbours and the national average of 14%. Recruitment of the new virtual school headteacher in February 2016 has ensured that significant progress is being made in refocusing the priorities of the virtual school.

49. The quality of the personal education plans is inconsistent. The majority require more detailed information about children's previous and current levels of attainment, progression data and details of where improvements are required. As a result, target setting is too generic. By contrast, the stronger plans that have been more recently completed ensure that clear target setting is present, with an identification of barriers to learning and strategies to improve outcomes. Personal education plans completed by social workers for children living out of the local authority area are subject to considerable delays, and are generally of poorer quality than those completed by virtual school staff.

50. During the inspection, 19 children looked after were placed in alternative provision, which is registered and contracted by the virtual school to deliver good-quality education placements. Ten of these children were on full-time programmes, and the remainder were following bespoke programmes to encourage and support increased participation and improved engagement.

Appropriate arrangements are in place to identify and track those children who are missing education and not receiving suitable education. When important safeguarding intelligence is identified, immediate action is taken and cases are referred for a children's social care service.

51. The local authority is successful in placing children together with their brothers and sisters, when this in their best interests. However, 'together or apart' assessments for brothers and sisters are not sufficiently detailed in the focus on attachment. As a result, it is difficult to understand how these significant decisions have been reached. The majority of children have regular contact with their families, when this is in their best interests. Children looked after are supported by their carers and children's home staff to engage in activities. Relevant delegated authority is agreed with carers.

52. Not all children living out of the local authority area have immediate access to education and health services to meet their needs. This is, in part, due to education and health colleagues not being party to key decisions regarding children's placements. The ISL health and well-being service does negotiate appropriate health services with host authorities once children are living in their areas. The virtual school and fostering service do not actively monitor these placements, and this limits effective oversight for children living out of area.

53. Placement choice is improving. A successful recruitment campaign over the past 18 months has led to a net gain of 34 foster carers. The improved offer to carers includes increased fees and better training. The local authority does not yet have sufficient foster homes for children aged over 12 years and larger family groups, and is now targeting recruitment for these groups. The impact of this gap in provision is minimised for the large majority of children, as the local authority makes good use of independent fostering agencies and residential placements.

54. The assessment and support of foster carers are effective. A detailed training programme is provided, and all carers are supported well to complete their training. Foster carer assessments are of a sound quality, and these assessments enable the fostering panel and the agency decision-maker to reach clear decisions. The agency decision-maker and fostering panel provide strong quality assurance. Carers appreciate the support that they receive through the ISL health and well-being service.

55. Children's needs are considered well when families are found. Foster carer profiles and introduction visits help to prepare children for their moves. However, the needs of 16- and 17-year-old children looked after are not being sufficiently well understood or met to reduce their risks. Although the large majority of children are encouraged to remain looked after until they are 18 years old, too many 16- and 17-year-old children looked after are living in settings that do not afford them the level of support and stability that they need.

56. Care planning is a significant area of weakness. Partner agencies who are involved in children's lives do not contribute to their care plans. Children's assessed needs, including their identity, ethnicity and diversity, do not inform plans, and social workers do not routinely consider children's friendship groups or their ability to make friends, when assessing or planning to meet their needs. Social workers, managers and IROs are not being vigilant in progressing plans or providing sufficiently strong oversight to ensure that plans are moved forwards within acceptable timescales for children. (Recommendation)

57. Only a minority of children attend their review meetings. These meetings are usually attended by the key professionals in the child's life, but are not seen as the child's meeting, to which they could specifically choose who is to attend. The lack of a detailed care plan means that professionals cannot be held directly to account for actions between review meetings. The IROs' caseloads are too great, and this limits their ability to follow through consistently and monitor the delivery of plans, or to track the progress of children between reviews. The IRO service has been without dedicated management for some time, and this has led to limited effectiveness of the dispute resolution process and means that its work is not being quality assured. (Recommendation)

58. Children wait too long to move into their permanent homes, due to poor permanence planning. At the second children looked after review, permanence plans are considered and agreed for children who are unable to go home. Adoption is considered for all children, for whom this is appropriate. However, the lack of effective tracking and follow through of agreements, particularly for older children, results in delays. The quality of working relationships between social workers, Cafcass and the courts is extremely variable, with some social workers lacking the expertise to engage productively with colleagues to achieve timely outcomes and permanence for children. Waiting to confirm long-term fostering placements until a child has been living with carers for up to a year is not supporting timely permanence. (Recommendation)

59. Social workers and managers do not fully understand their responsibility to children when they first place them with 'family and friends' carers. This means that some children are living with families for a period of time, during which risks have not been appropriately assessed, and it is not known whether their needs can be met by the carers. Once placements are more established, detailed fostering assessments consider effectively whether children's needs are being met and whether carers have the skills, both now and in the longer term, to care for children and to promote their outcomes. (Recommendation)

60. Children benefit from living in long-term, stable foster placements. However, the stability of placements has decreased over the past year, which is a concern. In 2014–15, 68% of children looked after under 16 years had lived in the same placement for at least two years. This decreased to 58% in 2015–16. The local authority does not yet understand this deterioration in performance.

