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Dear Amanda

Focused visit to York local authority children's services

This letter summarises the findings of a focused visit to York local authority children's services on 17 July 2019. The inspectors were Peter McEntee, Her Majesty's Inspector, and Neil Penswick, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for children in need of help and protection.

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

Overview

There has been a deterioration in the quality of services for children in need of help and protection since the last inspection of children's services in 2016.

Recently appointed senior managers understand the extent of the deterioration and have begun to put in place policies and processes to both measure the extent of the impact of poorer practice and turn this around. A trajectory for change has been established. However, some children continue to be exposed to risk, as this change is too recent to have had an impact.

There has been drift and delay in the progression of plans for some children. This has been exacerbated by staff turnover, which has resulted in children having too many changes of social worker and a consequent loss of focus on what needs to be done. Work in some cases has lost its way, with children remaining on a plan longer

than necessary and risks not being addressed effectively. Oversight and challenge by frontline managers and independent reviewing officers (IRO) are not effective in tackling drift or improving the quality of social work practice.

Children in need meetings and initial and review child protection conferences are being held on a timely basis, with broad multi-agency involvement. A wide range of support services are being offered to families to meet their needs. Where there is greater social worker stability and clearly articulated plans, more effective work is being achieved to reduce risk to children and meet their needs.

What needs to improve in this area of social work practice

- The quality of supervision offered to staff and the effectiveness of management oversight, including that of IROs, to identify delay and ensure timely progression of plans through supportive challenge.

- The quality of children in need and child protection plans to ensure that they focus on children's needs, make clear expectations on parents and carers that reduces risk, are written in a way that can be easily understood, and include a contingency plan should progress not be made.

- Ensure that visits to children and families are purposeful and are recorded in a way that is relevant to the plan and includes the child's voice.

- Implement an effective quality assurance framework that focuses on the experiences of children and leads to an increased understanding of, and improvement in, the quality of frontline practice.

- A reduction in the number of changes of social worker that some children are experiencing.

Findings

- Recently appointed senior managers have taken steps to ensure that they have an accurate understanding of the quality of social work practice and the action needed to begin to improve services for children and families in York. A recently updated self-assessment provides an honest appraisal and accurately reflects the shortfalls identified at this visit. The outcome of a recently commissioned peer review has provided a helpful focus on the areas for improvement. An improvement board has been established to monitor implementation of the appropriately focused improvement plan. It is too soon to see the impact of this in children's cases.

- Senior leaders have commissioned an independent review of all children in need and child protection cases. They have recognised that a strong culture of quality assurance and performance management has been absent in the authority for some time and are now taking steps to establish a more robust quality assurance

framework. They understand that more work needs to be done to enhance social workers' and team managers' understanding of what good practice looks like and to embed a challenge and learning culture. Political support is demonstrated by recent further investment in the service, including agreement for the recruitment of additional qualified staff over establishment.

- There is drift and delay in the progression of both children in need and child protection plans for some children. Too many children have had too many changes of social worker, and this has resulted in a loss of focus on what needs to happen to make children's lives better. Some children have been on plans for too long, some for several years, demonstrating a lack of progress and effective management oversight.

- A practice of allocating children in need cases to unqualified staff (children in need practitioners) has meant that these staff have been asked to work with, and take responsibility for, complex cases and, sometimes, inappropriate levels of risk. This has contributed to drift and delay in some cases. New senior managers have recognised that this practice is unacceptable and have already taken steps to begin to re-allocate this work to social workers. Newly qualified social work staff have also been expected to carry too much responsibility too early on in their development, including being given sole responsibility for child protection cases. The authority is seeking to stabilise the current high rate of turnover of staff through active recruitment and revised support for newly qualified staff, including the types of cases they hold.

- Case management oversight and supervision of staff are insufficiently robust. Managers are not identifying and tackling drift and delay and their direction on cases is not leading to improved quality of practice and outcomes for children. Supervision is often a descriptive update and does not offer reflection about progress or focus on areas of learning. IROs in most cases are not ensuring that work is progressed in conferences and reviews, nor are they escalating concerns where case resolution is needed. The authority has recognised that more needs to be done to ensure that there is a meaningful escalation of concerns. It has initiated training for IROs and managers, but it is too soon to see an impact.

- Child in need plans and child protection plans are not sufficiently focused on the child, their needs and outcomes to be achieved. There is too much focus on the parent and what they must do, and this is not linked to children's needs and what must improve. For many parents, this means it is harder to make the link between their own actions and risk to the child, and this confusion is a contributor to delays in resolving risk. Plans are not written clearly enough and are not clear about what needs to change and how. Language used is inappropriately complex and often vague. Contingency plans are often missing or, where they are present, are not clear enough about what will happen if things do not improve.

- Children in need meetings and child protection conferences and reviews are timely. They are well attended by other agencies and there is a good level of

engagement by partners. A wide range of support services are being offered to families. Where there is greater social worker stability and outcome-focused plans, more effective work is being done to reduce risk to children and meet their needs. Effective edge-of-care work is undertaken in some cases, which has kept children with their families through intensive direct work with young people.

- Use of the public law outline process has recently been strengthened through the introduction of a new fortnightly legal gateway process that helps to ensure that cases are tracked more effectively. However, letters before proceedings do not sufficiently detail the impact of parents' actions on children, which limits parents' understanding of their responsibilities.

- Case chronologies are not always available and, when they are available, they do not always contain appropriate information. The authority has acted to ensure that these are now completed and updated during the assessment process and has initiated training for social workers on their purpose and value.

- Visits to children and families are, in most cases, regular and often more frequent than the statutory requirement. However, visits are not always focused on progressing the child's plan. More long-standing social workers know children well but recording of work is not consistently capturing the voice of the child. Where there have been several changes of social worker, this has impacted on the relationship with some children, who are understandably more reluctant to engage with staff.

- Social workers in the children with a disability team demonstrate a good knowledge of and focus on needs arising out of disability. However, they have less experience of child protection work, as previously this work has been undertaken by social workers in the safeguarding teams. The authority plans to move the oversight of this work to the children with a disability team but has not yet ensured that these staff have all the skills to manage risk.

- The authority recognises that quality assurance processes have not been sufficiently robust. As a result, a new performance framework has recently been put in place. However, audit activity to establish the quality of practice in individual cases and provide learning for staff is not robust enough to give the authority a full picture of the strengths and weaknesses of practice. Audit judgements and template completion is not consistent or compliant with the authority's own grading policy and does not always identify key issues in cases, lessening the value of the audit. Assurance activity is overly focused on compliance processes and is less effective at looking at the quality of practice. Auditors are too optimistic and, in some cases, there has been little difference made to children's experiences following audit.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

This letter will be shared with the Department for Education.

Yours sincerely

Peter McEntee
Her Majesty's Inspector