Warwickshire

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: 2 May to 25 May 2017

Report published: 14 July 2017

Children's services in Warwickshire require improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

[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

Since the last full inspection of services for children in need of safeguarding and those in the care of Warwickshire, some areas of provision have not been sustained or made further progress. As a result, most services now require improvement to be good.

Greater stability in the senior management team in the past 18 months has enabled some progress to be made. Senior managers and political leaders are committed to making further improvements. They recognise that more work needs to be done to ensure that practice is consistently good across the service.

While early support and prevention are identified as priorities and there is an early help offer to families in place, the local authority cannot be assured that it is helping all families and children who need early help at the right time. Not all partners understand or are engaged in early help: the authority and the Local Safeguarding Children Board (LSCB) have not yet ensured appropriate engagement from all partners.

An effective multi-agency safeguarding hub (MASH) is in place that ensures that there is a single front door for referrals. Almost all partners have engaged well with the MASH, although work remains to be done to ensure full engagement from health. Thresholds for cases to be stepped up from early help or stepped down are not always consistently applied.

Some young people remain in police custody longer than they should, and further work is required by the authority and its partners to ensure that this incidence is reduced.

Risk is identified and children are kept safe across all services in almost all circumstances. While assessments of need are often of good quality, plans to tackle needs are less clear and sometimes overly optimistic about parental capacity to change, leading to slow progress in achieving better outcomes.

Some staff, including social workers and independent reviewing officers (IROs), have too much work. This, together with slow implementation of a new computer information system, has meant some delays in gathering information and ensuring that plans and decisions are updated quickly. Consequently, some children experience delay and make slower progress.

Designated officer arrangements for the management of allegations against professionals are insufficiently robust, and, as a result, interventions have not always been timely. This area of weakness was not sufficiently recognised by the authority until this inspection and, if left unchallenged, could have resulted in some children remaining in unassessed, risky situations.

Managers make the right decisions to accommodate children. Social workers know their children well and visit them regularly. In some teams, high caseloads make managing work more difficult. High caseloads for dual-role child protection

chairs/IROs make challenges to poor work more reactive, and, as a result, less effective in ensuring good outcomes that are timely. Some young people have had too many placements in a short time, and the local authority has not yet ensured a sufficient range of placement options to tackle this. In some cases, children's mental health needs are not being met sufficiently because of a lack of timely access to mental health services.

When children are at risk of sexual exploitation, the response is effective and well-coordinated by partners. Risk assessments are detailed and thorough. Through increased investment, the local authority has ensured that there is effective engagement through timely return home interviews with children who go missing from home or care. Work on child sexual abuse activity is child focused, and has led to a number of successful prosecutions and disruption activity in key hotspot areas.

When children are in the local authority's care, managers give early consideration to permanent living arrangements for most children. Children are matched well to permanent placements, and brothers and sisters are almost always placed together when this is in their best interests. Adoption is considered at an early stage for all children who may benefit from this. The local authority has worked effectively to make sure that the time between a child entering care and moving in with their adoptive family is quicker than the national average. Adopters feel well supported, and training prepares them well for the challenge of becoming an adoptive parent.

More needs to be done to ensure that all care leavers are appropriately prepared for independence. While many care leavers are in education, employment or training, there has been a rise in young people not actively engaged. The authority needs to do more to ensure that young people leaving care have greater access to employment opportunities and apprenticeships.

There is an active and engaged children in care council (CiCC), but the corporate parenting panel needs to do more to demonstrate challenge and influence in improving services. While there are good examples of children being heard and listened to, case recording does not always reflect the voice of the child well.

A move to a new information system has not been implemented with sufficient pace. Consequently, the local authority struggles at times to ensure that all its data is accurate without considerable validation work. The authority cannot be sure that it has a clear understanding of current progress in all areas of service and therefore of what needs to improve.

The local authority has a quality assurance programme that includes case auditing, but this is not consistently leading to learning and improved practice.

The local authority has worked to increase staff stability through a range of recruitment and retention initiatives and has been successful in reducing its use of agency staff.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The previous inspection of the local authority's safeguarding arrangements was in October 2011. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in October 2011. The local authority was judged to be good.

Local leadership

- The interim director of children's services (DCS) has been in post since 5 January 2015.
- The DCS is also responsible for adult services.
- The joint managing directors at chief executive level have been in post since 6 February 2017.
- The chair of the LSCB has been in post since 22 May 2014.

Children living in this area

- Approximately 112,262 children and young people under the age of 18 live in Warwickshire. This is 20% of the total population of the area.
- Approximately 13.0% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 8.8% (the national average is 14.5%)
  - in secondary schools is 7.2% (the national average is 13.2%).
- Children and young people from minority ethnic groups account for 14% of all children living in the area, compared with 26% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Indian and Other White.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 9.8% (the national average is 20.1%)
  - in secondary schools is 6.9% (the national average is 15.7%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At 31 March 2017, 3,318 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 3,195 at 31 March 2016.
- At 31 March 2017, 443 children and young people were the subject of a child protection plan. This is a reduction from 473 at 31 March 2016.
- At 31 March 2017, seven children lived in a privately arranged fostering placement. This is a reduction from 10 at 31 March 2016.
- Since the last inspection, eight serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2017, 699 children were being looked after by the local authority (a rate of 62 per 10,000 children). This is a reduction from 765 (68.1 per 10,000 children) at 31 March 2016. Of this number:
  - 282 (or 40.3%) live outside the local authority area
  - 19 live in residential children's homes, of whom 94.7% live out of the authority area
  - 10 live in residential special schools[3], of whom 80% live out of the authority area
  - 527 live with foster families, of whom 35.3% live out of the authority area
  - 52 live with parents, of whom 17.3% live out of the authority area
  - 78 are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there were 64 adoptions
  - 26 children became the subject of special guardianship orders (SGOs)
  - 325 children ceased to be looked after, of whom 2.8% subsequently returned to be looked after
  - 72 young people ceased to be looked after and moved on to independent living
  - no care leavers were living in houses of multiple occupation.

[3] These are residential special schools that look after children for 295 days or less per year.

Recommendations

1. Ensure that all children and families have access to good-quality early help services as soon as they need them and that the early help strategy is fully understood and delivered in partnership with all agencies.

2. Ensure that the workloads of social workers, including newly qualified staff, and IROs are reduced in line with the authority's stated aims to enable them to provide consistently high-quality services to children.

3. Accelerate plans to fully integrate the electronic recording system so that accurate data can be produced and used effectively by all staff to measure and improve practice.

4. Ensure that there are a sufficient number and range of good-quality placements to provide stable and well-matched homes for children looked after.

5. Ensure that appropriate work is undertaken with the police and Warwickshire Youth justice service to reduce the incidence of overnight stays in police custody for young people.

6. Review and revise arrangements to ensure that care leavers gain appropriate practical skills, including budgeting, before they leave care.

7. Ensure that pathway plans are effective to support and challenge young people to achieve better outcomes.

8. Consistently evidence the child's voice on the child's case record to ensure that their wishes and feelings about life at home are clearly recorded and understood and that, when appropriate, advocacy is made available to ensure that young people's views are heard.

9. Prioritise plans to reduce the length of time children looked after have to wait to receive support for their emotional well-being and mental health.

10. Strengthen assessment, planning and support when children looked after return to their birth parents and wider family settings.

11. Ensure that the corporate parenting panel offers sufficient scrutiny of services and challenge in partnership with young people to improve services.

12. Ensure that regular meetings between the agency decision-maker and the panel chair are embedded in practice to support accountability and discussions about the quality of the service.