61. Not all children in long-term foster placements benefit from life-story work. When life-story work is undertaken, the quality requires improvement, to ensure that children are able to explore their pasts throughout their childhoods. (Recommendation)

62. Children who have disabilities and who are looked after receive a service that is responsive to their needs. However, the 'disabled children's and young adults' team' and the care leavers' services do not have strong links. Consequently, planning is limited for children who have disabilities, as they transition to adulthood.

63. Social workers and managers do not sufficiently understand their responsibilities for unaccompanied asylum-seeking children, which means that requirements for service provision and age assessments are not well understood. A small number of unaccompanied asylum-seeking children have experienced a very poor service, with a lack of individual contact with their social workers. (Recommendation)

64. There is an active children in care council, which meets every three weeks. The CiCC organises a range of activities, such as an annual celebration event and a summer fun day. Children meet in one of three forums that are relevant to their age and interests: 'Big voices for little kids' (5–11 years), 'Who cares, we care' (12–16 years) and 'Speak out' (16+ years). Members of the two older groups regularly attend the corporate parenting board. Communication with the wider group of children looked after is underdeveloped.

65. The corporate parenting board is yet to evidence the impact on improving outcomes for children looked after in Worcestershire. The board has been invigorated in recent months by a change of both the lead member and the DCS. Previously, it was described by children to inspectors as being a 'talking shop' that achieved very little, apart from meeting the requirement to have a board. The board is now identifying a more structured work programme, and the meetings adhere to an agreed agenda and address some key issues for children looked after.

The graded judgement for adoption performance is that it requires improvement

66. Adoption is considered for those children who need it, when it is in their best interests. Increasingly, family finding is starting earlier, and social workers are appropriately referring children for adoption. The proportion of children leaving care through adoption in 2015 was 20%, which is better than the England average of 17%.

67. The local authority is ambitious to seek adoption for all children who may need it. A variety of children is successfully found adoptive homes, including those who are older, those who have complex needs and larger family groups.

Tenacious family-finding efforts have resulted in an increase in the number of children moving in with their adoptive families more quickly and, in the past year, timeliness has improved. Some 52 children were adopted in April 2015–16.

68. Some children experience delays when permanence is not progressed with the required urgency. The failure to progress adoption plans, as well as delays in arranging adoption medicals, contributes to this. However, the impact for children has been lessened by the extensive and persistent work of the adoption team, which accelerates matching and moving children swiftly, and within their own timescales, to their adoptive homes. (Recommendation)

69. In the past two years, the local authority has sought adoptive homes with determination for a number of children who have complex needs and who have been looked after for too long. These children have now been adopted, but the impact of their extended periods of care has affected the overall timescales for achieving adoption. The published scorecard for adoption shows that, between 2012 and 2015, the average timescale for a child entering care and moving in with their adoptive family was too long, at 649 days. This compares to the national three-year average of 593 days.

70. More recent data provided by the local authority confirms that timeliness is improving for children being adopted in the past year. The local authority continues to strive to find homes for children aged up to 10 years and has been diligent in finding homes for brothers and sisters to live together. This has inevitably slowed down their journey to adoption.

71. The time taken for matching children has also improved in the past 12 months. Notably, all but five children out of 17 with a placement order are linked with potential families. These five children have more complex needs and a range of health and developmental issues. They have been waiting for a relatively short time of three months. The local authority is seeking more information about their inherited health conditions, which is resulting in some delays for these children.

72. Social workers produce high-quality child permanence reports that convey children's needs well and assist in matching. Successful matching of children with their adoptive homes has led to very few disruptions, and only three have occurred in the past two years.

73. The recruitment of adopters is successful and has resulted in children being placed largely with in-house adopters. In 2015–16, 50 adopters were approved, and so far this year 21 have been recruited, in line with the local authority's sufficiency target. Word-of-mouth recommendations are attracting a diverse range of adopters, increasing the matching options for children.

74. Fostering for adoption needs much greater promotion. In the past year, only two children have benefited from being in a 'fostering to adopt' placement.

Both these children had to experience foster care beforehand. The lack of 'foster to adopt' placements is a missed opportunity to focus on the needs of children who could be placed with their adopters sooner. (Recommendation)

75. Adopters are not always suitably prepared to consider children who have more complex needs. As a result, over 30 adopters are currently waiting to be matched. Many have been waiting in excess of a year, and a few in excess of two years. All adopters have been forwarded to the adoption register and are appropriately supported to access Link Maker, facilitating adopter-led adoptions. The large volume of waiting adopters creates pressure for the local authority, with some overdue reviews and difficulties in maintaining contact with approved adopters.

76. The assessment of adopters is not always prompt, and only a third met timescales in 2015/16. A few assessments are appropriately extended, but many have been delayed by insufficient medical adviser provision and, occasionally, insufficient social work capacity. (Recommendation)

77. Good-quality prospective adopter reports support strong matching decisions. Adopters are positive about the assessment process and introduction arrangements. The very low rate of adoption disruptions is evidence of the successful preparation and support that adopters receive.

