Report of the Non-Executive Commissioner for Children's Services

Worcestershire County Council

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Introduction

1.1 The Ofsted inspection of Worcestershire County Council's (WCC) services for children in need of help and protection, children looked after and care leavers, carried out between 24 October and 17 November 2016, found its services to be "inadequate." Following consideration of the report, published on 24 January 2017, the Secretary of State judged that the Council is failing to perform to an adequate standard, some or all of the functions to which section 497A of the Education Act 1996 is applied by section 50 of the Children Act 2004 (children's social care functions). I was appointed Commissioner for Children's Services in Worcestershire on 10 March 2017. The Statutory Direction and Terms of Reference are shown as an addendum to this report. My approach, as agreed with WCC and the Department for Education (DfE) at the set up meeting on 16 March 2017 has been to use experienced managers and practitioners from Cornwall Council to assist me in analysis of practice and service effectiveness in safeguarding children. My review period coincided with an Ofsted monitoring visit (23 and 24 May 2017) and though, at the time of writing, the letter to the Council summarising findings has not been published, I attended the meeting where the lead inspector provided initial feedback to the Council.

Methodology

2.1 My review covered three principle issues:

- Are children still being left at risk of harm as a result of ongoing poor practice and lack of management oversight?
- Is there any evidence that remedial action taken to date and being undertaken is having or is likely to have the intended impact on the quality of safeguarding practice and effectiveness of services to help and protect children?
- Is there clear evidence of the capacity and capability required to bring about the necessary improvements and compelling reasons for not taking children's social care out of the control of WCC for a period of time in order to bring about the necessary improvements?

2.2 During the review period I conducted interviews with senior elected members, senior officers of the Council and partner organisations. I formed a review team of 10 senior managers responsible for children's social care (including 5 responsible for safeguarding), 3 middle managers and 2 practitioners from a voluntary organisation working with children in care and care leavers, one of whom is a former child in care. The review team was led by Jack Cordery (Service Director Children & Family Services) who contributed to the work of the Social Work Reform Group and the Munro Review of Child Protection. He was a member of the Children and Family Faculty of the College of Social Work and a senior sector representative on the development of the Ofsted Single Inspection Framework. The members of my review

team were informed by the documents, information and data provided by WCC. They also accessed the WCC and Local Safeguarding Children's Board (LSCB) websites and reviewed case records. Fourteen members of the review team visited WCC children's services in small groups between 28 March and 7 April 2017.

2.3 During their visits, my review team undertook the following enquiries

- Tracked contacts and referrals
- Observed practice
- Reviewed and audited cases
- Reviewed practitioner supervision records
- Met with service users
- Interviewed individual practitioners, managers and partners
- Interviewed business support, information system and performance data officers
- Held focus group discussions with practitioners, managers and partners
- Reviewed management responses to cases referred back due to concerns about the welfare and safety of children
- Reviewed the new performance dashboards

2.4 In addition to a considerable number of interviews conducted with WCC members, senior officers and partners, I have liaised with the independent chair of the WCC Improvement Board, the lead inspector for the Ofsted inspection undertaken in October/November 2016 and the senior Ofsted Her Majesty's Inspector (HMI) for the region in order to seek their views on the progress and capacity of the Council to improve.

2.5 I provided telephone feedback to the Council Chief Executive and the Director of Children's Services (DCS) following the visits of my review team and a more formal feedback presentation of initial findings to senior members and officers of WCC on 19 May 2017. DfE officials also attended the presentation meeting.

Practice and management oversight

3.1 There are some committed and skilled practitioners some of whom are achieving good practice standards and outcomes for children. However the system in which they are working remains seriously flawed and I have not found evidence that that the improvement plan is delivering any improvement in overall practice or contributing towards increased protection for vulnerable children. I have not included in this report all the findings of my review team about the quality of safeguarding practice they found but will concentrate on key areas that are core to the system and also reflect the overall performance of the system in helping and protecting children.

