St Helens Metropolitan Borough Council

Inspection of children's social care services

Inspection dates: 23 September 2019 to 4 October 2019

Lead inspector: Lorna Schlechte
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	Inadequate
Overall effectiveness	Inadequate

Since the last inspection in 2014, there has been a decline in the quality of services for children in St Helens. A focused visit by Ofsted in July 2018 identified areas for priority action because children were placed at risk, there was a lack of understanding in relation to thresholds and there was too much drift and delay, including for children subject to pre-proceedings.

The local authority promptly set up an independently chaired children's improvement board in September 2018, and a further focused visit in November 2018 identified some progress at the front door. However, there are widespread and serious failures in the quality of services for children in care due to significant drift and delay in permanence planning. Management oversight in this area of work is ineffective, and staff have limited awareness of the need for early planning for permanence. This is compounded by a lack of tools and systems to help the local authority understand the extent of the issue and intervene to remedy the situation at the earliest opportunity. Senior leaders fully acknowledge practice deficits

identified by inspectors, but they had been unaware of the extent of the problem. This has led to a significant number of children waiting too long to secure legal permanence and achieve their full potential.

The director of children's services (DCS) has recognised the shortfalls in practice and has driven the improvement plan forward. A new senior leadership team has been established in recent months and has begun to ensure that the right trajectory for improvement is in place. It is now recognised that there is a need to develop a culture in which more dynamic social work practice can be supported. However, recruitment to secure an experienced senior leadership team has taken a considerable amount of time and this, together with significant turnover of team managers in some teams over the last year, has created instability as a new workforce structure embeds. This has hampered the pace of progress, which has not yet been sufficient to ensure consistently better work.

Recent developments have led to some improvement for care leavers, the multi-agency safeguarding hub (MASH) and disabled children. The director of children's services (DCS) has ensured that frontline services are now overseen by experienced managers with a social work background. The quality assurance framework has been revised, but it is not yet fully implemented.

No children that require help and protection were found to be left at risk of immediate harm during the inspection. However, children and families are not yet receiving a good service. The volume of work has continued to increase, and numbers of children in care are high. The local authority has, at times, struggled to maintain a timely workflow and response to the needs of children and families because of high caseloads and staff instability.

What needs to improve

- The quality of social work assessments and plans, to ensure that intervention is purposeful, and progress with children and families can be measured.
- Management oversight and monitoring of services, including in pre-proceedings, to ensure that there is sufficient grip on the quality of practice, to avoid drift and delay for children.
- Permanence planning from the front door through to adoption, to ensure that the full range of permanence options are achieved in a timely way for all children in care.
- Support for children and families on the edge of care which is timely, responsive and effective.
- The quality and usefulness of pathway plans, to ensure that they help care leavers address a range of issues, depending on individual needs.
- Independent Reviewing Officers' (IROs') challenge in relation to the quality of permanence planning, to ensure that more robust oversight drives practice effectiveness.
- The quality of support to new social workers and close monitoring of caseloads for all staff, to ensure that they have the right support in place to work effectively with children and families.
- Corporate support on implementing improvement plans with pace.

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

1. No children were found to be left at risk of immediate harm during the inspection. However, children and families are not yet receiving a consistently good service. There is effective and timely decision-making at the front door. However, there is drift and delay in progressing plans within the duty and assessment teams, which impacts on the quality of work provided to vulnerable families in need of support.

2. The arrangements in the MASH are well embedded, partners are well represented and thresholds are now more consistently applied. This results in referrals being progressed in a timely way, with clear management oversight regarding next steps and consideration of historical factors. Consent is appropriately sought and recorded. Domestic abuse notifications are closely scrutinised through a daily multi-agency meeting. An effective daily 'high risk'

meeting is held with partners to consider children at risk of exploitation. Out-of-hours decision-making is prompt and well recorded, and it provides a clear interface with daytime services.

3. Children whose needs meet the threshold for early help are supported well, although early help assessments and plans vary in quality. An early help partnership coordinator in the MASH provides robust oversight of requests for early help and this ensures a timely response. Some families receive an effective service from early help, which leads to positive outcomes. However, decisions are sometimes made to reduce the level of support prematurely, resulting in the need for repeat statutory interventions in a short space of time. This is sometimes mitigated by the multi-agency 'Level 2' panel, which considers and addresses cases where escalating risk and need are identified. Vulnerable families who have been subject to previous court intervention are effectively supported through the PAUSE programme.

4. Child protection concerns are mostly responded to effectively. Child protection investigations are thorough and strategy meetings are well attended. This leads to a clear rationale for next steps. Some agreed actions are subject to delay due to a lack of management oversight regarding the completion of timely risk assessments. This leaves a small number of children in situations of unassessed risk. Allegations against professionals have not always been responded to robustly in recent months, as there have been delays in progressing and coordinating investigations. New arrangements have now been implemented by the designated officer that are supporting more effective oversight.