78. Quality assurance by the adoption panel and the agency decision-maker has been affected by a lack of continuity, with changes to senior managers. Learning from practice has not always been carried forward to support improvements. For example, the minutes from disruption meetings have not been scrutinised and shared with the adoption panel, and the gap in provision, whereby adopters are offered time with the medical adviser to review the medical histories of their children, has not been resolved. Thus, not all adopters may fully understand children's health conditions and their implications. (Recommendation)

79. Life-story work and later-life letters for adopted children are not all appropriately child centred or completed on time. The lack of appropriate quality assurance means that most children do not benefit from work that enhances their understanding of their experiences. (Recommendation)

80. Most adoption support plans reflect children's needs, and there is a good use of assessment tools and the adoption support fund, from which 70 families benefit. Over 100 families are receiving support, but there is a waiting list of between four to eight weeks for an assessment. An integrated team of specialists, jointly funded by the local authority and the Worcestershire Health and Care NHS Trust, is being expanded to continue its innovative work to provide training to parents and carers on therapeutic parenting. This means that most families can access immediate support with parenting while waiting for their assessment to be completed. Indirect contact arrangements are well

supported through the letterbox service, and there are 300 arrangements in place.

The graded judgement about the experience and progress of care leavers is that it is inadequate

81. Care leavers do not consistently receive the support that they need to make a successful move into adulthood, and the support provided to some is very poor. A lack of sufficient, suitable post-18 accommodation means that some care leavers are living in accommodation that is not appropriate to their needs. Seven care leavers were placed in bed and breakfast accommodation in the six months prior to the inspection. At the time of the inspection, a small number of care leavers were living in bed and breakfast establishments, with no immediate prospect of a move to more suitable accommodation. This is unacceptable practice, which leaves some care leavers having to manage in circumstances that leave them at risk of harm. (Recommendation)

82. The two care leavers' teams are staffed by capable personal advisers and team managers. Caseloads in these teams are large, averaging 28 at the point of the inspection. This limits the quality and extent of the support provided to care leavers. Care leavers told inspectors that personal advisers are 'well-intentioned', but not always available when needed. They also told inspectors that recent improvements in the stability of staffing mean that they are now more likely to be able to form a working relationship with their personal adviser, but were clear that support from the team had not progressed beyond being 'functional'.

83. Planning for independence does not start sufficiently early for children looked after. In almost all cases, personal advisers are not becoming involved with young people until just before the young people's 18th birthdays. Only one of the three teams that are working with children looked after is routinely ensuring that young people have a pathway plan. No pathway plans seen by inspectors were based on a clear assessment of need. Although 85% of care leavers supported by the care leavers' teams have pathway plans, most of these lack analysis and clarity. Plans are reviewed in a timescale that reflects minimum statutory expectations rather than the changing circumstances of care leavers' lives. This means that practice is generally reactive.

84. Care leavers have little sense of ownership of their plans. The plans are rarely used as a tool to shape or measure improvement. One young person described their plan as 'just a document'. Although the local authority is aware of these weaknesses, improvement planning is at a very early stage, and there is little evidence of improving practice. A new pathway plan template has been designed, but is not due to be implemented until April 2017. (Recommendation)

85. Some 48% of 18- to 21-year-old care leavers are NEET. This is poor. This is a decline from the last nationally published data for Worcestershire of 41% at 31 March 2015, and worse than the 38% average achieved by similar local authorities. A number of work placements have been made available through the NEET prevention team, with some good work experience placements achieved due to the tenacity of the participation workers, who work alongside personal advisers. It is also positive that 28% of care leavers are in higher or further education. However, this work is not well coordinated, and insufficient attention has been given to older care leavers. Only nine care leavers are in apprenticeships. (Recommendation)

86. The care leaving service has worked with the Department for Work and Pensions to try to reduce or eliminate the delays that care leavers experience when applying for benefits following their 18th birthdays. Training has been delivered to staff, and 'single point of contact' arrangements have been set up at job centres in each of the six district council areas. Although this has led to some improvement, a few care leavers are still experiencing delays in accessing support for job readiness, job searching and benefits advice. Care leavers spoken to by inspectors shared concerns that the benefits advice is not always clear and that personal advisers do not always have a sufficient depth of knowledge.

87. Despite the heavy caseloads of personal advisers, the local authority is in touch with 86% of its care leavers. This performance is better than the most up-to-date average figure available for similar local authorities of 81% (31 March 2016), but just below the national average of 87%. The 'staying put' policy is also supporting an increasing number of young people to remain with their foster carers after their 18th birthdays. At the time of the inspection, 21 care leavers were taking advantage of 'staying put' arrangements.

