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Dear Ms Knowles

Focused visit to Herefordshire children's services

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

This letter summarises the findings of a focused visit to Herefordshire children's services on 7 July 2021. Her Majesty's Inspectors for this visit were Andrew Waugh and Alison Smale.

Inspectors looked at the local authority's arrangements for children in need and children subject to a child protection plan.

The visit was carried out in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. The lead inspector and the director of children's services (DCS) agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19. The visit was carried out both on site and remotely, with inspectors interviewing staff in person, as well as using video calls. Inspectors looked at a range of evidence, including discussions with senior leaders and case discussions with social workers and team managers. They also looked at local authority performance management and quality assurance information and children's case records.

Headline findings

The local authority has made little progress in improving the quality of practice for children in need and those subject to child protection planning since the inspection in June 2018 and the focused visit that reviewed the same area of practice in December 2019. A current absence of team managers has resulted in limited supervision for social workers. This mean that leaders and managers have not been successful in creating the conditions needed to support the development of effective social work practice. Plans and intervention focus predominantly on parental needs, with little understanding of children's experiences and the impact these have had upon them, and this means that children's needs are not always met and risks not fully understood.

A recent High Court judgement detailed significant and systemic failings in practice within the local authority. These failings had a significant and adverse impact on some children and families over several years. Senior leaders and elected members have taken this judgement very seriously. The new senior leadership team has taken swift action in identifying and implementing strategic plans to improve the quality of social work practice. However, it is too early to assess the impact of the changes proposed.

Areas for priority action

- Address inconsistent and variable social work practice to ensure that children are the focus of assessments, planning and interventions.
- The frequency and effectiveness of case supervision and the monitoring of children who are subject to child in need and child protection planning.
- Shortfalls in case-holding capacity for social workers, including newly qualified social workers, to allow them to respond effectively to children in need of help and protection.

What needs to improve in this area of social work practice

- Assessment of children's needs, including direct work with children to understand their experiences.
- The oversight and grip of team managers in relation to the progression of children's plans.
- The quality of case audits.
- The voice of the child in case records and planning.

Main findings

The local authority has responded positively to the challenges of the COVID-19 pandemic. It has continued to provide services to children and families, with a blend

of face-to-face and remote visits. Social workers have continued to visit families at home where children were considered more vulnerable. Social workers have been well supported during COVID-19 and enabled to work safely and effectively according to their individual needs.

Herefordshire has made limited progress in improving the quality of social work practice for children in need and those subject to child protection plans since the last inspection in June 2018. The concerns highlighted at the last full inspection and the focused visit in December 2019 have not been addressed.

Significant changes have recently been made to the senior leadership team for children's services. The new leadership team, in place since March 2021, has completed a comprehensive critical evaluation of practice across the service. This team has begun to understand the challenges that need to be resolved in order to improve practice; they have accurately identified the necessary priorities for improvement. An improvement plan has been developed that appropriately addresses the concerns. This has corporate backing, including a financial commitment to support the improvement plan.

Assessments for children in need and children subject to child protection are too variable in quality. These range from poor to good. Most assessments are completed within appropriate timescales and include information from partner agencies that supports an analysis of risks. However, assessments of children's needs are not holistic and view the impact of separate incidents in isolation. When social workers talk about children, they are able to articulate a better understanding of children's needs, however, this is not reflected sufficiently in the recording of assessments. The voice of children is not consistently reflected in social workers' assessments, meaning children's lived experience and needs are not fully understood and do not inform subsequent plans.

Child protection plans are ineffective at demonstrating what needs to happen to reduce and minimise the risk of harm to children. Plans are overly focused on the needs of adults. Children's wishes and feelings are not taken into account. Parents struggle to understand what it is they need to do and when they need to do it by. The role of partner agencies is not made clear. Plans lack focus and fail to detail what will happen if the plan does not succeed or go well. For children subject to child protection plans for a long time, there is an absence of robust and effective challenge, meaning that some stay on these plans for too long. As yet, leaders and managers have no routine or effective mechanism for ensuring that this poor practice does not continue.

