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To all Members of the Education and Children's Services Scrutiny Board (2)

8th December, 2016
Our ref: C/MR

Dear Member,

Supplementary Agenda – Meeting of the Education and Children's Services Scrutiny Board (2) - Thursday, 8th December, 2016

The papers for the above meeting were circulated on 30th November, 2016. At the time of publication, the the monitoring visit letter was not available. The document has now been published and is attached to this letter.

- **Agenda Item 4. IMPROVEMENT BOARD REPORT - 14TH NOVEMBER, 2016** (Pages 3 - 6)

  Monitoring Visit Letter

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Michelle Rose
Governance Services Officer

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8 December 2016

Gail Quinton
Executive Director, People
Coventry City Council
Civic Centre 1
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CV1 5RS

Dear Ms Quinton

Monitoring visit of Coventry City Council local authority Children's Services

This letter summarises the findings of the monitoring visit to Coventry Children's Services on 8 and 9 November 2016. The visit was the first monitoring visit since the local authority was judged inadequate in March 2014. The inspection was carried out by two of Her Majesty's Inspectors, Peter McEntee and Karen Wareing.

The local authority is making some progress to ensure that their processes and systems for responding to contacts and referrals are effective. However, insufficient progress has been made to ensure that timely action is taken to manage and reduce identified risks. Interventions are not yet sufficiently robust to ensure improved outcomes for children in cases seen.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection, with a particular focus on the assessment of risk and children subject to child protection and child in need plans. We also looked at contact and referral arrangements at first point of contact and the multi-agency services hub (MASH) based on the recommendations and areas of inadequacy identified in the original inspection.

The visit considered a range of evidence, including the auditing and tracking of selected case files, sampling of electronic case records and supervision notes, discussions with social workers and senior practitioners responsible for casework and other information provided by staff and managers.

Summary of findings

- Senior managers are aware that considerable work needs to be done to ensure that services for children in Coventry are of a sufficient standard to ensure that outcomes for children are consistently good. Work has been done to reduce social work caseloads to a manageable level and to stabilise the workforce. Quality assurance of work is carried out using a good quality audit format, but this is not yet making sufficient difference to the overall quality of practice.

- Thresholds for intervention are understood in the MASH, but further work is required to ensure that the initial contact service consistently applies these thresholds. Decision making in the MASH demonstrates an understanding of risk and the need for a timely response when children and families need help.

- In assessments of need, issues of risk are identified and understood but in too many cases seen these have not been acted upon in a timely way to ensure that all children are safe.

- Plans and interventions are not sufficiently robust and do not lead to improved outcomes in cases seen.

- While managerial oversight is evident, there is insufficient challenge to the lack of progress and drift in cases.

- Chairs of child protection conferences are not providing sufficient challenge to lack of progress in cases and in some instances are not recognising increased risk as a result.

Evaluation of progress

The establishment of a MASH since the last inspection, and more recently a contact service, is ensuring a greater consistency of response at the point of referral and is helping to manage the volume of work into social care services. Thresholds are understood in MASH and informed decision making based on need is ensuring that requests for help are being responded to in a timely manner. The contact service that performs a triage function for all calls is less consistent in its application of thresholds and in some instances requests for help were diverted to early help services and were not passed on to MASH when they should have been.

Well-developed information sharing processes between agencies in MASH are helping to ensure that informed decisions underpin future actions. However, information from health partners is at times not as comprehensive as it could be because of a lack of staff availability. There is, however, good use of historical information relating to previous contacts and work with families, and this is being used well by managers to determine what actions they will take.

There is a comprehensive process that audits work in MASH, with managers checking the appropriateness of decision making three times a week. This is to ensure consistency and quality of response.

At the last inspection, social work caseloads were considered to be too high to allow a consistent response to the help and protection needs of families. Much work has been done to ensure lower caseloads. These now average at just over 20 per social worker in assessment teams, and staff say that this is more manageable.

Since the last inspection in March 2014, there has been progress in ensuring compliance with assessment and planning processes. In cases seen, this includes more timely assessments of need by ensuring that child protection case conferences and review conferences, core groups and children in need planning meetings are all held within appropriate timescales. Involvement of the family drug and alcohol court in cases is ensuring a more focused approach to assessment and planning.

In cases looked at by inspectors, children were being seen by their social worker and, where appropriate, alone. There is evidence of direct work with some children and when this is happening it is making a positive difference to them. Social workers say they feel supported and evidence demonstrates more regular supervision, although in most cases it is not reflective or analytical and there is a lack of focus on case progression. This is recognised by senior managers and there is some evidence of early action through training and development.

While there has been some progress in ensuring that assessments are in place for children and young people, these are not always updated when circumstances change. In some cases seen they have not adequately addressed the impact of parents' behaviour and lack sufficient depth of analysis to effectively determine need. This is an area which required improvement in the last inspection and remains the same.

There has been insufficient progress in ensuring that outcomes for children and young people in need of help and protection have improved. In cases seen, the majority of young people had not received appropriate responses to the risks they faced even though those risks were identified. In some cases, not enough consideration was given to continuing risk and lack of progress in reducing risk over sustained periods of time. Managers and child protection chairs did not recognise drift or take action to change plans when progress was not being made. This has left children and young people at continuing and, in some cases, increased risk. This has required senior management intervention as a result.

Although the authority has introduced a recognised model of practice to consider risks and strengths in families, it is not used on a consistent basis in child protection case conferences to measure risk and make decisions on agency response as a result. In some cases seen, this has led to young people not being subject to child

protection plans when they should have been. This means that they are not receiving the services they should to reduce risk.

Child protection plans and children in need plans are not always clear about the changes that parents and carers need to make to ensure a better outcome for children. Actions, particularly in children in need plans seen, do not have timescales for completion. These plans are not always used as a working document to ensure good multi-agency co-ordination with parents and carers by fully involving them in discussion and decision making. Insufficient progress has been made in this area since the last inspection.

Senior managers have introduced a quality assurance-based audit process that is effective in identifying key themes, alongside progress and outcomes from a child's perspective. This is innovative and has enabled managers to be aware of many of the current strengths and weaknesses identified by inspectors on this visit. However, its use is yet to make sufficient and the required difference both to practice and outcomes for children and young people in need of help and protection.

In summary, insufficient progress has been made in key areas of practice since the last inspection. Some children and young people remain at risk and as a result their outcomes remain poor. Progress has been made in terms of ensuring compliance in relation to processes but much remains to be done to enhance the quality of practice and decision making in individual cases.

We would like to thank all the staff who contributed to our visit and their positive engagement with the process.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Peter McEntee

Her Majesty's Inspector

The letter is copied to the Department for Education [at SocialCare.INSPECTION-IMPROVEMENT@education.gsi.gov.uk]