88. A system is in place to ensure that when children leave care, they have received information outlining their rights and entitlements. The information available lacks detail, so the local authority cannot be sure that care leavers continue to have sufficient awareness of their rights and entitlements. The care leavers' handbook has only very recently been updated, in consultation with care leavers, to include an outline of what care leavers can expect. However, plans to share information through other media, such as newsletters, emails and social media, are either insufficient or yet to be implemented. (Recommendation)

89. There is only one 'drop-in' facility available for care leavers. In a large, predominantly rural county, this limits care leavers' access to advice and support. This limitation was also seen at a 'leaving care fair' held in October 2016. Although this event was enthusiastically supported by those who took part, it was only attended by 25, approximately 8% of care leavers. (Recommendation)

90. At the time of the inspection, 145 of 155 16- to 17-year-old young people looked after had an up-to-date health assessment. Until September 2016, when the post was de-commissioned, the health needs of young people over 16 years and care leavers were being coordinated by the health-funded 16+ transitions nurse. For young people looked after who are coming up to 18, it is known that building relationships and sticking with young people is crucial to involving them in health assessments and making sure that they know about their health histories. The lack of an alternative plan to ensure that the functions of this role continue presents a risk to the health needs of care leavers being met effectively.

91. Personal advisers keep in touch with relevant agencies when care leavers have specific additional needs, such as those arising from mental ill health and offending or other risk-taking behaviour. However, outcomes for these care leavers are not good, and work with probation and youth offending services is not well joined up. Without an emotional health and well-being service that continues to work with care leavers beyond the age of 18, or effective transition arrangements with adult mental health services, care leavers do not receive the support that they need. In circumstances in which care leavers have higher levels of need or risk, the 24 hours a day, seven days a week availability of support staff from the outreach team is a very positive addition to the range of available services. The team provides flexible and responsive support to some care leavers. (Recommendation)

92. The care leavers' council, 'Speak out', provides a positive experience for those care leavers involved. However, this group currently has active involvement by only a small number of core members. Care leavers said that, although the group has not previously been well consulted, this is beginning to change, and they spoke positively of their engagement with the DCS and the lead member. Care leavers have recently been consulted about updating the care leavers' handbook to include a 'pledge'. Care leavers contrasted this recent engagement with an earlier lack of meaningful consultation. In particular, care leavers said that, while they were supported to attend the all-party parliamentary group for children looked after and care leavers, the local authority has not subsequently signed up to the care leavers' charter, and financial support for care leavers remains below the minimum recommended as good practice. (Recommendation)

Leadership, management and governance	Inadequate

Summary

The scale and gravity of the weaknesses identified in the services to children in Worcestershire are significant. Ofsted inspections judged safeguarding services as inadequate in 2010 and adequate in 2012. Since this time, services to children have significantly deteriorated, and the majority of areas of this inspection are inadequate. Despite knowing of the serious and widespread failures in the service, elected members and senior leaders have not taken sufficient action to ensure the protection of vulnerable children. This corporate failure leaves children in Worcestershire at continued risk.

A safeguarding improvement board established, following the local government association peer review in April 2015, has not given sufficient focus to addressing poor practice, and there has been a lack of management oversight of children's services. Consequently, children in need of help and protection, children looked after and care leavers do not consistently benefit from a range of services that meet their needs.

The application of thresholds across the service at every level is inconsistent and a critical area of concern. Management oversight at every level, including that of IROs and child protection chairs, lacks rigour and does not consistently lead to practice improvement. Social workers', IROs', child protection chairs' and personal advisers' caseloads, while decreasing, remain too large. This is a significant underlying factor in the poor-quality service that some children receive.

Strategic oversight of children at risk of sexual exploitation is not sufficiently rigorous. Performance data is not reliable, and learning from audits and complaints is not effective in identifying and addressing training needs. The corporate parenting board is yet to evidence the impact on improving outcomes for children.

Following the inspection findings, there is strong political support for change and a determined commitment to providing the required additional resources. The pace of change has very recently accelerated, with the reconfiguration of services at the 'family front door', children being offered return home interviews following episodes of missing, the implementation of the 'Connecting families' programme and the setting up of a strategic workforce board. These changes have led to some very early improvements in the services that children receive. However, services remain fragile and it is too early to see any sustained impact on outcomes for children.

Inspection findings

93. Following her appointment in June 2014, the chief executive identified the need to provide greater leadership of children's services. This resulted in decisive action to increase senior management capacity and the commissioning of a local government association peer review. The peer review, in April 2015, identified serious concerns about the quality of child protection and children looked after arrangements. Although elected members and senior leaders have taken some action to respond to these concerns, this action has not been effective in tackling the systemic failures. As a result, some children are not being protected effectively and remain at risk of harm.

94. Over the past 18 months, the safeguarding improvement board, chaired by the chief executive, has met monthly and has oversight of developments. A coherent, overarching, strategic improvement plan has not been in place to drive the pace of change and much needed improvements. Board minutes lack sufficient detail, and many actions are repeated without progress or improvement. Consequently, progress has not been swift or focused enough to secure improved outcomes for children. (Recommendation)

95. Compliance with practice standards by social workers and managers continues to be a serious issue for the local authority. A 'back to basics' website launched in 2015 to tackle these known deficits continues to be work in progress, with many sections of the website lacking detail or information. Social workers and managers report that they have stopped using it, due to information not being available. (Recommendation)

96. Following the appointment of a new DCS in June 2016 and, more recently, a permanent assistant director for safeguarding services (October 2016), progress is now tangible, with some very early signs of improvement. The DCS has brought a much-needed focus and has a clear understanding of the significant challenges facing children's services and the level of service improvement required. She has a strong ambition to produce long-term service improvements and better outcomes for children. Partner agencies and staff express confidence in the new leadership team, and say that progress against the improvement journey over the past four months is starting to take shape.