3.2 The Family Front Door is the gateway to services. It is not a safe system. In my view, the consideration of contacts and referrals is not fully compliant with Working

Together (2015). Decisions are not made within 24 hours and there is a lack of management oversight of key safeguarding decisions. Thresholds are not properly understood and applied consistently. The organisation of the 4 assessment teams leads to work backlogs and excessive caseloads. This means that vulnerable children who may be at risk of harm do not always receive adequate and timely assessment of their needs or receive the appropriate help and protection. The case transfer processes are complex and unclear and contribute further to delay and a risk of assumptions that another worker is doing something when they are not. This potentially leaves children at increased risk of harm.

3.3 The system and process for accessing early help is through a variety of channels which leads to a lack of coherence and consistency in decision making, including targeting help to the children and families most in need. The review team was told the early help hub was "subsumed" into the Family Front Door in 2016 but there is a lack of clarity in the Family Front Door as to what constitutes the early help offer. Early help is not properly recognised nor valued as a service that can make a significant contribution to safeguarding children, prior to, or at the same time, or following social care intervention. Early help provision is not routinely accessed as part of plans for children open to social care. This represents a systemic failure to safeguard children.

3.4 Looked after children aged 16/17 who are settled and in foster care are allocated social workers but some care leavers aged 16/17 living in the community who are, therefore, likely to be the most vulnerable and most at risk do not have an allocated social worker. Visits to care leavers were variable and not in line with statutory timescales or guidance. Some vulnerable young people had not been visited for lengthy periods of time. This means that the current risks are not known, understood or mitigated.

3.5 There is evidence of supervision and management oversight but this is variable. The effectiveness and impact of the current approach, including the introduction of performance dashboards, is not evident in terms of improving the quality of practice and outcomes for children. Delays in seeing vulnerable children are not always identified and supervision is generally process based, managerial instruction rather than reflective consideration of safe practice focusing on outcomes for children.

3.6 Service dashboards, introduced in March 2017, are well designed and a useful management tool providing 'live' performance information on a service, team and individual level in relation to some aspects of performance and safe practice. The dashboards are welcomed by managers who see them as a useful tool in improving grip and oversight. The dashboards are not yet having a positive impact

on practice but have the potential to play a part in addressing shortfalls if incorporated into a more coherent overall improvement journey.

3.7 A “Back to Basics” intranet tool has also been recently introduced. This is another potentially useful tool but is primarily an operating procedure and not an overall statement or guide for practice quality standards for areas of practice such as assessments, child protection enquiries or plans. There is no clear indication of what Good looks like for practitioners and managers and it is hard to therefore understand the criteria being used for rating the quality of work through case audit other than the opinion of individual managers/practice supervisors. Back to Basics has the potential to be an effective guidance document but needs to be underpinned by a commonly understood unifying theoretical model supporting by appropriate approaches and interventions.

3.8 The integrated children’s system, (Framework) has not been used to its full potential by management to identify shortfalls in the quality of practice and performance through exception reporting. As a result managers do not have an adequate line of sight or grip on the quality of practice or individual team performance in a way that enables them to identify and correct shortfalls in practice that can impact negatively on the welfare and safety of a child. Case audits have consistently identified delays in decision making and getting work started and finished. It is unclear, however, how the learning from case audits is helping raise the quality of practice, inform professional development and improve the effectiveness of services and outcomes for children.

3.9 Quality assurance and performance management is not yet effective because there are no practice quality standards for practitioners to work to and, therefore, no common understanding of what Good looks like. If deficits are found in the case audits there is not yet an established process for subsequent action to address such deficit.

3.10 During my review period, it has not been possible to look in depth at the Human Resources, Legal, Finance and IT support to Children’s services from the Council and a ‘deep dive’ into these support services and systems is important as a further piece of work. This was due to time constraints of my review period. I did conduct a series of 20 minute phone interviews with senior managers from the Council from these areas and they were keen to demonstrate further the Council’s commitment to Children Services.

3.11 No system was identified for ascertaining the wishes and feelings of children routinely as the basis for understanding their lived experience including ensuring children are seen in a timely way and alone. Case audits and conversations with

practitioners reinforced the impression that the focus is on parents and carers rather than individual children.

3.12 Poor social work practice is deep seated and despite notable individual examples of high quality work, many practitioners showed a lack of urgency and understanding as to the seriousness of shortfalls in safe practice. Whist some managers stated that they had not been surprised by the findings of the Ofsted inspection and were able to articulate the failings that had resulted in a rating of 'Inadequate'; they were less able to identify the impact of this on the outcomes for children and young people or show either a robust approach to rectify those shortfalls or a sense of urgency about correcting those shortfalls.