Children are appropriately stepped down from child protection to children in need plans. Despite child in need meetings and core groups being held regularly, with the right partners consistently attending, social work interventions for the children involved focus mainly on the needs of parents. Children are visited regularly at home, but little attention is given to them. In some plans, children's needs are not fully

understood. This means that social workers and their managers have no realistic understanding of a child's lived experience and therefore cannot be assured that the plans they make are the right ones. Where direct work is undertaken, it is rarely recorded on children's records and does not inform ongoing assessments or plans. As a result, it is difficult to understand what the impact of this work is and it is not possible to correlate how parents' behaviour impacts upon their children's experiences. This means that managers and leaders cannot be assured that progress for children is being measured and how much this poor practice contributes to drift and delay.

For children where plans are not progressing or concerns are escalating, the decision to initiate pre-proceedings is not always considered quickly enough. Once a decision has been made, regular legal planning meetings set out actions to be taken and these are well recorded. This means that progress is timely and most cases conclude at between 12 and 16 weeks. An effective system is in place to track children through the pre-proceedings process. As a consequence, the quality and timeliness of pre-birth assessments has been strengthened. This has resulted in improved focus on permanence planning for these young babies. The quality of pre-proceedings letters to families is poor and not helped by jargon and impersonal language.

Family support workers are a valued asset within teams and contribute effectively to planned work with families. They work intensely with families, developing trusting relationships and delivering programmes of work which enable families to improve their parenting skills to the benefit of their children. However, there is a significant lack of emphasis on working with children and understanding their experiences and perspectives of life and family relationships. The lack of valuing the child's experience means that social work practice is never fully focused on the child and the analysis of professionals is always incomplete or skewed.

There is good family support work but, as identified at the focused visit in December 2019, concerns of neglect are still not always recognised. Graded care profiles are not completed within the child's timescales and actions identified through the graded care profile tool are not acted upon quickly enough. This means that children's needs are not fully understood and they remain too long in neglectful situations.

Recruitment and retention of social work staff continues to be a challenge. A high turnover of staff, reliance on agency staff and a number of vacancies are still an issue. This is exacerbated by the fact that almost half of social work staff are inexperienced and newly qualified, and this results in practice which varies between poor and good in its quality. Further, and of concern, is that team managers do not have sufficient capacity to consistently oversee staff, due to vacancies and sickness at team manager level. The strategy put in place by the previous leadership team to recruit and retain staff has not been effective in tackling the authority's long-standing problem of being unable to attract skilled and experienced permanent social workers.

Social workers do not receive supervision frequently enough. Team managers report that they do complete supervision, but it is not always recorded due to competing priorities. Some children's records do not evidence any case supervision, while others have lengthy gaps. Discussions, rationale and guidance from team managers between supervision sessions is not recorded. This lack of management oversight means that social workers do not have clear direction and clarity about how plans should progress. For some children, there is evidence of drift and delay in the progression of their plans. Where supervision is recorded, actions lacked sufficient purpose and timescales, which further compounds the drift and day in planning.

Complexity and volume of social worker caseloads varies between teams. In some teams, social workers find their caseloads unmanageable. This leads to them feeling under enormous stress, not keeping children's records up to date, working overly long hours and feeling 'burnt out'. Should social workers become unavailable or leave, some children would not have records that are accurate in identifying risk and needs. Almost half of social workers are newly qualified and have caseloads that are not reflective of or appropriate for their skills and knowledge. They do not consistently receive much-needed guidance and oversight from managers, leaving them vulnerable and at risk of leaving the service.

Staff reported that during the COVID-19 pandemic they felt supported by managers. Protective equipment was available, along with systems to enable them to continue working with children and families. Social workers completed risk assessments for visiting children, with those most vulnerable continuing to be visited face to face.

Senior leaders have recognised that the current quality assurance framework does not provide an accurate reflection of social work practice and is not effective in improving social work practice and experiences of children. Audits are overly optimistic in their evaluations of practice and are not moderated to provide a benchmark of good practice. Actions resulting from audits focus on process and do not support social workers to learn and improve outcomes for children. The local authority is introducing a new quality framework to address the current shortfalls.

The senior leadership team is new to Herefordshire and is implementing strategic plans to improve the quality of social work practice. The DCS has arranged drop-in sessions and regular briefings for staff to share their views and air their concerns. Social workers report feeling listened to and that senior managers are having a greater focus on children. However, it is too early to assess the impact of the changes that are proposed.

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

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to the area for priority action within 70

working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Andrew Waugh
Her Majesty's Inspector