Summary for children and young people

- When children and families have problems at home, almost all get help, but some families do not get the help they need at the right time.
- Social workers, police and teachers talk to each other so that they can make sure that they know what help children need to keep them safe. If a child has a social worker, the child will be seen regularly and spoken to about how they feel. Plans for children are not always clear about what needs to change and by when, and what will happen if things do not improve. Children do not always have their wishes listened to as part of making the plan. Social workers know this needs to improve.
- When children are unsafe, social workers and police work hard to make children safe and get them the support they need. They also use other people, such as teachers and nurses, to help them. Managers make sure that everyone understands about children being at risk of sexual exploitation and why it is important to work together to keep children safe.
- Sometimes children cannot stay with their families. Social workers help to find good homes with other adults, such as foster carers. Social workers will continue to help families and will try to make sure that children can go home if it is safe to do so. If they cannot go home, social workers will try to make sure that children stay with their brothers and sisters and see their parents.
- Social workers make sure that children who need permanent new families get them quickly. Children are helped to understand why they are not living with their parents through detailed stories and pictures about their lives.
- There is a very good CiCC, which represents all children in care and care leavers. These young people tell adults who make decisions about what needs to change to make things better for them. Young people are working with managers, social workers and IROs to make meetings better and to make sure that children's wishes are heard.
- Young people who have left care do not always get the support they need at the right time. Although most young people are in suitable accommodation, some have not been given the help to learn to live on their own.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Children who need help and protection in Warwickshire receive services that keep them safe. However, services are not yet sufficiently effective, consistent or coordinated to ensure that outcomes are improved and sustained. Social workers build purposeful relationships with children and families, but the quality of case recording is inconsistent, and many records do not always reflect the efforts made to engage parents or seek the views of children about their day-to-day experiences.

Partner agencies do not yet fully understand or engage in the early help offer. While some partners are completing early help single assessments, the overall quality and timeliness of the assessments are variable, often lacking detail, analysis and the voice of the child. There is a significant shortfall of early help single assessments from health partners. The early help offer is not yet providing a consistent approach to supporting vulnerable families to prevent escalation to statutory services.

Demand at the front door is high and the MASH has engaged most partners effectively to ensure that systems and processes are in place to manage all new contacts and referrals. These arrangements are still becoming established and do not always result in timely and consistent application of thresholds. This is particularly so for cases that are stepped up and down across the spectrum of early help and statutory services.

Social work assessments are of good quality. Despite the limitations of a recently implemented case-recording system and high caseloads in some service areas, assessments show effective social work practice that is often analytical and focused on risks, strengths and protective factors in families. However, plans can sometimes be too vague, lacking in contingency arrangements and overly optimistic about parental capacity to change in the light of longstanding historical concerns.

Initial child protection conferences are not always timely, although effective arrangements are in place to ensure that children's needs are met prior to a multi-agency conference. Designated officer arrangements for responding to and overseeing the management of allegations against professionals are insufficiently robust and require greater management oversight. The response to child sexual exploitation is robust and effective, and is leading to improved outcomes for children. Return home interviews are undertaken more effectively because of a strengthened service that ensures timely information sharing and engagement with children.

Inspection findings

13. The local authority has an established early help offer but not all partners have a sufficient understanding of their role in preventative early help services. Although the local authority has processes to monitor the quality and progress of early help single assessments, oversight by the early help officers based in the MASH is not yet sufficiently rigorous to ensure improvement in all cases. Early help assessments completed by partner agencies are not always promptly completed or sufficiently focused on children's needs. This means that some children and families are not receiving the right help at the right time. (Recommendation)

14. Local authority family support workers offer more intensive early help support when designated as lead professional in more complex early help cases. This has ensured better-quality assessments, underpinned by direct work with children and families. Plans for intervention are well targeted and clearly linked to attainable outcomes.

15. Children and families have access to a range of universal and targeted early help provision from children's centres, Targeted Youth Support and family/parenting support services. A recognised parenting programme provides a major focus of work with families, and a range of staff across partner agencies are trained to deliver the programme. Family group conferences help identify additional support from extended family members for some children in need. Locality panels are in place to scrutinise early help support when cases are 'stuck', due to lack of engagement by families, and this helps to ensure further progress in these cases.

16. The MASH has been in place for 12 months and provides an effective front-door response to referrals and requests for advice. When there is an immediate presenting risk, children are kept safe and progressed promptly to children's social care teams for a single assessment. When parental consent is required, consistent efforts are made in most cases to secure this, and managers understand when it is appropriate to dispense with consent in the interests of children's safety. Feedback is provided to referrers in the majority of cases. There is a robust triage system that provides effective decision-making when professionals and members of the public contact the MASH with concerns about children's welfare.

17. Most agencies have responded positively to the creation of the MASH. Consequently, the availability of information and consultation from other professionals at the point of referral are effective. However, the absence of a health representative in the MASH is unresolved, despite consistent attempts to progress this issue by the authority, making it difficult to ensure that children's health needs and history inform timely decision-making at the front door.

18. Thresholds are understood by partners at the point of referral, and immediate risk is identified and responded to effectively by staff within the MASH. However, thresholds are not always consistently applied when cases need to step up to statutory services or step down to early help, following work at a statutory level. As a result, some cases are not responded to at the right level of service in a timely way.

19. Domestic abuse is appropriately risk assessed and triaged in the MASH to ensure that support is offered to children and families at the right point of service. Partner agencies have worked together closely so that domestic abuse notifications are progressed through to children's locality teams or early help in a timely manner. The identification of support to victims depending on need is via police domestic abuse risk officers, independent domestic violence advocates, the Safer Neighbourhood Team and a commissioned provider. However, there is a limited range of interventions and tools to address the impact of domestic abuse on children and minimal access to perpetrator programmes.

20. The out-of-hours social work support is effective and responsive and provides a good interface with daytime services, offering appropriate advice and guidance to professionals and members of the public. The service has access to four dedicated foster carer placements. However, some young people are remaining in police custody overnight inappropriately. (Recommendation)

21. Most strategy discussions are held in a timely and effective way and provide a thorough consideration of risk. Decisions are recorded clearly, together with actions that reflect good coordination between partners. Most strategy meetings are held in the MASH with a range of partners. However, when meetings are held by locality teams, these are not always attended by appropriate agencies, particularly the police, although information is made available.

22. Assessments clearly highlight what needs to change to improve children's welfare and take account of the impact of risk and protective factors on children's development. Assessments are mostly sensitive to disability, ethnicity and cultural considerations, and social workers take appropriate steps to ensure effective use of interpreters when language is a barrier. Inspectors saw some effective child-centred practice with children who have disabilities, by workers who form good relationships with families and encourage creative use of direct payments following assessment. Management oversight is evident in allocation processes and supervision records. In the best examples, this oversight has provided clear direction to social workers on the key considerations prior to undertaking an assessment via an allocation summary completed by managers.

23. The implementation of a new case-recording system has hindered the retrieval of historical information for social workers completing assessments. In some cases, social workers did not know where to look for records of previous involvement. While the local authority has taken steps to provide system

champions in every team, system difficulties have made the task onerous and time-consuming. However, social workers know their children and families well, seek to engage them purposefully and use this knowledge effectively to help assess children's needs.

24. The voice of the child is not consistently recorded well. Although social workers reported that they undertake direct work with children and were able to give examples, this too is poorly recorded and, as a result, the work undertaken by staff is not always well evidenced. (Recommendation)

25. Some children wait too long for safeguarding risks to be considered in a formal meeting. The timeliness of initial child protection conferences has declined, with only 53% held within the 15-day target timescale in the last six months and the remainder within 30 days. Child protection chairs report that the delays are due to a combination of late notifications by social workers following strategy meetings, staff capacity and meeting venue availability. However, appropriate protective actions are taken to ensure that children are safeguarded while they wait for their conference to be held. Multi-agency core groups are held regularly and review progress against child protection plans effectively in almost all cases. This ensures that risk is minimised and children and families achieve positive outcomes.

26. The quality of plans is inconsistent. Plans are not always clear about what needs to change to make improvements to children's lives, they are not always specific enough about timescales for achievement and they lack detail about contingency arrangements. This is particularly evident in relation to some cases of parental substance misuse, domestic abuse and mental health, in which there has been over-optimism about the capacity of parents to change. However, when situations change and risk increases, in most cases this is recognised by managers and social workers. Action is then taken, including through Public Law Outline processes and applications to courts when necessary.

27. Multi-agency forums, such as multi-agency risk assessment conferences (MARACs) and multi-agency public protection arrangements (MAPPA), assess and manage risk effectively for families with multiple needs, such as domestic abuse, substance misuse and parental mental ill-health. These forums are well coordinated and held more frequently to respond to increased demand, and there is evidence of good attendance from most partner agencies. When there have been issues about irregular attendance, this has been appropriately escalated to relevant agencies and addressed to ensure improvements. There are clear pathways from the MASH, which triages cases of high-risk domestic abuse prior to the MARAC to ensure that effective safety plans are in place. Medium-risk cases can also escalate to the MARAC if there is a pattern of repeat incidents.