97. The variability in the skills and knowledge of first- and second-line managers undermines the much-needed improvements through inconsistent and often poor management oversight. The constant turnover of social workers and managers has resulted in drift and delay at every stage of the child's journey, including in the convening of strategy discussions and initial child protection conferences, implementing legal advice and applying PLO processes. Critical decisions regarding children's futures take too long to be made. (Recommendation)

98. The local authority does not have a recruitment and retention strategy, and has not been able to ensure that the workforce is suitably experienced to deliver a good-quality service for children.

99. The DCS is acutely aware of the negative impact of an unstable workforce on the quality of support to children, and has made this a top priority. The introduction of a strategic workforce board in October 2016, chaired by the DCS, aims to address recruitment, training, development and staff performance. Although this is a positive move in the right direction, the local authority remains too reliant on agency workers, with 31% covering vacancies at the time of the inspection compared to 23% in 2015. (Recommendation)

100. Caseloads, while decreasing, remain too great in many parts of the service, particularly when taking complexity and experience into account. Some staff, including newly qualified social workers, have responsibility for more than 22 children. This is a contributory factor to the slow pace of improvement in the quality of practice. The quality and frequency of supervision are too variable, because managers do not consistently ensure that actions are completed, that plans progress and that risks to children decrease.

101. Senior leaders were unaware of many critical issues identified during the inspection, for example the initial screening and contact officers making decisions at the 'front door' when they are not qualified to do so, the use of bed and breakfast establishments for vulnerable care leavers and the unknown whereabouts of four unaccompanied asylum-seeking children.

102. The IRO service and child protection chairs are struggling and stretched, as they hold excessive caseloads. Professional relationships between frontline social workers and IROs are not effective. As a result, constructive challenge in driving good practice and improving outcomes for children is insufficient. (Recommendation)

103. The local authority training needs analysis, which intends to support improvements in key areas of practice, is limited. Senior managers have commissioned training, such as in preventing child sexual exploitation, in age assessment and, more recently, in court skills. However, training such as in permanence planning and assessment has been delayed due to competing priorities. The evaluation of training is poor and is not supporting the local authority to focus on the areas of greatest priority. (Recommendation)

104. Quality assurance activity is ineffective and is not supported by an up-to-date framework. The local authority has yet to review all section 20 arrangements and cannot be certain that all arrangements are appropriate and necessary. Many of the shortfalls in practice identified in the local authority's own audit work were evident in the children's files seen by inspectors. In the worst of these cases, children were left unprotected and at risk of significant harm. In three cases identified by inspectors, involving six children, the local authority had to take legal action to ensure the protection of children. (Recommendation)

105. A wide-scale review of 1,550 children's circumstances between June and August 2016 led to the closure of 65% of children in need cases open to children's social care statutory services. The local authority acknowledges that the review was fundamentally flawed, being based on inaccurate data and a lack of management oversight. Subsequently, 15% of these children were re-referred for statutory intervention, due to re-emerging or increased concerns following closure. A recent local authority audit of a sample of 20 children closed through this review identified that 75% were closed without sufficient evidence to support the decision. Senior managers have begun to respond to this significant weakness in decision-making. However, they have not yet taken rigorous action to assure themselves that the decisions made for all of the children were appropriate. (Recommendation)

106. The broad range of performance information available to leaders and managers lacks rigorous analytical commentary. Data is not sufficiently reliable, due to delays and inaccurate recording by frontline staff. Adoption and care leaver data is particularly poor, and placement stability is not considered. A weekly 'back to basics' performance report is available for managers to track compliance. This has led to some improvements, particularly in the number of children receiving return interviews following missing from home episodes. However, performance relating to the timeliness of return home interviews, initial child protection conferences and children seen and spoken to during assessment is still not good enough. (Recommendation)

107. The local authority has not made good use of feedback from children and families. The learning from complaints is limited, with no analysis and little evidence of focused management efforts to inform subsequent service provision. Complaints take too long to investigate, with a number taking many months. (Recommendation)

108. The children and families overview scrutiny panel has not offered sufficient challenge to the local authority about the effectiveness of services provided to vulnerable children. The safeguarding improvement plan has not been on the panel's agenda since March 2016.

109. Strong cross-party political support for children's services is demonstrated by the considerable investment of additional resources and a commitment to improving corporate parenting and safeguarding arrangements, for example an additional investment of £2 million into in-house residential placements. An additional and recurring funding of £3 million has been made in response to the peer review. However, sustained and systematic change is not yet evident, and some children in Worcestershire remain at risk of harm. (Recommendation)

110. As corporate parents, elected members have failed to discharge their responsibilities for children looked after and care leavers. Induction training to ensure that a wider group of elected members became aware of their responsibilities had a very poor take-up, with only six of 57 new councillors attending. The recently appointed lead member (May 2016) chairs the

corporate parenting board. There are early signs of improvement, with a vice-chair appointed and terms of reference refreshed. The board receives little performance information, and this limits its ability to provide scrutiny. The board is in a development phase. Many work strands are required for the board to become fully functioning, so that it can have effective oversight and challenge services for children looked after and care leavers. The local authority has not signed up to the care leavers' charter, and financial support for care leavers remains below the minimum recommended as good practice. (Recommendation)

