Halton Borough Council

Inspection of local authority children's services

Inspection dates: 02 March 2020 to 13 March 2020

Lead inspector: Shabana Abasi
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Since the last inspection of the local authority children's services under the single inspection framework (SIF) in November 2014, the focused visit in July 2018 and the joint targeted area inspection (JTAI) in July 2019, the local authority has made positive improvements in some service areas. Focused strategic planning and an understanding of the need to prioritise areas of higher risk have resulted in effective early intervention services, a strengthened initial response to children needing help and protection and strong arrangements to tackle extra-familial risk.

Slower progress has been made in other aspects of the service, and weaknesses found during this inspection mirror some of those areas requiring improvement in the SIF inspection. The application of thresholds in the integrated contact and referral team (iCART) is not always consistent, and the need to seek or dispense with parental consent is not fully understood or recorded. Some children remain living in situations of chronic neglect for too long before decisive action is taken. The management oversight of work with children within the pre-proceedings process has recently been strengthened but is not yet sufficiently robust to ensure that decisions

are always made within a timescale that is right for children. Private fostering arrangements are not consistently identified and assessed. Effective management oversight and challenge are not sufficiently embedded in all service areas.

A focused approach to recruitment and retention and a commitment to increasing staffing capacity have resulted in greater workforce stability, for both management and frontline staff. Following a period of senior management instability, a newly formed senior leadership team is in a better position to accelerate the pace of improvement.

What needs to improve

- Consistency of application of thresholds and understanding of parental consent in iCART.
- Quality of assessments, and plans, including personal educational plans (PEPs) and contingency planning.
- Management oversight, challenge and supervision, to support consistent, good-quality social work practice.
- The sufficiency of high-quality placements to meet children's needs.
- Strategic planning to support service improvement.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children and families who need help at an early stage have access to a comprehensive range of services to support their needs. Well-coordinated packages of support build family resilience and improve the experiences of children. When need and concerns increase, children's cases are appropriately stepped up from early intervention so that they receive a statutory social work service.

2. The iCART provides an accessible single point of contact for families and professionals seeking advice and support and seeking to make a referral to children's social care. The co-location of partner agencies in iCART helps ensure prompt and appropriate sharing of information to support decisions about next steps and the safeguarding of children.

3. When children need a social work assessment, most are transferred from iCART to child in need and child protection teams appropriately and without delay. However, the criteria for making decisions about the thresholds at which children receive different levels of intervention and services are not always consistently applied in iCART. For a small number of children, the initial assessment of need

is not robust, resulting in children's cases being signposted to early help when a social work assessment of their needs would have been appropriate. This means that children and families do not always receive the right help at the right time. The purpose and practice of obtaining parental consent is not fully understood and not always well recorded. In some cases, information is sought and shared by iCART with agencies without informed parental consent.

4. When children are at risk of significant harm, they receive a prompt and effective response. Their needs are prioritised, and cases are swiftly transferred for a child protection response. When children are referred outside office hours, the emergency duty team responds appropriately to contacts and communicates efficiently with iCART. Records are completed promptly, show the actions taken and provide the detail of what further work is required by the day service.

5. Timely and well-attended multi-agency child protection strategy meetings, effective information-sharing and an effective focus on risk are leading to appropriate decisions and actions to protect children.

6. Social work assessments are not of a consistently good quality. While the majority are detailed and identify risk, this is not rigorously analysed and the impact on the child is not fully considered. This impacts on the quality of subsequent plans.

7. Disabled children benefit from comprehensive assessment of their needs, which leads to strong planning and child-centred interventions for children and families. This means that disabled children are safeguarded effectively through prompt recognition and response to risk.

8. Plans are not always clear about the outcomes desired or timescales for actions to be completed, and they lack detail about contingency planning. Some plans are overly focused on adults. This means that actions to address risk and improve children's circumstances are not always as effective as they could be or completed in a timely way. Managers are not always challenging the quality of poorer assessments and plans, and this is hindering improvements in practice. Senior managers are aware of these weaknesses and are addressing this through practice workshops. Plans are in place to strengthen practice through the further roll-out of the preferred social work model, which is not fully embedded.

9. Children are seen regularly and in accordance with their needs. Home visits are purposeful, and direct work undertaken with children enables social workers to understand children's daily experiences.

10. Multi-agency reviews take place regularly and are well attended. However, when some children's circumstances do not change, there is not always a sufficiently swift response to address this. Managers and child protection chairs are not challenging drift appropriately in these cases, and this creates delay for some

children in receiving a more protective response. Not all plans are sharply focused on what needs to change. For some children, an over-optimism by social workers and managers about parental capacity to sustain change has meant that cases have been stepped down prematurely to lower levels of intervention.