28. When children are at risk of sexual exploitation, the partnership response is effective and coordinated. There are clear pathways from the front door to the

child sexual exploitation team. Risk assessments are detailed and thorough and inform the multi-agency child sexual exploitation (MASE) process to ensure intelligence sharing and planning to keep children safe. The work is child focused and supportive. This has led to a number of successful prosecutions and disruption activity in key hotspot areas.

29. Children who have been missing from home are offered timelier and better-coordinated return home interviews following the appointment of five additional staff within the child sexual exploitation and missing service. Most return home interviews are completed promptly. After a safe and well check by police, return home interviews are offered to children for every missing episode, including to children looked after who are placed in Warwickshire by another local authority. Intelligence from every return home interview is then shared with police and with other agencies as appropriate. This helps to make sure that the process informs planning for children effectively to keep them safe. Out-of-hours social work support includes making telephone contact with children found after a missing episode, prior to the return home interview. This offers added assurance to both child and carer following a missing episode.

30. The local authority communicates its expectations to schools about children missing education (CME) through clear guidance. All cases, currently 80 in total, are competently risk assessed by an education officer based in the MASH, who checks with a range of other agencies to ensure that children still missing education after a few days are monitored closely. Lateral checks are carried out at regular intervals to mitigate risk and to see whether CME have re-emerged. Those children who continue to be deemed missing are logged with the national Department for Education missing database.

31. The vast majority of schools have put in place an effective e-safety programme. There is an established process to monitor the use of all school computers, and there is a prompt and effective response to concerns. Schools identify and respond to bullying through their reporting of prejudice-related incidents. As a result, schools more readily take action and report incidents to the local authority to keep children safe. The local authority analyses the nature of incidents and intervenes directly with schools when incidents appear high.

32. Children at risk of female genital mutilation are protected by the authority. The profile and understanding of female genital mutilation has been raised through partnership activity and a local action plan. Female genital mutilation is recognised and responded to effectively, evidenced by two female genital mutilation protection orders obtained within the last 12-month period.

33. The 'Prevent' duty message has been widely shared across the county, and this is leading to appropriate referrals to the Channel Panel. Although Warwickshire is not a priority area for the 'Prevent' duty, education providers, social workers and other professionals have made a number of referrals. Additional support is available from the MASH service manager, who is the conduit between children's services, the police and community safety. This shows increased

awareness about the risks to children from radicalisation and their potential origins.

34. In most cases of homeless young people aged 16 and 17, the young people are assessed and supported to ensure that appropriate accommodation is identified in accordance with a clear local protocol. When assessment identifies vulnerability or risk, future support is provided directly through a child in need plan or, if necessary, entry into care.

35. A new process is in place for private fostering to ensure that social workers complete timely assessments that identify risk and support needs effectively. Although there are only seven children identified as living in private fostering arrangements, publicity has been prioritised and information disseminated across a range of agencies, including faith and community groups. Training for staff in the MASH has ensured an effective response at the front door. This has led to an increase in referrals and the appointment of a dedicated private fostering social worker.

36. Insufficiently robust designated officer arrangements have resulted in delays in responses in several cases. In a small number of these, it has meant a delay in ensuring that children are safeguarded quickly enough. The local authority has not been aware of this until it was raised by inspectors. In response, managers took appropriate steps to ensure that this was addressed.

37. Although 178 children have benefited from the services of an advocate in the last 12 months, not all children and families who could benefit have timely access to advocacy services. This makes it more difficult for children to voice their wishes and feelings effectively without assistance during meetings.

38. Service user feedback is sometimes sought following the completion of an early help single assessment. Creative methods of feedback using mobile phone technology are available for families to access and express their views on the quality of service. However, feedback is not routinely sought, collated or used to inform planning for all children and families.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Decisions for children to enter care are appropriate. Social workers visit children regularly and often build relationships of trust that support improved outcomes. However, high caseloads and a recording system that is not supporting good practice effectively are having a negative impact on the ability of social workers to consistently do their best for children. Early consideration is given to securing permanent homes for children. The local authority acts quickly to secure adoption for all children who could benefit, including those for whom it is harder to find a placement. Adopters and children benefit from good post-adoption support. For the few children for whom there is delay in achieving permanence, the monthly permanence panel is increasingly effective in recognising and correcting this. When the aim is to achieve permanence by return to birth parents, these plans lack rigour and consequently are not consistently successful.

The local authority is not providing stable long-term placements for all children. Placement stability is below that achieved by similar local authorities. The local authority is working hard to tackle this, with an increasing range of placement options, enhanced support to foster carers and a well-considered new sufficiency strategy. However, these measures are either relatively new, yet to be implemented or are only providing services for a very few children and so have not had a significant impact. Services for children looked after who have disabilities and those in specific circumstances, such as unaccompanied asylum-seeking children and those at risk of sexual exploitation or of going missing, are effective. However, those who have emotional well-being problems or mental ill-health wait too long for a service. The virtual school works well with schools to enhance educational attainment of children looked after but has not been successful in reducing fixed-term exclusions, which remain high.

IRO caseloads are excessive. Minutes from review meetings often wait months to be uploaded into electronic case records, exacerbated by the challenges of the new electronic recording system. This makes it more difficult to track actions and children's progress between reviews. Not enough children benefit from the support of an advocate or independent visitor. Their use is not routinely considered or offered for children looked after.

A large majority of care leavers live in suitable accommodation and are supported by social workers and personal advisers who know them well. However, preparation for independent living is not strong and suitable accommodation is not always readily available for care leavers who require higher levels of support. Some care leavers experience placement breakdown and moves as a result.

Inspection findings

39. When decisions are made to bring children into the care of the local authority, these are appropriate. In all the cases seen by inspectors, no children were being looked after unnecessarily. There are a few children who could have been brought into care earlier. These are mainly children who were living in homes where they were experiencing chronic neglect, and existing services had not been successful in reducing risk. Some of these children had to wait until concerns escalated from chronic to acute, and then came into care in an emergency rather than in a planned way.

40. Children looked after receive regular visits from social workers. They get to know them well and, in many cases, build relationships of trust with their social workers. However, high, and in a few cases excessive, caseloads and a case-recording system that is not currently supporting good practice effectively are reducing the ability of social workers to consistently do their best for children.

41. When children come into care through the court system, the local authority has systems in place to make sure that this is achieved swiftly. These include fortnightly case decision-making meetings, a Public Law Outline tracker for cases that are likely to come before the court, and a case progression monitoring system. The local authority monitors closely how work is progressing, thus ensuring that there is no unnecessary delay. The current timescale for court proceedings is 29 weeks, compared to the national target of 26 weeks. The local authority has worked hard to achieve this and to improve the quality of court assessments completed by social workers, which are mostly good, clear and analytical. This progress was commented on to inspectors by the local authority's partners in the Children and Family Court Advisory and Support Service (Cafcass) and the judiciary.

42. For most children who become looked after, early consideration is given to finding them permanent homes. This includes early consideration and good use of 'twin-tracking' and foster-to-adopt placements for children who are the subject of court proceedings. However, the local authority is not achieving such early consideration or finding permanent homes for all children. The monthly permanence panel meeting recently reviewed the situations of a number of children looked after, who had been in care for over nine months without a plan for permanence, and put in place remedial actions when necessary. Alongside an earlier review of children voluntarily looked after under section 20 of the Children Act 1989, this shows that the local authority is strengthening its focus on achieving permanent homes for children as soon as possible.

43. Children are generally well matched to permanent carers. Fostering and children's social workers work well together to complete the matching assessments and to provide support to children and foster carers. Sensitive and age-appropriate life story work is helping many children make sense of their pasts and supporting better outcomes. Brothers and sisters are almost always placed together when this is in their best interests. The local authority's work to

manage and, when appropriate, promote contact is sensitive to children's wishes and needs. When children may have mixed feelings about contact, when family dynamics are complicated or when there may be ongoing concerns about some family members, the local authority is rigorous in making sure that arrangements are safe and in children's best interests.

