Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

12 January 2024

Tanya Miles
Executive Director of People
Shropshire Council
Abbey Forgate
Shrewsbury
SY2 6ND

Dear Ms Miles

Focused visit to Shropshire children's services

This letter summarises the findings of the focused visit to Shropshire children's services on 23 November 2023. His Majesty's Inspectors for this visit were Rebekah Tucker and Rebecca Quested.

Inspectors looked at the local authority's arrangements for children subject to a child protection plan, with a particular focus on the quality and impact of pre-proceedings interventions.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

Since the last inspection in February 2022, when Shropshire children's services were judged to be good, there has been a deterioration in the quality of social work practice for those children subject to child protection plans. There are serious and widespread systemic failings, leading to weaknesses in child protection practice, which leave children at risk of inadequate protection and significant harm. These concerns were known to senior leaders at the time of this visit, but the plans for improvement outlined in the self-evaluation have not yet had the necessary impact on the quality of practice to ensure that children's needs are sufficiently addressed.

Too many social workers and managers fail to ensure that child protection processes are followed to investigate and manage escalating risks to children. There is a lack of systematic management oversight of frontline practice. This means that children are exposed to the risk of harm for extended periods without proactive action being taken when risks increase. For example, the local authority is not always holding strategy discussions in a timely way, there are delays initiating child protection enquiries and decisions to start pre-proceedings are taken too late. This has contributed to children experiencing significant drift and delay.

There have been considerable challenges in the recruitment and retention of staff since the inspection, which has led to an over-reliance on agency workers in the case management teams. This has resulted in very frequent changes of social worker for some children and families. The situation is compounded by the significant turnover of team managers and one service manager in the last 12 months, which has created a level of inexperience across the case management and court teams. This has led to inconsistent and ineffective management oversight of plans to support children.

Capacity within the quality performance and assurance service is insufficient to meet demand, due to the increased numbers of those children who are in care and subject to child protection plans. Caseloads for child protection conference chairs are too high. As a result, child protection plans do not receive the appropriate level of independent scrutiny and challenge when there is a lack of progress for children. There are also vacancies in key quality assurance posts, which has impacted on the ability of managers to gain assurance about the quality of social work practice in this area of the service.

Senior leaders recognise the significant practice deficits raised by inspectors during this visit and are committed to making the necessary changes to improve the quality of child protection practice and pre-proceedings interventions. There is a stable senior leadership team, whose members are supported financially and politically by corporate leaders in the council. There has been considerable investment in children's services, including at the 'front door', TREES, the local authority exploitation team, residential services, the parenting team, early help and Stepping Stones, the local authority edge of care service.

Areas for priority action

- Weaknesses in child protection practice, which leave children at risk of significant harm, including the quality of management oversight and decision-making, staff supervision, and appropriate challenge by child protection chairs.

What needs to improve in this area of social work practice?

- The consistent understanding, and application of, pre-proceedings interventions to ensure that children are appropriately safeguarded in a timely way.
- The quality and effectiveness of child protection plans.
- The quality and timeliness of strategy discussions and initial child protection conferences.
- The effectiveness of multi-agency core groups to ensure that progress is measured, and that drift and delay is challenged by all partner agencies.
- The quality of quality assurance activity, including auditing of social work practice, across the service.

- The training and support provided to social workers and managers in relation to statutory child protection procedures.

Main findings

Since the last inspection, senior leaders in Shropshire have continued to develop early help services and Stepping Stones, the local authority edge of care service. The targeted growth of these areas has resulted in some staff gaining internal promotion into these new teams, which has resulted in an increase in vacancies in case management teams. As a result, vulnerable children who are subject to child protection planning receive an inconsistent response to escalating need and risk. The impact of these changes on the quality and delivery of child protection services has been significant, with some children left at risk of harm for too long.

The quality of children's assessments of their need is variable. For a small number of children, their voice is captured well and their lived experience is clearly articulated. For other children, the impact of historical parental risk factors on their emotional and physical development is not sufficiently considered. Some children within the wider familial circle are not identified, or taken into account, as part of the assessment. When children are referred to children's social care, there is a variability in response. This is sometimes due to delays in partners making referrals. Some pre-birth assessments are completed in a timely way and children are considered at an initial child protection conference appropriately due to the identified risk of harm. This results in some children coming into care at the right time. For other children, there are missed opportunities to undertake a pre-birth assessment, and they remain in situations of unassessed risk for too long. Private fostering assessments are not always completed promptly, or to a suitable standard.

There is an inconsistency in the quality of visits to children. Most children are visited by social workers at a frequency that meets their needs, although for a small number of older children, they are not seen alone. For most children, these visits are purposeful and social workers develop positive relationships with them and their carers. There is variability in the quality of recording of visits, as some are too brief and do not sufficiently focus on the voice of the child. Direct work is not routinely undertaken with children to understand their wishes and feelings. As a result, it is not possible to gain a clear view of children's experiences to inform the progress of plans and the management of risk.

Statutory child protection processes are not routinely followed for some children. For example, strategy discussions are not always timely or undertaken appropriately as risks escalate, so some children remain in situations of unassessed risk for too long. Section 47 child protection enquiries are not always appropriately escalated to an initial child protection conference, despite the risk of significant harm to children.