11. Pre-proceedings work has recently started to have an impact on the timeliness of cases that need to progress to care proceedings or that need a lower level of intervention. The new arrangements in place show more effective management oversight. However, for some children, progress in this area has been too slow, and critical challenge provided by managers and child protection chairs has not been robust or effective. As a result, some children have remained in situations of neglect for too long.

12. Children at home or in care who go missing, or who are at risk of exploitation, receive robust, well-coordinated strategic and operational multi-agency support to help reduce risks. Effective multi-agency working ensures that all intelligence is shared and that links with other vulnerable young people are identified. This enhances risk management and the planning of support. When children have been missing, return home interviews are timely and the information gathered is used effectively to inform safety planning.

13. There are well-embedded systems and robust management oversight for tracking, assessing and safeguarding children who are missing or at risk of missing education. Children who are home educated are monitored effectively by the education welfare service and supported if their circumstances change.

14. There is not a consistently robust response to 16 to 17-year-olds presenting as homeless. Assessments of need are not sufficiently comprehensive. This means that not all young people receive an appropriate and timely response to meet their needs. Private fostering is not well understood. Children living in these arrangements are not promptly identified in order to ensure that their needs are assessed and they are safeguarded effectively in a timely way. The local authority has firm plans to address both these areas of practice.

15. The monitoring of allegations against adults working with children is undertaken by a number of independent reviewing managers (IRMs) working in the role of designated officer. This is not supporting consistently good oversight of the progression of cases. Although initial responses to risk are appropriately managed, senior managers are aware that the current arrangements are not as effective as they could be, and are implementing plans to improve the practice and processes underpinning this work.

The experiences and progress of children in care and care leavers: requires improvement to be good

16. Decisions for children to come into care are mostly timely and in the best interests of children. However, for a small number of children for whom there are long-standing concerns about neglect, earlier opportunities to intervene are being missed.

17. Permanence planning for children is routinely considered from an early stage. Children who are unable to return to their birth families are supported to live with foster carers, or connected-person carers, including under Special Guardianship Orders (SGOs). Pre-birth assessments are of a good quality and inform early permanence planning well. Viability assessments of potential carers for children from within their extended family networks are timely, providing a clear analysis of risk, strengths and the capacity to meet children's needs and to protect them.

18. When children return home from care, this is informed by appropriate assessments and careful transition planning. Good support packages and regular monitoring ensure that children's needs are met, that risks are reduced, and that children continue to be safeguarded and protected.

19. Children in care are visited regularly by their social workers, who also see them on their own when this is appropriate to their age and circumstances. Most social workers know their children well. Most direct work undertaken with children is of a high quality. However, for a small number of children, direct work is limited due to the competing demands of some social workers' caseloads. This means that children's experiences are not always fully understood.

20. Comprehensive and well-written social work reports for reviews support detailed care planning. Most children have up-to-date care plans that are regularly reviewed and well informed by children's views. However, they do not all contain contingency plans, and so alternative permanence options are not always well considered.

21. Most children make meaningful contributions to their reviews. Advocacy and independent visitor support are appropriately considered within reviews. Most reviews are regular, child-focused, well attended and measure the progress of children's plans. However, IRMs do not consistently provide challenge, and this means that, for a small number of children, planning lacks pace and focus.

22. Arrangements for children to spend time with their families and other people who are important to them are well considered and promoted. This means that children are able to maintain and develop significant relationships. Children are supported by their carers and social workers to engage in hobbies and interests. This encourages children to broaden their experiences.

23. Since the JTAI, improvements have been made in meeting children's physical and emotional health and well-being needs. The emotional well-being panel provides a high-quality, multi-agency approach to providing mental health support. There are a range of effective services to provide support to children at risk of child exploitation and that help reduce risks.

24. The virtual school has a positive presence and is held in high regard by schools. It has an accurate picture of strengths and areas for improvement, and a number of new initiatives have been implemented to improve educational outcomes for children in care. However, the impact of these initiatives is not yet evident, for example from the work to improve children's attainment at key stage 4. Children's personal education plans at key stage 1 and key stage 2 are completed thoroughly and well. However, children's personal educational plans at other key stages are too variable, and some lack clear targets for improvement and do not support educational planning effectively.

25. Most children are living in placements that are meeting their needs and are helping them to make good progress, including those in specialist provision and placed outside the local authority. Some children have to wait too long to be matched with foster carers. As a result, a few of these children are experiencing ongoing insecurity and anxiety about their future care. Senior managers have recently introduced tracking systems to ensure that historical delays are addressed and permanence decisions for children in long-term foster care are made within children's timescales.