44. Placement with friends or family members through SGOs or 'connected persons' foster care arrangements is an increasingly frequent and generally positive permanence option for children in Warwickshire. For a small number of children, however, these placements have not worked well. Placements have broken down, and children have had to move to new homes. When inspectors looked at the viability assessments that had led to these placements, they found that they were over-optimistic about carers' ability to provide stable long-term homes for children and lacked clear analysis.

45. When the plan for a child looked after is to achieve permanence through returning to live with their birth parents, the assessments and subsequent support and rehabilitation plans lack the rigour that is applied to other permanence options. Consequently, children and their families do not always experience successful returns home. The emotionally harmful impact of this on children, who have already been removed from their birth families once, can be significant. While inspectors did see some examples of very well-managed rehabilitation plans and packages of support, these were in the minority. (Recommendation)

46. Unaccompanied asylum-seeking children receive a good service in Warwickshire. Social workers are trained in age assessments, have good access to interpreters, support young people in liaising with the Home Office and display cultural competence in their work with young people from diverse cultures, religions and nationalities. This is ensuring appropriate accommodation, including placement with foster carers and spot purchasing of high-support need accommodation in cases of high risk of trafficking, and further education opportunities.

47. The range of placement options for children and support to foster carers have not been sufficient to ensure stable and lasting placements for children in Warwickshire. At the time of the inspection, children's short- and long-term placement stability was below that for similar local authorities and had reduced slightly over the last year. The local authority is aware of this and has taken action to improve matters, including wider placement options (such as 'solo' placements for young people who have more challenging needs, and a new mother and baby foster placement) and enhanced support to foster carers (including doubling the frequency of supervision, strengthening annual appraisals, and the recent addition of psychological support, which foster carers value). A detailed and comprehensive new three-year sufficiency strategy, aimed at improving the volume, breadth and quality of placements available for children, has been created and will soon be implemented. While these measures are all positive and well focused, most of them are either relatively

new, yet to be implemented or only provide services for a small number of children and consequently have not yet had a significant impact. Ensuring the availability of a sufficient breadth and number of well-supported placements for children therefore remains a significant challenge for the local authority. (Recommendation)

48. Schools are making some progress in closing the attainment gap between children looked after and all children. At key stage 2, results have improved steadily over the last two years, and children looked after have performed better than similar children nationally. There has been further improvement at key stage 4, with the proportion achieving good grades in GCSE English and mathematics now at 25%, against a national average rate for children looked after of 18%. At 16, the proportion of children looked after who progress to a positive destination, such as a college place, has improved over the last three years. It was 93% in 2016 and had increased over the previous two years.

49. The virtual school supports and monitors schools effectively in their use of the personal education plan (PEP) process to focus on improving the educational experience and attainment of children looked after. Access by schools to pupil premium funding is directly linked to the completion and quality of PEPs and is managed well by the virtual school. The pupil premium has supported after-school activities and essential equipment such as an 'eye-gaze recognition' computer to support a young person's communication in placement. Most PEPs completed by schools have clear targets and a good focus on children's broader welfare needs. However, PEPs completed by colleges are not consistently of the same quality and, consequently, support to these students is less well targeted.

50. The school attendance of children looked after is at the level of children looked after nationally. However, fixed-term exclusions, at 13%, are higher than the 10% average for England. Measures taken by the virtual school to tackle this have not been sufficiently effective. The local authority takes a lead in quality assuring alternative education providers, and the majority of the 92 pupils attending such provision access 25 hours per week or more. When they attend for less time, it is for legitimate reasons and is well monitored.

51. At an average level of 117 at the time of the inspection, and with some much higher, the caseloads of IROs are exceptionally high. This has been exacerbated by the challenges of the implementation of the new recording system. The impact of this is that, although review meetings for children looked after are consistently timely, minutes and actions from them routinely wait months to be uploaded into children's electronic case records in some cases. This makes it more difficult for IROs, social workers and others to track actions and children's progress between reviews. IROs are still exercising some limited challenge and scrutiny of how children's plans are being progressed. Such challenge and scrutiny are often reactive to problems that arise for particular children, rather than proactively monitoring the progress made by all children, including those in long-term and stable placements. (Recommendation)

52. Children looked after generally attend their review meetings when this is appropriate and are often engaged well by social workers and IROs. A pilot project under way at the time of the inspection has supported some children to chair their own meetings. This is a very positive development. However, the use of advocacy to enhance children's involvement and strengthen their voices is not routinely considered or offered. As a result, only a small proportion of children looked after in Warwickshire are benefiting from the support of an advocate. Social workers' reports to review meetings typically provide a helpful summary of key events since the last review but do not consistently provide a sufficiently strong analysis of key issues for discussion, future needs or clearly articulated recommendations. This does not support the best use of care plans, which are not generally treated as 'living' documents that are updated to reflect children's changing needs. (Recommendation)

53. When children looked after are at risk of sexual exploitation or as a result of going missing, this is consistently well addressed. Return home interviews are usually swift and used to inform planning, while the completion of child sexual exploitation risk assessments and close working with the police help reduce risk and keep children and young people safe. Inspectors saw examples of timely and effective intelligence sharing between the local authority and the police, leading to children looked after being protected from harm – for example, through the issuing of child abduction warning notices to disrupt the activity of suspected perpetrators.

54. A large majority of children looked after who have disabilities are supported effectively by care and other services that are well matched to their individual needs. Their transitions to adult services are well managed. Leaving care social workers and personal advisers are also involved in this process when their particular knowledge can further strengthen the support that children receive. The mental health needs of children looked after are less well addressed. When Journeys, the local authority's commissioned emotional health and well-being service for children looked after, or child and adolescent mental health services (CAMHS), are providing support to children looked after, this work is helping children and young people to achieve better outcomes. However, waiting times are lengthy. This is a significant problem because children are often not receiving help at the time when they most need it. The local authority is aware of this weakness and is working with its health partners to address it. A well-considered CAMHS re-commissioning programme, which involves positive direct input from children and young people in the design of services, is well under way but has not had an impact on practice, as the new services are not yet in place. (Recommendation)

55. Initial health assessments for children looked after are not completed in good time, and this has been a longstanding problem. Recent significant improvements in how long these take are very positive with the rate in April at 81% being completed on time, but this will need to be sustained from a very poor performance in March 2017 of only 24%. The timeliness of completing review health assessments is much stronger, at an annual rate of 82%.

Strengths and difficulties questionnaires are completed for all children from the age of four years, with the tool used by Journeys to measure pre- and post-change for young people in care who commence treatment.

56. The CiCC is a vibrant and active group. A well-designed system of elections to the CiCC helps to ensure that children looked after and care leavers of various ages are involved, currently from age 12 to 21. CiCC members feel a real sense of responsibility to, and representation of, all children looked after and care leavers. The CiCC has instigated and been involved in some positive pieces of work, including designing new age-banded booklets for annual foster carer reviews and working with IROs on a pilot project for children looked after and care leavers to chair their own review and pathway plan meetings. The corporate parenting panel's engagement with the CiCC is progressively strengthening and has the capacity for further development.

The graded judgement for adoption performance is that it is good

57. Those children for whom adoption is the best means to secure permanence are identified at an early stage in care planning. There is suitable urgency in decision-making to ensure that adoption plans are timely and this urgency supports early family finding.

58. Children's progress is tracked effectively, to avoid unnecessary delays, through weekly case decision and agency decision-makers' meetings, which monitor progress. These ensure that permanency decisions are carefully examined throughout care proceedings and planning. An early alert system about potential adoption, via the case decision meetings, is further supported by placement allocation meetings. These meetings involve children's social workers and adoption workers, and information is shared about children's needs and individual circumstances. As a result, the adoption team is fully informed about children for whom adoption is the plan, and is able to consider at an early stage not only approved adopters but also those being assessed.