5. The quality of assessments is not consistently good enough and they are not always updated after significant events. Analysis is sometimes weak and the voice of the child is not always clear; in the stronger examples, the new model of practice is used to understand risks, strengths and protective factors. There is an increasing focus on using the graded care profile tool to understand the impact of neglect on children.

6. The quality of plans is too inconsistent. Too often, plans are generic and lack clarity regarding what actions need to be completed, by whom and by when. The number of children subject to child protection plans for a second time has increased this year. This is linked to plans not always being realistic, timebound or sufficiently purposeful to ensure that change can be sustained over time before statutory intervention ceases.

7. Multi-agency reviews take place regularly for children subject to child in need and child protection processes. They are mostly well attended and review the child's plan appropriately to ensure that progress is being made. Appropriate efforts are made to engage parents constructively in the consideration of risk and the needs of their children. Actions are progressed appropriately within core groups, although the updated plan does not always reflect the progress

made and how this will be addressed. Some children have access to an advocacy service in their review meeting, although managers recognise the need to develop this further for younger children.

8. Management oversight of work is not consistently good across the service once work is progressed from MASH into the duty and assessment teams. Supervision records are not clear enough about what actions social workers need to take. The absence of clear direction in children's plans is compounded by many changes of social workers and frontline team managers, leading to significant drift and delay for some children. Delayed transfer between teams following an assessment results in some families remaining in the duty teams for too long without a coherent and continuous programme of intervention being undertaken. This means that some children do not receive the support they need in a timely way, and concerns about their welfare can escalate.

9. A review of all delays on case transfers in recent months was conducted during the inspection, and it identified that there had been delays of up to two months for some families. This means that some children and families have not received timely interventions in line with the local authority's own practice standards. This situation has begun to improve; a weekly case tracking meeting is now held to ensure tighter scrutiny and, consequently, delays have reduced. This is a very recent development and impact is limited.

10. Pre-proceedings work is under-developed. Historically, legal gateway arrangements have not been robust and tracking the progress of pre-proceedings work, including those cases in the public law outline (PLO) work, only came into place recently. This legacy means that inconsistency in the quality of practice is still evident. Although no children have been left at immediate risk, there has been delay in securing the correct legal status for some children. The new arrangements in place evidence more effective management oversight of legal gateway mechanisms and cases in pre-proceedings, with PLO reviews appropriately brought forward in several cases. However, progress in this area has been too slow, despite it being identified in the local authority's previous inspection and in focused visits.

11. Social workers know their children well, although case records do not always consistently capture children's views. Some children build stable and meaningful relationships with their social workers and are seen regularly. For others, frequent changes of social worker due to organisational restructure, staff changes and sickness mean that children sometimes have to repeat their stories to different people too often.

12. The response to domestic abuse and neglect is improving. Both are a significant feature of children's lives in St Helens, and services are increasingly coordinated to respond to the range of needs that children present. A new neglect strategy was launched just prior to the inspection, although there is

more to do to respond to chronic neglect in a timely way to ensure that families receive the right help at the right time.

13. Children at risk of exploitation are recognised and responded to effectively. Multi-agency child exploitation (MACE) meetings are held to facilitate multi-agency consideration of risk, and plans are put in place to protect children. When children go missing, return home interviews are offered by a commissioned service, and in most cases explore any push and pull factors in a timely way when the offer of an interview is taken up.

14. Children who are missing education are clearly identified and tracked, and strong multi-agency working by electively home educated (EHE) and children missing from education coordinators leads to prompt follow up of concerns and robust reporting with schools and wider agencies.

15. Private fostering services for children are under-developed. Although numbers are very small, there has been a recent re-focussing of this work by new senior managers. More needs to be done to ensure that all professionals are effectively identifying children living in these arrangements so that their needs can be assessed, and that they are effectively safeguarded in a timely way.

16. Sixteen- and seventeen-year-olds who present as homeless have direct access to appropriate support and guidance to ensure an effective response to their needs.

17. The children with disabilities team was described as a service 'in crisis' in a peer review completed almost a year ago. Following an appropriate review of all work in this team, better arrangements are now in place. This ensures that some disabled children are held in the permanence service by an experienced worker from the children with disabilities team. Although changes of manager and social workers have affected the consistency and quality of work in the children with disabilities team, safeguarding is now recognised and responded to more effectively than it was a year ago.

The experiences and progress of children in care and care leavers is: inadequate

18. The quality of services for children in care and care leavers has declined since the last inspection. The lack of recognition of the need for permanence and the very poor quality of permanence planning by social workers and managers is widespread. Significant drift and delay is experienced by children who are left too long in situations where their legal security is unclear or unmet. The full range of permanence options, including special guardianship and adoption, is not routinely considered in a timely way, and sometimes is not considered at

all. This means that children are subject to unnecessary statutory involvement in long-term fostering arrangements for too long.