111. Multi-agency arrangements for the delivery of services in response to child sexual exploitation have recently improved. Nevertheless, strategic oversight of children at risk of sexual exploitation is not sufficiently rigorous. During the inspection, the local authority struggled to supply the inspectors with the number of children at risk of sexual exploitation who are in receipt of statutory services. This is partly due to managers using a combination of different methods to identify these vulnerable children. The local authority accepted this and made changes to the recording system during the inspection. (Recommendation)

112. Training and awareness raising have been coordinated by the LSCB and, more recently, by a commissioned service working with licensed premises. There have been some effective mapping and joined-up work as a result of coordinated activity through the operational group to counter child sexual exploitation. This mapping and coordinated activity have led to some successful disruption activity. However, a recent case audit, by the local authority, of child sexual exploitation identified poor risk management and a lack of understanding of the difference between sexual abuse and exploitation, with a number of cases requiring immediate action to ensure that children were safe. (Recommendation)

113. Children and families are one of four corporate priorities for the council, as a whole, in the corporate plan. The children and young people's plan (2014–17) sets out the key priorities for children, is aligned with the joint strategic needs assessment and health and well-being strategy and is overseen by the children and families strategic group, a sub-group of the Health and Wellbeing Board (HWB). However, the children and families strategic sub-group, which is scheduled to meet twice a year, has not met since June 2015. Consequently, there is a lack of strategic drive and reviewing mechanisms that ensure the effective progress of partners individually and collectively, and make sure that services for children and families are integrated and that outcomes for children are improving.

114. The implementation of a single point of contact at the 'family front door' in July 2016 is starting to demonstrate some very early signs of improvement. However, more work is required to ensure the consistent application of thresholds at every stage of the child's journey, and that partner agencies understand the pathways for early help and statutory intervention.

115. Commissioning plans are in place, informed by a number of work streams. Progress has been effective in reducing waiting times for children who require emotional health and well-being services. Targeted commissioning is in place to provide housing and floating support for vulnerable young people, as well as support for young carers. Work has recently focused on improving NEET figures for children looked after and care leavers. The youth council has been fully involved in commissioning positive activities for young people. However, significant gaps remain in the provision of critical services, and a number of services have been decommissioned without full consideration of the impact on children. For example, the cancellation by the local authority of its own commissioned over-18 supported living provision, in 2015, further reduced the stock of suitable accommodation available for care leavers.

116. The local authority is in the process of implementing 'Connecting families', a transformational whole-system approach to improve the way in which agencies work together to support vulnerable families. A successful pilot of the new approach in one district demonstrates effective outcomes for some children. This needs strategic ownership by partners to implement the model across the county. However, through the redesign of commissioned services, to ensure a focus on supporting the children and families who need it most, significant reductions are planned across early help services, including children's centres. These planned reductions have led to anxiety across the partnership and a lack of understanding regarding ownership of, and pathways to, early help.

117. The engagement of the local authority with Cafcass and the judiciary is good, with strong and positive relationships with senior managers. The local authority is an active member in the local family justice board. However, some children's cases, particularly those that include chronic neglect, come too late to the court.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The Worcestershire Safeguarding Children Board (WSCB) requires improvement to be good. The board is meeting its statutory responsibilities, and governance arrangements are clear. The independent chair brings appropriate and persistent challenge across the partnership. The WSCB annual report provides an honest appraisal of the quality of services available to children. The LSCB cannot be assured that children in Worcestershire are effectively safeguarded.

The restructure of the WSCB and the appointment of the new chair in 2016 have begun to strengthen engagement, following a period of inconsistent attendance by some partners and gaps in sub-group chairs during 2015–16. The board's interface with the family justice board and the local authority corporate parenting board still needs to be formalised.

The board has detailed multi-agency performance information, supported by a coherent structure, to monitor the effectiveness of frontline practice. Audit activity provides rich information, but needs strengthening to reach clearer findings to enhance the board's ability to evaluate practice, progress and impact. Further work is required to ensure that the board has access to all information that it needs about children at risk of sexual exploitation, to enable a coherent and informed approach.

The board has reviewed and reissued the levels of need guidance, circulating it widely and providing training to over 400 partners. Early help pathways are not yet clear enough, and there is anxiety across the partnership regarding the local authority's plan to reduce commissioned early help support.

The board takes a rigorous approach to monitoring the effectiveness of multi-agency training, which is informed by needs analyses. There is a structured learning and improvement framework, including learning from reviews, child deaths and serious case reviews (SCRs). Findings are disseminated and inform the development of multi-agency training. Case review action plans require more rigorous monitoring to ensure full partnership compliance.

The board has undertaken a comprehensive evaluation of multi-agency training and has assurance that programmes effectively target training needs. Staff value the training provided. However, the board is less able to demonstrate that the work that it does to disseminate learning or the training that it coordinates are yet resulting in changes to practice or improved service delivery for children.