59. Children in Warwickshire continue to benefit from successful adoption planning, and 55 children were adopted in the period 2015–16. In the 12 months prior to the inspection, adoption orders were granted for 75 children. In the same period, a decision for adoption was taken for 72 children, 47 of whom are placed, and families are being actively sought for 25. The current cohort includes five children who have a disability. However, adoption performance data is not sufficiently focused on specific issues that may make it more difficult to adopt children, and is not routinely capturing children who have complex needs and disabilities. This is a missed opportunity to demonstrate the service's drive and effectiveness in family finding for this group of children.

60. The time between the children entering care and moving in with their adoptive family is improving, and is better than the national average and the majority of the statistical neighbours, as is the time between receiving the court authority and placing the child with their adoptive family. When there have been delays, scrutiny of decisions by inspectors found that the delays were not due to a lack of purposeful planning, tracking and/or monitoring. Indeed, there is demonstrable commitment and tenacity to secure families for even the most challenging and 'hard to place' children (though family finding may take longer), ensuring that children benefit from the experience of living within a stable family. Sixty-four per cent of children waited less than 16 months from entering care to moving in with their adoptive family, which is much better than the most recent national average of 47%.

61. Family finding is purposeful, and workers pursue options and links for children through a range of contacts, including Adoption Match, Link Maker and the local adoption consortium. Matching is enhanced through life appreciation days, in which those involved in the child's care share information with potential adopters. This contributes to adopters gaining a better understanding of the child's life history. There is an appropriate focus on the early consideration of in-house adopters, with a realistic recognition that a suitable match may not be available when taking account of the child's individual needs. The authority is successful in finding suitable adoptive families for more difficult to place children. For example, in 2015–16, seven brother and sister groups of two, and two groups of three, were successfully matched with their adoptive families. In the current cohort, there are nine brother and sister groups and five children who have a disability.

62. For some children for whom the plan was adoption, this has not been achieved. Between 2013 and 2016, the plan for adoption for 22 children was changed to an alternative permanence option, and two adoption plans were not agreed in care proceedings. All of these children are in long-term placements. The large majority of the children either returned to or remained with carers with whom they have a strong relationship and attachment. Although this means that they are now in stable placements, this outcome could have been achieved sooner for some by considering adoption with their existing carers or long-term fostering.

63. Good matching contributes to stable placements for children. The number of placements that have broken down over the past three years has been relatively low (six). However, it has not been possible to establish whether the learning and actions from work undertaken in May 2016 about adoption disruptions were a contributory factor and had a positive impact on preventing the disruptions that have occurred since that time.

64. Adoption support is a priority and a strength in Warwickshire. Arrangements to support children and adopters before and after adoption are effective and responsive. Timely assessments are completed to identify individual needs and tailor support packages. The adoption support team offers a wide range of

therapeutic interventions and packages of support, ensuring a joined-up approach when more sensitive situations require close monitoring. There is recognition that the adoption service needs to widen its range of prospective adopters so that the authority is better able to sustain its ability to meet the needs of older children, in particular those who have complex needs. The current plans to develop the regional adoption agency are seen as a good opportunity to increase the diversity and range of adopters.

65. Marketing activities are effective, resulting in good levels of interest and enquiries. Adopters seen by inspectors reported positively on the information and welcome they received. They told us that they were well informed through information events. One adopter described the impact of an event, saying that '[It] got me very excited. I couldn't wait to fill out the forms.' The pre-approval training prepares adopters well for the challenge of becoming an adoptive parent. Adopters spoken to demonstrated a good understanding of the impact that a troubled early life has on a child's future development and behaviour. The adopter assessments seen by inspectors were timely, robust and child centred with clear analysis to support the recommendations.

66. At the time of the inspection, 26 approved households were awaiting a match, of which four were linked to children waiting for the adoption panel's consideration and recommendation to approve. Approved adopters are referred promptly to Adoption Match and Link Maker when the adoption service is unable to identify a child for matching. Some adopters wait longer for a match because they choose to wait for a child who looks like them or is from the same religious background. In these cases, the service demonstrates robustness in its commitment and responsibility to safeguard children through their reapproval process to make sure that adopters remain safe and suitable to adopt.

67. The achievement of developing and using 16 fostering to adopt placements is a strength in Warwickshire. Foster to adopt is routinely discussed with all fostering and adoption enquirers and applicants, and all are asked to consider this option in relevant cases. This is further enhanced by the training provided to a range of professionals, including hospital staff, to promote a better understanding of this arrangement.

68. Assessments to determine whether brothers and sisters should be adopted together are of good quality. The rationale for the decisions about children being separated or staying together is well founded. Furthermore, assessments capture and take account of parents' views, even when those views are not in the child's best interest.

69. The child permanence reports seen by inspectors were child focused, reflected on the impact of the child's journey and experiences and sensitively dealt with the reason for children to be separated from their parents. This ensures that children can understand why they cannot live with their birth family. However, children's voices were not always as prominent as they should be in some of the written work seen, such as in assessments and plans.

70. Life story books and life story work seen were of good quality and child focused, and sensitively captured the child's journey and ongoing experiences. These were supported by later life letters that were timely, well written and sufficiently detailed, so that young adults can fully understand their lives before adoption, why they could not remain with their birth parents and why they were adopted. Managers recognised, and inspectors were told by adopters, that there are delays in the preparation of life story books. Adoption staff have provided training to social work teams to enable them to carry out this work in order to better help children to have a clear understanding and to make sense of their histories.

71. The adoption panel applies the right level of scrutiny. The records of panel recommendations and challenge are appropriately detailed and ensure that the agency decision-maker is assured of the robustness of the panel process. While the members of the panel are knowledgeable about adoption, there is a challenge for the authority to recruit panel members from more diverse backgrounds to more accurately reflect the communities. Although the agency decision-maker is making timely decisions based on the information provided as well as advice, there are no formal arrangements for the agency decision-maker and panel chair to meet. This limits the level of accountability and challenge to the service about the quality of its work. (Recommendation)

72. Children are prepared well for adoption. Adoption support plans are completed with care and sensitivity, providing good information to adopters about the support that each child requires. Careful introductions involve foster carers, adopters and parents to support the child's move into their permanent home.

73. Good use has been made of the adoption support fund to commission the right assistance for adoptive families. The adoption team has taken steps to engage adoptive families at an earlier stage of the adoption journey, for example through the mentor scheme. Training to support adopters' understanding of parenting responses to children's attachment needs is particularly highly regarded by adopters. Individual therapy and psychological support have been effective to help families improve relationships and attachments between the child and parents. Relatives of adoptive families have also received training to help them understand about adoption and the experiences of the adoptive child. Additional post-adoption support is appropriately commissioned through voluntary and independent agencies. The service supports 1,600 letterbox contacts.

74. Birth parents and birth families that may need support are identified at the earliest opportunity. It is encouraging that the birth parents' support team engages a high percentage of birth fathers. Support is provided at all stages of the adoption journey and is available for as long as it is needed.

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

75. Social workers and personal advisers know their young people well. They work hard and effectively to maintain good-quality contact with young people. Caseloads are manageable, and transition arrangements between social workers and personal advisers as young people approach adulthood are carefully and sensitively planned and managed, and tailored to individual needs. Transition planning for children looked after who have special educational needs and/or disabilities is effective and, when necessary, personal advisers are allocated well in advance to ensure that appropriate housing solutions and specialist services are commissioned in a timely way.

76. Workers understand the entitlements of care leavers, and make sure that they are enabled to access appropriate financial and associated benefits. Care leavers speak positively about their relationship with workers and the efforts that they make to provide support. Management oversight is consistently present on case files, though not always focused on monitoring progress against plans and key objectives for young people.

77. Despite this positive picture, not all care leavers are well prepared to make secure plans for the future. Some stated that they found living independently a challenge and, for example, were uncertain about budgeting for domestic bills that they had not foreseen. While some care leavers received tailored one-to-one support from personal advisers, there is no formalised independence preparation work or training programme provided or commissioned by the local authority to ease the transition of children into post-care accommodation. In a minority of cases, this lack of preparedness has led to the breakdown of accommodation arrangements for some young people. Senior managers are seeking to redress this and an independence preparation programme provided by Barnardo's is being piloted with a small group of young people over the 2017 summer holidays. Senior managers also recognise that they do not provide enough opportunities for young people to try out independent living prior to leaving care. (Recommendation)

78. Care leavers, particularly those living independently, feel that they have insufficient access to help from their workers outside office hours. Senior managers acknowledged their awareness of this issue and plan to review the provision of more flexible support arrangements.

