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Dear Ms Butler

Focused visit to Oxfordshire county council children's services

This letter summarises the findings of a focused visit to Oxfordshire county council children's services on 5 and 6 February 2020. The inspectors were Kate Malleson and Brenda McInerney, Her Majesty's Inspectors.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan. Specifically, inspectors considered the identification of the impact of the cumulative effect of neglect on children and the timeliness of interventions in response to children's escalating needs.

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

Overview

The majority of children in need, and those subject to a child protection plan, receive an effective service at an appropriate level of intervention. Since the last inspection, the local authority has improved the quality of planning for unborn children and the timeliness and effectiveness of pre-proceedings work. Disabled children receive good-quality services. Providing children with good services is a high priority for senior leaders and elected members. They are not complacent about the continuing stubborn challenge of addressing the cumulative impact of neglect for children. A small minority of children are living for too long in circumstances where they continue to experience neglect and emotional harm. Management oversight and planning require strengthening so that drift and delay are prevented and that all children's lives improve quickly.

The local authority knows itself well. Senior leaders and members are responding appropriately to the challenge of meeting increased demand with the planned introduction of a new service delivery model. This includes a commitment to increasing the number of social workers who work with children in need and children on child protection plans.

There are no priority actions.

What needs to improve in this area of social work practice

- Practice and management oversight so that drift and delay for children are consistently recognised and challenged and children receive a more timely and effective response to the impact of cumulative neglect.

- The quality of planning to enable the pace of progress to be measured and evaluated.

- The attendance of partners at child protection conferences and reviews.

- Children's participation in child protection conferences and reviews.

- Quality assurance processes so that they have more impact on improving the quality of social work for children.

Findings

- Thresholds for children in need of statutory intervention and those in need of early help are applied appropriately. In the large majority of cases, inspectors saw persistent and skilled work, sometimes involving complex cases, and often with large family groups. There were no children receiving help at a statutory level who should not have been. This is good progress made since the last inspection, when some children were unnecessarily experiencing statutory intervention. However, in a very small number of cases seen, professionals' over-optimism led to the premature closure of children's cases. This has the potential to undermine progress that has been made.

- The timeliness and effectiveness of pre-proceedings work is improving. A very small number of children have experienced lengthy periods of child protection planning without effective oversight or review of their circumstances. This ineffective oversight has led to drift and delay in escalating cases to pre-proceedings. However, more recent practice shows better work with timely escalation and more consistent management oversight. As a result, children are being diverted from entering care. The positive recent appointment of a case progression officer has the potential to further strengthen the improvement in this area.

- The quality of planning for unborn children has improved and is now consistently timely. Early assessment of the needs and risks to unborn children and, where appropriate, healthy scepticism about parental truthfulness, ensures the child remains central to planning, and that planning is proportionate.

- Written plans, but more significantly, planning in general, are not consistently or reliably improving children's circumstances quickly enough. The local authority has identified that written plans need to be specific about what needs to happen and when it needs to be completed so that real progress for children, not just parental compliance, can be accurately and realistically measured and analysed. However, the wider impact of poor planning, including what will happen when expectations about meeting children's needs remain unmet, requires a more determined focus.

- Partnership attendance at initial and review child protection conferences is too inconsistent and too many conferences are not quorate. Cases seen included important decisions made to end child protection plans without significant agencies being present and involved in those decisions.

- Children's voices are not well represented at conferences and not enough children have the support of an independent advocate to participate in these important discussions about their lives.

- Management oversight and supervision mostly takes place regularly, but managers do not consistently provide rigour and challenge or take a fresh look at a child's circumstances. This means that weaker practice and delay are not reliably being identified. Additional scrutiny in the system, such as child protection panels and independent oversight, are also not always effective in identifying when children's circumstances are not improving quickly enough.

- Social workers mostly visit children regularly, and inspectors saw some evidence of direct work using a child's preferred method to understand their wishes and feelings. Practice is child-centred in the majority of cases, and is supported by the developing practice of recording visits by writing 'to the child'. This powerful methodology brings the child to life and helps social workers and supervisors to better understand the child's lived experience and provide children with a valuable sense of their lives if they later read their case records.

- Social workers and family support practitioners know their local communities well, and the co-location of services in targeted areas of the county means that families benefit from holistic support. Children and families are supported by an accessible range of specialist services to address risks from substance misuse and domestic abuse. Where possible, families are allocated social workers who have been previously known to them, which assists the building of trust and relationships. The local authority 'grows its own' social workers, some of whom have been family support workers, and this adds value to the workforce.

- Action taken by the local authority and the safeguarding partnership to ensure that the issue of neglect is effectively addressed has had limited impact on improving practice. The local authority is aware that there is more to do. Although the issue is more visible, training has been provided, and professionals can access a good range of resources and tools, these are not being routinely used. In a few cases, there is an over-reliance on the ability of very vulnerable and compromised parents to be able to enforce written agreements to keep their children safe. This includes women experiencing domestic abuse. Progress, or lack of progress, is not routinely measured or specifically assessed and analysed. As a result, social workers, supported by early help workers, cannot be certain about the extent of progress being made or of when more assertive action needs to be taken.

- Disabled children who are at risk of significant harm receive effective help and protection. The whole-family approach to child in need and child protection planning, with strong management oversight, ensures that the needs of all children in the family are well addressed and that children's circumstances improve.

- The corporate commitment to improving children's services is evident. The local authority is introducing a family safeguarding model, which includes the recruitment of additional social workers to meet increased demand and expand the capacity of local family safeguarding teams. The practice of a few child in need cases being supervised by early help workers will cease under the new arrangements.

- Despite an appropriate focus on routine auditing and performance monitoring activity, leaders acknowledge that the current arrangements are not having enough impact on improving the quality of social work practice. Regular and themed audits are carefully analysed and monitored, and they accurately identify deficits in practice. However, some issues have been longstanding and difficult to progress. Monthly audits are crude checklists which are largely focused on the completion of tasks and lack detailed reflection about whether decisions and work have made a difference for children. Managers do not complete the required number of audits and so auditing activity is not providing the depth of information or the breadth of coverage which is needed to progress improvement and embed organisational learning. Senior leaders have a plan to strengthen quality assurance processes.

- Social workers told inspectors they are well supervised and have manageable caseloads. However, there is increasing demand and a lack of capacity at practitioner, and managerial, level in some teams, which is having an adverse impact on the quality and timeliness of work.

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

Yours sincerely

Kate Malleson
Her Majesty's Inspector