Recommendations

- The board should ensure that there is an agreed governance structure in place for an effective interface with the family justice and the corporate parenting boards.
- The board should strengthen its oversight of the response to child sexual exploitation practice, by ensuring that the operational sub-group is represented by all agencies that are able to offer a sufficient level of oversight and analysis.
- The board should strengthen its case file audit programme so that findings provide a clear baseline from which to evaluate practice and measure impact.
- The board should ensure rigorous monitoring of action plans, including single-agency action plans that arise from critical incident reviews.

Inspection findings

118. The appointment of the new independent chair in April 2016 has resulted in a restructure of the LSCB and a refreshing of governance arrangements. Partners consider that the new chair has brought renewed focus, including a more streamlined approach, to board business. These changes are beginning to strengthen partner engagement, with chairs and vice-chairs now identified for all sub-groups.

119. The board's three priorities drive an ambitious, overarching three-year strategic plan for 2015–18. This plan is drawn from an analysis of performance information and frontline practice, and is informed by learning from audits, surveys and children's views. The board's business plan sets clear actions to deliver the priorities, including a wide range of methods to evaluate the effectiveness of frontline practice. It focuses appropriately on the need to ensure robust safeguarding practice, and is particularly focused on vulnerable children, including those who have disability, those who are missing, and those at risk of sexual exploitation.

120. A large-scale survey carried out by the board in 2015 resulted in almost 2,500 children's views informing the board's strategic priorities. Children's participation is becoming increasingly visible throughout the board's work. The board commissions the youth advisory board to carry out development work, including a children's and young person's version of the board's annual report and strategic plan. This is a solid foundation, and children's views are beginning to inform developments. For example, the delivery of the whole-schools approach, recently implemented by the board to encourage a more consistent approach to raising awareness of healthy relationships, is a priority that was identified by children.

121. The chair attends the HWB to present the WSCB Annual Report and meets with the Chair of the HWB separately, twice a year, to discuss strategic priorities and crosscutting issues. There is also a protocol in place between the HWB, WSCB and the Worcestershire Safeguarding Adults Board (WSAB), soon to include the Safer Communities Board. The chair, by being a member of the local authority improvement board and having regular meetings with the lead member, chief executive and the DCS, provides a firm basis for effective governance and accountability of the board.

122. The review of the annual report at the children and families overview and scrutiny panel provides further assurance. There is an absence of structured governance arrangements between the WSCB and the corporate parenting board. This reduces the board's assurance of the effectiveness of practice to safeguard children looked after. Neither is there a formal arrangement to ensure an interface with the local family justice board. (Recommendation)

123. Schools' engagement with the board has been strengthened to include representation from all schools, although this does not yet include academies. Local authority education services' representation is lacking at a number of critical sub-groups. This results in gaps in information, and these weaken the board's understanding of the effectiveness of operational partnership working. (Recommendation)

124. The board developed an ambitious action plan against child sexual exploitation in 2015, driven by the strategic and operational sub-groups, to counter child sexual exploitation. These sub-groups have experienced multiple changes and inconsistency in membership, particularly on the part of the police and children's services, which have hampered the progression of the action plan. As a result, delivery of some key actions has been too slow. More recently, the sub-group has reinvigorated the action plan by making actions more realistic and deliverable, although the board is not yet assured that practice has improved.

125. The sub-groups to counter child sexual exploitation have maintained oversight of some effective work across the partnership, to identify, understand and respond to children who are missing and at risk of sexual exploitation. The operational group has a comprehensive multi-agency dataset. However, there is an absence of consistent data on children who are open to ongoing statutory service intervention. The board has been rigorous in seeking to have oversight of frontline practice with missing children and children at risk of sexual exploitation, highlighting deficits in the response to missing children effectively through its audit activity. The change from the child sexual exploitation panel, which was originally set up to review individual cases, to the operational child sexual exploitation and missing group in 2015, means that the board does not have consistent oversight of the effectiveness of multi-agency responses to children who are receiving ongoing statutory intervention and who are at risk of sexual exploitation. (Recommendation)

126. The board has monitored progress of the delivery of the early help offer, identifying this as one of its core priorities. As well as reviewing performance information about the take-up of early help across the area, the board has undertaken its own multi-agency case file audit (MACFA) to examine the effectiveness of provision. The delivery of early help by the wider partnership is not well understood. Partners have identified concerns regarding planned reductions in early help under the local authority's new 0 to 19 early help strategy, and have identified a lack of coherent understanding about early help pathways. The board has sought clarity regarding the governance arrangements for early help under these new arrangements, meeting its statutory responsibilities.

127. The board relaunched the revised levels of need guidance in July 2016, to coincide with the implementation of the 'family front door.' The 'improving frontline practice' sub-group has overseen the development of the revised levels of need guidance, alongside other policies and procedures, managed through a joint arrangement with three other LSCBs. The levels of need guidance has been widely disseminated, and the board has facilitated awareness raising events for over 400 professionals. The guidance does not provide sufficient detail about early help pathways. The board is reviewing the levels of need guidance, and the WSCB practitioner network is piloting a level of need survey in preparation for an audit of thresholds planned for January 2017.