3.13 The Review Team identified a pervasive culture of lack of participation of children and young people and their parents throughout the service and particularly in relation to looked after children and care leavers. Senior leaders are not effectively communicating the importance of this or modelling how to place the child's lived experience at the centre of social work practice.

Leadership and governance

4.1 In November 2014, the WCC Chief Executive approached the Local Government Association (LGA) to conduct a Peer Review of children's safeguarding. The review took place in April 2015 following a £5 million recurrent investment in the service. The review raised serious concerns and resulted in an improvement plan overseen by an improvement board chaired by the Chief Executive.

4.2 Four priorities were highlighted by the Peer Review:

- 'back to basics' improvement plan
- fixing the front door
- detailed financial recovery plan
- reviewing and defining the role of Early Help

4.3 The Improvement Board began work in May 2015 with the formal Peer Review report being received in June 2015. Between that time and the Ofsted Inspection in November 2016, there was considerable senior management change including an interim DCS from August 2015 and a permanent DCS appointment in February 2016 who began her role in June 2016. A permanent Assistant Director of Safeguarding was appointed in June 2016 and began working in October 2016.

4.4 It is evident, and generally agreed by senior elected members, senior officers and partners, that the improvement work prior to November 2016 was ineffective. No senior appointments have resulted in overall improvement to vulnerable children and families in Worcestershire as yet. An Independent Chair for the Improvement Board, Nigel Richardson, a former DCS was appointed from 20 March 2017.

Revised terms of reference were agreed following the publication of the Ofsted report in January 2017. The primary aim of the Improvement Board is to ensure that the post Ofsted revised improvement plan is successfully delivered.

4.5 The revised Improvement Plan covers the key areas identified for improvement by Ofsted and is wide ranging and challenging but needs greater prioritisation. My recommendations that refer to the Improvement Plan are intended to assist in this prioritisation though I recognise many are already in the current plan. My concerns are that insufficient attention has been paid to the systemic failings and cultural issues that have led to inadequate safeguarding services over time. The cultural issues are deep seated and have resulted in many front line workers failing to recognise the need for change and/or being motivated to change.

4.6 Although there has been considerable activity and the Council is giving priority to improving children services both corporately and within the Children Families and Communities Directorate, including significant financial support, the changes being made focus mainly on process rather than deep seated systemic analysis which centres on the child's lived experience and the need for a unifying theoretical model based on outcomes and supported by evidence-based practice. Because this has not been fully understood, 'Back to Basics' concentrates on process rather than practice quality standards.

4.7 The nationally accepted work of Eileen Munro and Moira Gibb are the primary reference points for why this is essential. Because the analysis has not been systemic the improvement work by the Council has not been systematic. The activity has been largely piecemeal and disconnected. Whilst there has been considerable activity and commitment by senior officers and Members, this has not resulted in improvement in terms of the services being received by vulnerable children and their families. Whilst it would be optimistic to expect significant cultural change and operational improvement in the 6 months since the Council were made aware of Ofsted's findings, my concern is that there is no compelling evidence of "green shoots". There is considerable confidence expressed by senior partners and elected members in the DCS and the Assistant Director of Safeguarding but during my interviews I could not establish beyond this confidence why the Council was so optimistic this improvement plan would succeed when the previous one had failed.

Conclusions

5.1 The failings in WCC Children's Social Care Services are deep seated and complex and are continuing. These failings have clearly existed for some time, and appear to have become embedded in the thinking and behaviours throughout the whole service and are widespread. The view of the Council at a senior level and partner organisations at a senior level is that the fundamental building blocks

are in place for required improvement to succeed. This view is supported by the Independent Chair of the LSCB. My concern is that the findings of the review team demonstrate a lack of evidence to date that the improvement plan is delivering genuine benefits for children, young people and their families beyond process and structural change. The two primary examples of this are the inadequacy of the early help offer to target support to vulnerable children at an early stage and the dysfunction of the Family Front Door introduced in July 2016 which is clearly not working and is still leaving children at risk of harm. In Children's Services systems, if the "front door" is dysfunctional to this degree, its failings permeate the whole system.