There is variability in the timeliness of initial child protection conferences, which means that some children are left at risk of harm for too long before their

circumstances can be fully considered by multi-agency partners. Initial and review child protection conferences are usually well attended by partners who contribute appropriately to decision-making. When families disengage from child protection plans, multi-agency challenge is not sufficiently robust in core groups and review conferences to effect change, and there is an absence of effective scrutiny from child protection chairs about next steps.

Some child protection plans are detailed in their identification of risk to ensure that families are aware of what needs to change to improve children's outcomes. Most plans are too adult-focused, contain out-of-date information, and do not capture the views of parents or children. Some plans are not accessible to parents with a learning need, lack clear contingency planning, and have not been signed off by managers.

Children remain on child protection plans for too long and there is an absence of robust and effective challenge by child protection chairs. A small number of children remain on child protection plans for significant periods with no progress made to achieve sustainable change. Some children have been subject to multiple child protection plans over several years. Disabled children who require child protection planning experience drift and delay. Visits to disabled children do not take place regularly and children are not always seen, or seen alone.

Although core groups are usually well attended by partners, who actively contribute to meetings, this does not always lead to an effective multi-agency response for children. Parents are not routinely involved in core groups, which means that plans are not developed collaboratively with families. Core groups do not consistently develop child protection plans in a timely way and professionals are not held to account to improve children's experiences and reduce their exposure to harm.

The impact of this is that the pre-proceedings stage of the Public Law Outline (PLO) is mostly commenced too late, and care proceedings are not initiated in a timely way for children. There is insufficient grip of practice by social workers, managers and child protection chairs in driving forward plans. This is exacerbated by frequent changes in social worker, leading to a 'start again' approach, in which children and families have to develop new relationships with social workers. Parental non-engagement or disguised compliance is not always challenged in the pre-proceedings stage. Decisions to enter pre-proceedings are taken too late for these children, which means that they are left in situations of risk for too long. For a very small number of children seen by inspectors, decisions to bring children into care were appropriate.

Since the last inspection, when practice was recognised as needing to be strengthened, there has been ongoing work to improve the pre-proceedings process, including revision of the PLO tracker and letters before proceedings, development of a PLO toolkit and staff training. The impact of these changes has not been fully embedded and there is still much more to do in this area. Although senior managers routinely track and review children who are in pre-proceedings, this is not effective in

progressing children's plans to ensure that escalating risk is quickly recognised and responded to in a timely way. As decisions to start pre-proceedings are taken too late and for too few children, early consideration is not given to secure the legal permanence for children within the family when this is in their best interests.

Letters before proceedings are poorly written and some contain inaccurate information and oppressive language. Most letters lack clarity about what the concerns are, how the parents will be best supported to meet their child's needs, and how the planned actions will inform next steps.

Stepping Stones, the local authority's edge of care team, provides an effective service that has successfully supported and diverted a number of children on the edge of care to have their needs met and remain with their families in the last six months. Workers in this service are resilient, provide effective interventions and make concerted efforts to engage with families.

The senior leadership team acknowledges the significant practice shortfalls identified during the visit and expressed their commitment to improve the quality of services for children in Shropshire. Despite this, the pace of improvement has been too slow, and there has been a lack of clear strategic direction and action in this part of the service to address practice deficits. During the inspection, the director of children's services told inspectors that a children's improvement board will be set up, to be chaired by the chief executive of the council, to ensure that there is more robust oversight of improvement plans in this part of the service.

Recruitment and retention of social work staff continue to be a challenge. This has been compounded by a churn of agency staff, the departure of the court project team, and a new management structure. There have also been gaps in key leadership roles, including in the quality performance and assurance service, which has led to a lack of management scrutiny and direction. Recent recruitment to these posts has been successful, although the posts remained vacant at the time of this focused visit.

The workforce strategy put in place by the senior leadership team to recruit and retain staff has not been sufficiently effective in tackling the staffing issues. Senior leaders acknowledged this in their self-evaluation and told inspectors during the visit that there is a need to adapt their strategy in order to attract skilled permanent social workers. The local authority has been successful in recruiting some agency social workers into permanent roles very recently.

Supervision is held regularly with social workers. The quality and impact of supervision is variable and it is not consistently effective at progressing children's plans. Supervision actions lack sufficient purpose and measurable timescales, which further compounds the drift and delay in planning for children. When senior managers do identify shortfalls in practice, this does not always result in remedial action being taken. Performance information is not routinely used to improve the

quality of practice and the redesign of the PLO tracker has not led to effective change. As a result, some children's plans drift and their experiences do not improve.

Senior leaders have recognised that the current adherence to the quality assurance framework has declined since the last inspection and that it is not effective in improving social work practice and the experiences of children. The number of case audits has reduced, due to the workforce challenges. This limits the ability of senior leaders to understand the extent of practice shortfalls or to gain sufficient assurance about strengths and weaknesses in this part of the service. Audits are mostly moderated appropriately, and this adds value, as moderators appropriately identify when auditors are over-optimistic. Audits are not sufficiently clear about what remedial actions need to be taken to improve practice. Senior leaders acknowledge that there is more to do in this area, including the training of those staff who undertake audits, and the development of clear actions to 'close the loop' and to promote greater consistency across social work teams.

Social workers report feeling listened to and very well supported by their team managers and senior leaders. They value the comprehensive training offer available to them and told inspectors that their personal development was prioritised by their managers. Senior leaders were described as approachable and visible by all staff.

Ofsted will take the findings from this focused visit into account when planning the 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 these areas 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

Rebekah Tucker
His Majesty's Inspector