79. The quality and timeliness of pathway plans are not consistently good. There is still much work to do to achieve greater consistency of practice across all care leaving workers. In some instances, plans are not completed to timescales and, in most cases, action planning is insufficiently detailed and unclear about responsibilities for actions, and timescales for their completion. Only a minority of pathway plans are used well to guide and support care leavers as a living

and meaningful document. Consequently, for many care leavers, their pathway plan is not as effective as it should be to help them understand how, when and by whom they will be supported to meet their identified needs. Care leavers described feeling detached from pathway plan meetings, which too often failed to involve them at the heart of the discussions. (Recommendation)

80. The current template for pathway planning, in operation since November 2016, replaced the previous plan that had been co-designed with care leavers. The less appealing structure of the new electronic template has led to workers struggling to engage young people in developing their pathway plans. The voice of young people is rarely well recorded, and this is not driving their plans effectively.

81. Most care leavers report feeling safe and well, and workers are alert to ensuring that child sexual exploitation issues, alcohol and drug misuse and other risk-taking behaviours are consistently identified. When children are identified as being at risk of sexual exploitation, thorough and robust risk assessments are undertaken and, when appropriate, risk is managed well through the coordinated action plans emerging from multi-agency sexual exploitation meetings, with evidence that risks are minimised as a consequence. In some cases seen in which risks are assessed as high, specialist out-of-area provision is identified to disrupt patterns of child sexual exploitation activities.

82. The large majority of care leavers are housed in suitable accommodation. However, for those who require higher levels of support, accommodation appropriate to their needs is not always immediately available. This is particularly the case for step down accommodation for young people moving on from residential care. The local authority is engaging with its partners to recommission accommodation to better meet the needs of vulnerable care leavers and to increase the portfolio of emergency accommodation provision. This work has been slow in its implementation.

83. There are no care leavers in bed and breakfast. Workers go to great lengths to prevent breakdowns in young people's tenancies when these are at risk. Of those young people inspectors met, all feel safe in their accommodation provision.

84. The option for young people to 'stay put' is well considered and actively encouraged in all appropriate cases. In the current year, 25 care leavers have benefited from the option to remain with their foster carers when that has been assessed as being in their best interests. The proportion of care leavers 'staying put' has increased slightly over the last two years.

85. Personal advisers provide support to arrange local registration with a doctor, dentist and optician. However, many workers and managers lack awareness of planning securely for the long-term health needs of care leavers. While systems are in place to trigger health reviews, workers are not effective in encouraging young people to attend or in ensuring that they have access to their health

histories. This means that young people may not be suitably aware of health concerns in their lives or of their immunisation records. When mental health needs are identified and CAMHS or adult mental health services are referred to, in many cases there are lengthy delays in the provision of such services. Consequently, young people's therapeutic needs are left unaddressed, impacting negatively on their capability to successfully sustain accommodation or employment.

86. While the council's in-house apprenticeship scheme guarantees care leavers an interview, managers have not succeeded in enabling enough care leavers to access the scheme, and no care leavers have so far been able to successfully complete their course. However, seven care leavers are engaged in employer-led apprenticeship schemes. Twenty-one care leavers are attending university and this is a slightly improved figure on previous years. Personal advisers have established good links with university outreach staff around the country to ensure that care leavers are settled and that they succeed. This has necessitated well-negotiated changes of accommodation to meet care leavers' needs and conversations with university staff to help care leavers to meet the demands of their courses.

87. A commissioned service provides work-related support to care leavers. Those not in education, employment or training (NEET) have advisers who seek to maintain contact and meet with them regularly. Advisers have a good overview of the factors that can prevent care leavers from securing employment, education or training, such as illness, parenthood, offending behaviour and emotional problems. This knowledge helps them to shape the nature of the support needed.

88. In the current year, 33% of care leavers aged 19 to 21 failed to move into suitable education, employment or training – a small increase on the last two years but better than the national average. Up to Year 11, children looked after are guided by specialist career advisers who signpost them to up-to-date information about courses and training opportunities at age 16. Such specialist careers guidance is not available beyond 18, the point at which the NEET figure rises. The local authority is seeking to deploy funds to establish a post-18 service to address this decline.

89. The service is successful in staying in contact with most of its care leavers. At the time of the inspection, it was not in contact with only 14 young people (4.2%), a figure that has remained constant over the last few years. Clear records are kept on these young people, including evidence of attempts to maintain and renew contact. They are written to, to remind them of their entitlements and of how to contact their worker. The local authority is currently exploring the development of the care leavers' website and the use of the MOMO app to enable more accessible means for young people to communicate with their personal advisers.

90. Care leavers are aware of their entitlements to financial support to set up home or to access education and training. Workers communicate this information well and ensure that young people are enabled to access support. An additional 'entry to employment' fund, approved by elected members, is used flexibly and appropriately to help individual young people to travel, and to purchase equipment for their studies or one-off items that they may require to help them in training or employment. Those moving to university have their maintenance costs met and accommodation costs during holidays.

91. Events to celebrate care leavers' educational and personal achievements are held annually in conjunction with the virtual school. These are well attended by carers, social workers and elected members, and provide a good platform for care leavers to be publicly recognised for the good progress that many make. Awards range from celebrating excellent GCSE results to excelling in kickboxing.

92. The local authority's actions are guided by its care leavers' pledge and charter, and care leavers are actively encouraged to become members of, and participate in, the CiCC. A care leavers' group has been established to review and comment on the redesign of housing services.

Leadership, management and governance	Requires improvement

Summary

Senior managers and political leaders understand their roles and are committed to providing good services for children and their families. Some progress has been made in the creation of an effective MASH and in a robust multi-agency response to children at risk of sexual exploitation. However, progress in other areas has been slow, although improvements have now started. The local authority recognises that more work needs to be done to ensure that practice is consistently good across the service. The corporate parent panel is not yet providing sufficient oversight and monitoring of services.

Some early help services are in place, but they are not yet able to demonstrate that they are making a difference for children, and not all partners are actively engaged or involved.

Performance information is not used effectively to promote improved practice. Inaccurate data is preventing the local authority from having a clear understanding of progress and areas for improvement. Management oversight and case auditing activity are regularly taking place, but lack an established process that consistently leads to learning and improved practice.

The change from one information technology (IT) system to another has been too slow. Six months after the new system went live, many historical documents have still not been migrated, and some social workers cannot easily use the system or readily access all the information they need.

Workloads of some social workers, including newly qualified staff and IROs, is too high, which is impacting on their ability to provide consistently good practice.

Outcomes for children looked after are generally positive, and adoption is considered for most children at an early stage. However, there is a lack of planning around the needs of care leavers, who are not always fully supported and prepared to live independently.

The local authority has worked to increase staff stability through a range of recruitment and retention initiatives, and as a result has been successful in reducing turnover and use of agency staff.

Inspection findings

93. The pace of progress to maintain effective and responsive services for children and families in Warwickshire since the last full inspection of services has been too slow. Greater stability in the senior management team in the past 18 months has enabled some progress to be made, particularly in the recruitment and retention of staff, in the development and implementation of a MASH and in ensuring effective responses to children at risk of sexual exploitation.

94. The head of service is regarded as a stable influence by political leaders and staff, all of whom have confidence in her ability to make the necessary progress to ensure that services for children are good. While the current DCS leaves his post in September, the incoming DCS already works in Warwickshire and is familiar with the developing social care transformation plan and its priorities.

95. The joint managing directors of the authority, together with political leaders, are fully aware of their respective roles. They discharge their responsibilities appropriately and understand the priorities for children's services. The leader of the council takes her role as corporate parent seriously, and is well informed about the experiences and issues of concern for children.