5.2 In the presentation of my findings to the Leader, the Chief Executive and the DCS and other senior colleagues, it was clear that my analysis was not fully accepted and I am concerned that there is an over optimism around the improvement plan along with a reluctance to undertake a systemic analysis of the issues and a better prioritised series of actions aimed at addressing the deep-seated cultural problems. I fully understand and appreciate that this is not something that can be achieved quickly but I believe there is still a need to embed the building blocks of a new culture in order to be confident of sustainable improvement.

5.3 The current leadership and management arrangements from the Council are not in themselves sufficient to bring about the necessary improvement. Senior management needs to be strengthened not only to underpin the long term improvement plan but also because it is crucial that immediate steps are taken to better protect vulnerable children.

5.4 The terms of reference require me to recommend whether or not the evidence is sufficiently strong to suggest that long term sustainable improvement to children social care can be achieved should operational service control continue to remain with the Council. I cannot find compelling evidence at this stage why the Council should retain these services. This is not because of a lack of commitment at a senior political or senior officer level, it is because I have not been convinced that the analysis to date has been of the fundamental nature required and, therefore, the many initiatives are unlikely to be effective or show significant signs of being effective. The Council have not fully accepted my view during the review period.

5.5 For these reasons, I cannot support Children's Services remaining in Worcestershire County Council in their current format and an organisational form that is more likely to deliver whole system improvement is more likely to achieve the intended outcomes.

5.6 I am mindful that organisational change imposed on the Council and the considerable organisational development work required has the potential to detract from the immediate need to better protect children. A two track approach is essential in firstly adding additional senior expertise to deliver safer services and

then to work with the Council, if the Council is prepared to do so, to develop an alternative delivery model. I am aware the Council has engaged consultants to explore alternative delivery models and I have encouraged this but because the primary message from the Council is the wish to retain services and work on the improvement plan accordingly I have yet to explore such alternatives with them. The next stage for a Commissioner following this report should be to work on new models with an understanding that this is necessary and it is not appropriate to continue with the current arrangements.

5.7 It is a commonly held view arising from my interviews that the appointment of the permanent DCS (10 months) and the Assistant Director for Safeguarding (7 months), together with the Improvement Plan and the oversight of the Improvement Board will make the positive changes necessary in Worcestershire. However, in my view this will not be sufficient to bring about the necessary improvements. I have concluded that the Council should take immediate steps to commission external expertise to address the systemic widespread failings through a revised improvement programme. This expertise needs to include suitably skilled and qualified individuals to work alongside the existing leadership but with authority to require change.

Recommendations

6.1 The Council to commission external expertise to work with the Local Authority (LA), partners and schools to develop long term improvement and address systemic and widespread failings through a revised improvement plan. This process to be quality assured by the Children's Commissioner;

6.2. The Council should work with the commissioner and Department for Education to develop an alternative model of delivery for children's services involving external expertise as necessary;

6.3 The Council and partners make provision to resource the improvement journey and the development of the alternative delivery model;

6.4 The Council's support services prioritise the development of an alternative delivery model and the successful implementation of the revised improvement plan; and

6.5 Develop a revised Improvement Plan to prioritise the following:

a. Implement the recommendations of the Munro Review

b. Set out a statement of mission and values – aimed at re-culturing the service with a focus on the child's lived experience

c. Establish a unified theoretical model for children's social care

d. Adopt and develop evidence-based interventions in line with the model

e. Set out practice quality standards for key areas of practice

f. Establish a core curriculum to support practitioners

g. Improve the quality and effectiveness of professional and case supervision

h. Put in place a framework for Quality Assurance and Performance Management that is forensic and relentless in its focus on core safeguarding practice

i. Immediately reconfigure the Family Front Door – to promote case ownership and partnership working

j. Review and reconfigure the Early Help offer

k. Implement the recommendations of the Social Work Reform Board – establishing a career and qualification pathway for all social care practitioners

l. Consider the development of multi-disciplinary social care teams – including case holding social care practitioners who do not possess a social work qualification

m. Establish a participation unit to encourage the involvement of children and young people in the design and delivery of services – re-inforce a culture of respect and participation

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