128. The performance analysis activity group rigorously scrutinises multi-agency performance information and reports quarterly to the monitoring effectiveness sub-group. A comprehensive multi-agency performance dashboard supports the board to scrutinise the effectiveness of safeguarding services. This includes oversight of children held in police custody overnight, performance information on CAMHS' assessment and treatment timescales, as well as a wide range of other performance information. The dashboard would be strengthened by the inclusion of designated officer investigation outcomes and investigation timescales, although the board does receive the designated officer annual report. Information about children missing education and those electively home educated would provide further important data to strengthen the dashboard further. The board has taken robust action to obtain this data, escalating its concerns when the data was not initially forthcoming, and has very recently received the required data and analysis.

129. The board is robust in holding agencies to account, evidenced through its challenge log. However, due to a delay in the local authority providing data on private fostering, the board was unable to include information about private fostering in its annual report. This data was subsequently received from the local authority.

130. The board monitors performance information about children looked after, including children from other local authority areas and placed in Worcestershire, for whom there are concerns regarding 'missing' episodes or sexual exploitation. The work stream for children who have disabilities has recently

mapped additional work to assure the board that this group of children is effectively safeguarded. Despite this productive work, there has been no analysis of performance information about the number of children who have disabilities and who are on child protection plans. A recent mapping exercise identified this shortfall, and work is underway to obtain this data.

131. The board ensures oversight of frontline practice through MACFAs, safeguarding conversations and scrutiny of performance information. The board has not sought assurance from partners regarding single-agency audit activity, but has recently taken action to resolve this shortfall.

132. Assurance and audit are appropriately driven by evaluation and intelligence gathered from a range of activities. MACFAs provide rich information about children's experiences and have effectively highlighted critical issues, but only consider a small cohort of cases. The quality assurance group has successfully engaged general practitioners (GPs) in the audit process. Although there has been consistency of engagement by the police, consistency of police personnel attending the group has not yet been realised. However, MACFAs and other audit activity do not always identify clear findings, instead focusing on broad themes, having moved away from audit activity that historically made too many recommendations. Although MACFAs provide a rich source of information, the lack of conclusive findings and recommendations leaves the board without an effective baseline from which to evaluate practice improvements or to measure impact. (Recommendation)

133. The practitioner network and use of multi-agency safeguarding conversations enhance the board's line of sight of frontline practice. The board runs four safeguarding conversations per year, each of which involves an in-depth review of a child's situation with the allocated practitioners and provides the board with first-hand evidence of the quality of practice across the partnership. The learning from safeguarding conversations, MACFAs, SCRs and child deaths is summarised into concise, informative, annual overview reports and learning and improvement briefings. Although the board has appropriately sought assurance from partners that learning briefings are disseminated across the children's workforce, it is not yet able to evidence that the learning leads to changes in practice or improved services to children and families.

134. Partner agencies are required to undertake biennial section 11 self-assessment audits, to give assurance to the board regarding the effectiveness of arrangements to safeguard children. At the time of the review, two agencies' returns were overdue. Follow-up action was already in hand to ensure submission. Effective mechanisms for quality assurance of the section 11 process are in place, including work underway to 'dip sample' a selection of audits returned by partner agencies in 2016, to test compliance.

135. The SCR sub-group has an effective process to review cases of concern. A number of cases referred to the SCR sub-group over the past year did not meet the SCR criteria. The sub-group has taken action to respond to this, introducing

guidance and protocols to ensure a more robust approach to referring cases for consideration.

136. No SCRs have been initiated in the past two years. Opportunities for learning from multi-agency practice lead to appropriate reviews, and one such review is currently in progress. The last SCR, published in 2015, was widely circulated to staff across the partnership, and the learning informed the development of multi-agency training. The board has sought assurance that learning has been disseminated by agencies, but cannot demonstrate how learning has resulted in practice improvements. The monitoring of single-agency action plans in respect of this review has not been sufficiently rigorous. (Recommendation)

137. The child death overview panel (CDOP) is effective. Learning is cascaded through learning and improvement briefings through the CDOP annual report and through presentations to the WSCB and the HWB. The child death overview sub-group has been instrumental in driving wider developments, including the roll out of a West Mercia-wide 'Safer sleeping' programme, initiated by the WSCB and CDOP.

138. The 'improving frontline' practice group oversees the delivery of training and learning effectively. The multi-agency safeguarding training strategy 2014–17 and the learning and improvement framework support the board to monitor and evaluate the effectiveness of multi-agency training. By the end of September 2016, 740 participants had attended WSCB multi-agency training events. An up-to-date training needs analysis informs training provision, and the board monitors training take up.

139. The board takes a robust approach to evaluating training. A comprehensive training evaluation, reported in May 2016, identifies that attendees rate WSCB multi-agency training highly, and that their knowledge and confidence improve as a result. The board is less able to evidence how training impacts on practice or outcomes for children and it recognises that there is further work needed to strengthen evaluation in this respect. A training and workforce audit is in progress, to enable the board to establish whether single-agency training is effective, and a learning and challenge event is planned for November 2016 to test agency compliance.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

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