96. The work of the corporate parenting panel is not yet fully effective. Although there is a range of performance information available to the panel, it does not offer a sufficient focus on young people's experiences. For example, the report does not include areas of weakness, such as placement stability or the use of advocacy. This limits the panel's ability to scrutinise and challenge practice effectively. However, the panel has supported some initiatives, including the design of age-appropriate booklets for children in care to complete for foster carer reviews. It has also taken steps to widen panel membership, which now includes district council representation and the health commissioner. Young people from the CiCC attend regularly, and a member of the corporate parenting panel attends the CiCC at every second meeting. These arrangements facilitate positive relationships. Young people have reported that they have felt able to influence the panel about improvements to practice, including the distribution of leaflets from the Who Cares Trust on rights and entitlements of all children in care. (Recommendation)

97. The local authority has a wide range of social care data and performance measures in place. However, accuracy of data is challenged by the slow integration of a new IT system. Use of information could be improved by more detailed analysis of trends and performance against targets.

98. The migration of information to a new IT system has not been fully implemented yet, despite its set up six months ago. Consequently, social workers are using two, and in some cases three, systems simultaneously. Not all staff have received training on the new system, and many social workers have difficulty accessing reports and documents. The transition has meant that current data is not always immediately accurate, and at times considerable

work has to be undertaken to ensure the validation of information. For example, service-level managers could not easily report on how many care leavers are NEETs, and were unable to accurately report the number of cases stepped down at MASH to early help. This limits the local authority's ability to fully understand current performance and to analyse weaknesses effectively in order to improve practice. (Recommendation)

99. Ready access to and use of information in frontline practice needs to improve. Some team managers do not have easy access to, for example, the current number of open cases on their team or of how many children are subject to child protection plans or social workers' caseloads. This poor access limits their ability to understand and respond to workload pressures.

100. A quality assurance framework is in place, and there is a forward plan of auditing intentions. Case work auditing is beginning to highlight areas of strength and when actions are required to improve. The local authority's own auditing of work closely corresponded to findings in this inspection. Key points for learning are identified and shared with staff following each auditing cycle. However, a full cycle of learning from quality assurance, which ensures that changes in practice occur and are sustained as a result of auditing activity, remains underdeveloped.

101. The Health and Wellbeing Board is well attended by key partners. The board has an active focus on identified priorities within the local authority's transformation plan, the 'Journey of the Child', which seeks to ensure a seamless process for access to services for vulnerable children. A dedicated commissioning team uses information effectively, including from the joint strategic needs assessment (JSNA) about the needs of local communities, to inform its commissioning strategy, and provides adequate scrutiny of commissioned services to monitor quality. A commissioning strategy aligns priorities and reflects the work of strategic boards.

102. The local authority has not yet been able to engage fully all partners in its work to safeguard children. The police are committed, strong partners and work closely with children's services, resulting in effective joined-up services for children, particularly in the delivery of the MASH and the arrangements for missing children and those at risk of child sexual exploitation. However, there is no dedicated health representative in MASH, which means that information is less easily available for strategy discussions or information sharing. While health professionals are contacted by staff in the MASH, there is a missed opportunity for enhanced professional dialogue and collaborative practice.

103. Considerable work has been done to ensure a viable early help offer and, when appropriate, integrate some early help services with children's social care services. Schools complete the majority of early help assessments but continue to struggle with a consistent understanding and application of thresholds. Health partners are not fully involved, and, while there are some good examples of frontline health practitioners doing effective work with children and

families in individual cases, only 3% of all early help assessments completed are done so by health professionals. This is much lower than comparators and means that some younger children, not yet of school age, may not be identified and recognised as in need of early help services. More needs to be done to ensure that partners are able to demonstrate how they contribute to positive outcomes for children at this preventative stage. (Recommendation)

104. Effective partnership arrangements robustly address the needs of young people at risk of child sexual exploitation. These arrangements are working well to keep children safe. They promote the coordination of a range of strategic and operational interventions that deliver appropriately focused multi-agency responses to safeguard children. Partners, managers and political leaders work together well to understand the prevalence of child sexual exploitation and to establish effective ways of responding to and reducing risk. Operationally, joint working with the police at the front door ensures early identification of young people who go missing from home or education. Children generally receive appropriate and timely return home interviews by a specialist team, which also offers wider assessments of risk and a range of support services. Warwickshire, together with neighbouring authorities and the police, has been successful in achieving prosecutions in a number of cases concerning exploitation.

105. The current range of placement options for children and support to foster carers is not sufficient to ensure stable and lasting placements for all children. Short- and long-term placement stability is below that for similar local authorities and has reduced slightly over the last year. A detailed, new three-year sufficiency strategy has been created in response to this and is due to be implemented. However, these measures are yet to be implemented and consequently this remains an area of challenge.

106. Children wait too long for a service from CAMHS, which means that they do not always receive the specialist help they need in a timely way. Clear and effective referral pathways for children in care are not yet in place. Senior managers have recognised these concerns and have a clear plan to address them with refreshed commissioned services due to be put in place in August 2017. There is some support for foster carers and children placed with them from a dedicated psychologist post, but this does not compensate for the lack of sufficient, dedicated mental health provision for children. (Recommendation)

107. Outcomes for many children in the care of the local authority are positive. Permanence options are considered for most children at an early stage. Practice in the adoption service is effective, ensuring that adoption is considered for all children who would benefit from this. Children who are looked after have opportunities to get to know their social workers well and build relationships with them. However, some young people are not prepared well enough for independence and this limits their ability to succeed after leaving care. (Recommendation)

108. Leaders and managers in Warwickshire have identified workforce stability and sufficiency as high priorities. Many staff spoken to during the inspection spoke very positively about working for Warwickshire, and identified the support of their managers as a strength. As a result, social work turnover rates have reduced from 21% in 2016 to 15% in March 2017. A range of recruitment and retention initiatives, such as an enhanced pay and training offer, have helped to reduce the use of agency staff to 9.54%.

109. The local authority is committed to reducing social work caseloads, with a target of 15 children for each social worker. However, this is taking too long to happen and some workers have high numbers of cases. The authority has taken steps to remedy this by recruiting 26 social workers this year, with a plan to recruit 40 more over the next 12 months through an invest to save strategy, which will also help reduce IRO caseloads through additional resources. Most team managers have some allocated cases and, while there is a rationale for doing this in the very short term, some team managers have held cases for too long. (Recommendation)

110. Newly qualified staff are fully engaged in a well-designed support and development programme. They receive enhanced levels of supervision fortnightly, and benefit from a programme of group case discussions. Many newly qualified staff were positive about working for Warwickshire. However, despite the authority's intentions, it is not effective in ensuring that such staff have managed and manageable caseloads, and expectations on some of these staff are currently too high to ensure that they are able to learn and offer good-quality work at the same time. (Recommendation)

111. Staff receive regular supervision, but the recording of sessions does not always capture evidence that supervision is helping to progress children's plans or that managers actively contribute to raising practice standards. Senior managers are encouraging improved practice through targeted training and the recent creation of eight principal social work practitioners who support staff to work to practice standards and develop their knowledge and skills.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Warwickshire Safeguarding Children Board (WSCB) meets its statutory requirements, but the pace and effectiveness of challenge and progress against all the board's priorities have been insufficient. The board does not yet have enough oversight of the quality of practice and services.

A delay in reviewing and evaluating the effectiveness and quality of the current threshold document means that thresholds are inconsistently understood across the partnership.

Strengthened governance arrangements are beginning to result in improved accountability and a greater level of challenge across the partnership. The board is well attended by a range of partners, and the contribution of lay members is a strength. Monitoring and evaluation of frontline practice is beginning to improve. The board has successfully implemented an ambitious programme that has resulted in a much-enhanced response to child sexual exploitation and greatly improved awareness across partners and the community.

Some progress has been made in responding to issues of neglect, such as the publication of a neglect strategy. However, insufficient progress has been made in ensuring the use of screening and assessment tools, which remain in draft and are not yet in use.

The board has sought to assure itself that children living in certain geographical areas of the county, particularly those who have disabilities and those from minority ethnic groups, are receiving an equitable service. Actions planned by the board to understand this and take action if necessary have not progressed sufficiently.

The board has not yet ensured effective monitoring and evaluation of multi-agency and single-agency auditing of safeguarding practice across all partners.

Greater ownership and commitment across the partnership are making vulnerable children more visible to partners, providing an impetus to practice and service improvements as a result.

The board is responsive in identifying and progressing serious case reviews and in ensuring that learning from these cases is available to a wide range of multi-agency staff. It has identified key priorities to further improve outcomes for children as a result.