26. Placement sufficiency is a challenge that the local authority is aware of. Concerted efforts in the last 18 months have seen a small increase in the number of foster carers. Foster carers speak positively of the support and training they receive from the fostering service. Placement choice remains limited, and, as a result, a small number of children have been placed in unregistered settings. The commissioning arrangements for these placements have not been sufficiently robust to ensure quality in all cases.

27. For most children whose plan is adoption, permanence is achieved promptly. Decision-making for adoption is well informed and well documented. Assessments are thorough and there are a range of support initiatives to ensure that adoption support is available when families need it. Most child permanence reports and life-story work are of sufficiently good quality. Brothers and sisters are placed together unless assessments indicate that they would benefit from being placed apart.

28. Care leavers are supported effectively by personal advisers who know them well. Personal advisers maintain contact at a level that is appropriate to young people's needs. Most care leavers have up-to-date pathway plans, which clearly reflect their views, identify needs and the necessary actions to address these. Care leavers receive practical support to help them develop their independence

skills. They have access to a broad range of services, and are supported well with education, employment or training needs, as well as emotional and physical health issues. Care leavers live in suitable accommodation and are supported well in their placements. The local authority has plans to further improve the choice available for 16 to 18-year-old care leavers. There has been a reduction of care leavers in employment, education or training (EET). The local authority is seeking to improve the range of opportunities available.

29. The children in care council (CICC) is a vibrant and energetic group, and the members are very positive about the activities they are increasingly involved in, as well as the opportunities they have had to contribute to further improving services.

The impact of leaders on social work practice with children and families: requires improvement to be good.

30. Leaders have prioritised and implemented changes that have resulted in solid improvements being made to some services provided to children and families. Arrangements in the iCART have been strengthened, ensuring that multi-agency information-sharing is efficient and effective and supports the safeguarding of children. The scale and effectiveness of early intervention services is resulting in more children and families having access to timely and appropriate support. This is improving children's experiences and avoiding the need for statutory intervention when this is appropriate. Children at risk of exploitation and going missing receive a robust service that is helping to reduce risk.

31. A lack of consistent effective strategic oversight of all areas of practice means that there are still some core areas of social work practice that require further improvement to ensure that children and families get a consistent response. These include children's assessments, plans, management oversight and case supervision. Senior managers' plans to address some of the practice deficits have been hindered by workforce instability, social workers' workloads and sometimes a lack of critical self-challenge.

32. The safeguarding and children in care partnership boards and scrutiny committee provide relevant oversight of, and challenge to, operational services when deficiencies are highlighted. Senior leaders are held accountable for the performance of services and the experience and progress that children make.

33. There is a whole-council commitment to improving services for children and families. Significant investments have been made to increase workforce capacity, early intervention services and commissioned services. Although leaders across the local authority have an overall understanding of strengths and weaknesses in children's social care, they do not have a full understanding of the scale of improvement required to provide consistently good services to children and families.

34. The local authority's self-assessment is overly positive, presenting a picture of where it would like services to be, rather than where they are currently. Senior managers know that practice remains variable, but there is no overarching transformation plan to drive effective service improvement. The local authority has ambition and capacity to improve services for children and families, but more needs to be done to embed the quality of practice so that all children receive a consistent response to meet their needs.

35. Senior leaders and managers have access to comprehensive performance management information. However, turnover of frontline and senior managers in the last year has meant that performance culture is not sufficiently embedded. It is positive that leaders have recognised and addressed workforce instability and inexperience and now have the capacity to take this forward, but this will take time to embed.

36. Quality assurance activity is not wholly effective. A focus on measuring compliance rather than quality of practice means that frontline managers do not always make an accurate evaluation of social work practice and what this means for children. Senior managers have recognised this, and a revised quality assurance framework is being implemented. It is too soon to see an impact on practice.

37. Management oversight of frontline practice, including by child protection chairs and IRMs, is not always leading to timely planning for children. Case supervision does not evidence sufficient challenge or reflection about weaker practice and, in some cases, the focus of supervision is on the process rather than the impact for children.

38. Social workers feel well supported by accessible managers and have access to a wide range of appropriate training. They are positive about working for Halton. Consistent challenge to support practice improvements is less well embedded. While most social workers' caseloads are manageable, some social workers have higher caseloads. The volume and complexity of their workloads mean that some social workers are not able to spend as much time with children as they need, and their ability to clearly record children's progress is reduced. In some cases, this causes delay in securing the best outcomes for children. Senior managers have firm plans to address equity in workloads.

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