Recommendations

- Complete a review of the effectiveness of the early help offer without delay. The board should ensure that a threshold document is in place that helps partners to understand and apply thresholds when making decisions about their roles in supporting families or referring to children's social care.
- Ensure effective monitoring and evaluation of multi-agency and single-agency auditing of safeguarding practice across all partners.
- Ensure that the board has a full understanding of any gaps in the provision of equitable services to children who have a disability or are of a different cultural and ethnic background, in order to assure itself that services are meeting the needs of all children.
- Ensure that neglect screening and assessment tools are implemented and that a plan is in place to review their effectiveness.

Inspection findings – the Local Safeguarding Children Board

112. WSCB meets its statutory requirements, but strengthened governance arrangements are only just beginning to result in a more effective approach. Improvements in membership have resulted in most agencies being represented at an appropriately senior level. Subgroups are now chaired by board members across the partnership, resulting in greater accountability and ability to challenge, and these subgroups are beginning to strengthen the board's influence with partners.

113. The independent chair is well respected by board members, who are motivated and committed. Mostly well attended, but with the notable absence of NHS England, the board is able to demonstrate consideration of a wide range of issues and perspectives. Lay members are appointed and demonstrate confidence in participation and contribution. An annual self-assessment gives a greater understanding of strengths and areas for improvement. This assessment informs the annual report, which identifies areas of strength and weakness, including lessons from reviews and child deaths. The business plan includes key priorities agreed by board partners, but not all of these have progressed with enough pace and impact.

114. The safeguarding board has strong links with other strategic partnerships, but these are not yet formalised in an agreed memorandum of understanding. Relationships are, however, well established through the work of the board chair. The board has successfully influenced the work of other boards, ensuring, for example, that the JSNA includes a focus on child sexual exploitation, and the CAMHS redesign and development of a combined website with the local Safeguarding Adults Board.

115. A more rigorous approach to monitoring the effectiveness of local services and practice, including a more robust programme of multi-agency audits, has only recently been put into place. Recent audits have mainly focused on the MASH and the quality of assessments. Forward plans are now in place to broaden the scope of multi-agency audits. Additionally, oversight of single-agency audits is not comprehensive. For example, children's social care audits had not been monitored for over a year, nor included in the board's forward plan. The board does not undertake staff surveys, which would add more depth to the board's understanding of quality of practice and its impact for children. (Recommendation)

116. The board's ability to monitor and evaluate frontline practice is improving, but it does not yet have a substantive enough evidential baseline across the partnership to assure itself of the quality of multi-agency practice. A less than complete evaluation of local performance is not yet able to robustly influence and inform the planning and delivery of high-quality services. (Recommendation)

117. The board has ensured that there is greater scrutiny and challenge of a comprehensive data set by ensuring that it is discussed at the beginning of each board session. Recent changes to subgroups have resulted in greater ownership and commitment across the partnership, and are making vulnerable children more visible to partners. In turn, practice and service improvements have been achieved, such as mandatory training in child sexual exploitation awareness for taxi drivers, improved return home interviews for children missing, making sure that a paediatrician is now always available for child protection examinations and consultation, recommissioning of young carers' services and strengthening of MARACs.

118. However, some key areas still remain in which progress has not yet been sufficient, such as proportionate participation of health in the MASH and completion by health staff of early help assessments. Despite evidence of challenge in relation to health participation, the chair and board have not yet been successful in ensuring complete partner ownership of the early help agenda. For children, this means that those aged under five, in particular, are not receiving an appropriate level of partnership involvement from health colleagues at the point of early prevention.

119. The board has begun to engage with the Warwickshire CiCC and produced some key messages to professionals from young people. The board has also accessed Respect Yourself project boards, composed of young people, to shape a number of child sexual exploitation-related projects, including Respect Yourself's communications campaign. This offers a strong basis for further development of WSCB's work with young people, but the board is yet to engage young people systematically in evaluations of its work.

120. The board has recognised in its business plan that children living in particular geographical areas of the county, particularly those who have disabilities and

those from minority ethnic groups, may not be receiving an equitable service. However, despite partnership agreement that the quality of data and information in these areas required improvement, this has not yet been achieved, and there are continuing gaps in data from some partners. (Recommendation)

121. The board and the special cases subgroup are active in identifying and progressing serious case reviews, and ensuring that learning from these cases is available to a wide range of multi-agency staff. The board has identified key priorities to improve outcomes for children as a result. These include a neglect strategy that has informed the development of the Smart Start Strategy, including use of the HOME Inventory assessment in early help. However, progress has been slow in developing other screening and assessment tools for using when children are experiencing neglect, and these remain in draft form and are not yet implemented. Monitoring of action plans has now passed to the recently formed business group, which already has a busy agenda and the capacity of which remains untested. (Recommendation)

122. An appropriate section 11 audit process is in place, although the quality of the submissions from individual services is inconsistent. The board is aware of this variability through its effective evaluation of action plans and identification of themes – for example, identifying that there are variable rates of take-up of safeguarding training and then requiring agency representatives on the board to respond to issues highlighted.

123. There has been delay in reviewing and evaluating the effectiveness and quality of the current threshold document due to a court challenge. The board is aware that thresholds are inconsistently understood across the partnership. The board's current threshold document lacks clarity, particularly in helping agencies other than social care understand and decide their own range of responsibilities in supporting families or referring to children's social care. This has contributed to higher levels of referrals and re-referrals. (Recommendation)

124. The board's website provides comprehensive information that outlines membership, purpose and access to a range of key documents. The board ensures that there are appropriate policies in place, including, for example, a runaway and missing from home and care joint protocol, providing procedural clarity for all partners.

125. The board has developed a robust understanding of children missing and children at risk of sexual exploitation in Warwickshire and oversees effective information sharing and a local strategy and action plan. Successful implementation of an ambitious programme has resulted in a much-enhanced response to child sexual exploitation and increased awareness across partners and the community. In particular, the introduction of the multi-agency child sexual exploitation team and Sexual Assault Referral Centre ensures a robust response. Awareness campaigns are well embedded and include mandatory training of closed-circuit television (CCTV) operatives and pharmacy staff and

campaigns developed in partnership with young people. Young people are involved in informing and developing the subgroup's work. Young people, trained as relationship and sexual education champions, have developed an online relationship checker and a clear definition of child sexual exploitation, and designed and presented at conferences for young people. Importantly, participation in this work has improved their skills and enhanced individual life chances of those involved. For example, one young person on the verge of exclusion went on to become head boy at school.

126. A comprehensive training and development programme is in place. The subgroup for training and development is proactive, providing core training as well as developing and adapting training as needs emerge, including lessons from serious case reviews. A range of media are used to maximise impact, which include training the trainers to facilitate more single-agency training, newsletters, conferences and workshops. Child sexual exploitation awareness raising is a particular area of strength. As well as statutory and voluntary sector partners, the board has reached young people, to raise their awareness of child sexual exploitation, and faith groups, in relation to female genital mutilation and honour-based violence. Screening of 'Chelsea's Choice' has reached nearly 5,000 secondary school pupils, with well-planned partnership working across children's social care, health, education and the police providing a support timetable for its delivery. Consequently, pupils and staff have been supported to respond appropriately to concerns, and this approach has resulted in a number of disclosures. However, capturing and learning from training feedback in a more systematic way could be strengthened.

127. The child death overview panel subgroup operates effectively to review child deaths and recommend changes or improvement to services. It operates on a sub-regional basis across three authorities. A robust approach to tracking and ensuring that actions are completed ensures shared learning. Development of profession-specific templates for gathering information has improved information sharing. The involvement of parents in the process represents good practice, and this has resulted in improved information and specific actions to improve services, such as the provision of a 'goody bag' to new parents, with advice and items to support safer sleeping.

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 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 that 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.

The inspection team consisted of 10 of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Peter McEntee

Deputy lead inspector: Susan Myers

Team inspectors: Lorna Schlechte, Dominic Stevens, Tony Gallagher, Lolly Rascagneres, Kate Malleson, Andy Waugh, John Roughton, Alison Smale

Senior data analyst: Matthew King

Quality assurance manager: Christopher Sands

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk/ofsted