19. Services for children on the edge of care are not yet offered to families in a consistent way. Although this is an acknowledged gap and significant funding has been identified to develop the service, progress to implement plans has been too slow.

20. Appropriate decisions are made for children to come into care when risks escalate. Alternative places to live are identified either with family members or foster carers. However, for a small number of children who live with friends or family members, viability assessments are not completed to assess any potential risks, and these connected carers are not always offered appropriate support by the fostering service.

21. Plans to return home are not supported by a full risk assessment or progressed in a planned way. There is no evidence of specific family support consistently being provided to address the complex family issues which resulted in the child entering care. This means that some children experience drift and delay in returning to their families. Placement with parent regulations are poorly understood. When children do return home and make progress, there is further delay progressing the revocation of care orders or securing legal permanence through special guardianship arrangements. This means that children cannot be assured that living with their carers is a secure arrangement until they reach adulthood.

22. Most children are well cared for and their living arrangements are not subject to disruption. They are able to live with their brothers and sisters when this is in their best interests. However, children who need to be adopted are not always identified early enough, and there is not yet a robust system in place to ensure that family finding starts at the earliest opportunity.

23. The special guardianship policy was considerably outdated until a few months ago, which has led to this option not being explored proactively with families when it is clearly in the best interests of children to do so. There has been insufficient rigour in progressing permanence once children are placed with carers, and some children have waited years for permanence decisions to be made while living with their extended families or foster carers.

24. A recently developed permanence tracker is due to be implemented, and there are plans to re-instate a permanence panel to monitor the progress of plans for children who are yet to secure legal permanence and ensure that formal matches take place. These are positive developments, but at the time of the inspection there was no clear mechanism for senior managers to understand the extent of drift and delay and the level of poor practice in this area.

25. When adoption is identified as the permanence plan, children receive a good and timely service. Management decisions to progress plans for adoption are supported by a clear rationale from the agency decision-maker, and this is sensitively written for each individual child. Adopters describe a positive experience of their preparation, assessment and approval to become adoptive parents, and they speak highly of the support they receive from the adoption team of social workers. The quality of adopter assessments is generally good. There is a good range of adoption support on offer, including post-approval training and therapeutic support groups. There is good interagency working through the regional adoption agency (Together for Adoption) to ensure a consistent response.

26. When children's cases are presented to the court in care proceedings, the quality of applications is sufficiently clear to inform the court process. Children mostly have up-to-date care plans that are regularly reviewed, but the quality of plans is inconsistent and unclear, especially in relation to permanence planning. Too many care plans still fail to identify opportunities for more permanent arrangements for children, particularly through special guardianship or adoption. Where the need for SGOs are identified, timescales for the plan to be completed are absent and this means that there is significant drift and delay for some children.

27. Reports of reviews provided to the child are well written. The reviews are held regularly and relevant partners attend to share their views and contribute to decision-making. Children are supported to see their parents when it is safe to do so, and this is considered in line with the child's needs. There is limited evidence of IROs systematically raising concerns in relation to drift and delay in permanence planning.

28. Children are seen regularly, and seen alone, where this is appropriate. Children are engaged in some direct work to gain their wishes and feelings. The local authority recently held a celebration of achievement of children in care. This was well received, although long overdue. The children in care council played a key role in this development. It is well supported by a participation worker and has been formed for just over a year. Children's views, and the views of care leavers, are beginning to influence service development and raise the profile of children's experiences.

29. Children in care who are at risk of exploitation are identified promptly, and risk assessments are carried out in a multi-agency forum through MACE meetings. This is helping to reduce risks for some children.

30. Children in care have their health needs appropriately met. Although there is sometimes an issue regarding timeliness, children do receive health assessments, and dental and ophthalmology appointments are monitored in children's reviews. Care leavers are not always provided with their health

histories to enable them to have a thorough understanding of their health needs.

31. The virtual school is supporting children in care to achieve in education, and it provides strong leadership, which is leading to improved outcomes for children. There is a clear view of areas for improvement. PEPs have been re-designed, are quality assured and lead to high completion rates. There is a wide range of training and support for all stakeholders. There are now opportunities to celebrate the success of pupils on a regular basis. In some areas, such as post-16 care leavers and alternative provision, it is too early to see effective and sustained impact. There is an accurate understanding of the need to improve key stage four outcomes, and re-shape post-16 provision for care leavers.

32. The fostering service recognises that it needs to improve. Its strengths lie in the stability and commitment of its staff team, but the volume of work and staff shortages have prevented it from making the necessary changes and improvements. More training is required, and the inspection identified issues in relation to panel quoracy, which means that the panel has not complied with regulations. This has triggered a review of all recommendations over the last two years by the senior assistant director to ensure their validity.

33. There have been some recent improvements to the care leaver service. A diagnostic exercise, commissioned in January 2019, reported that the care leaver service was under-developed and in need of urgent action to improve. Since then, improvements have been made. A new team has been established, an experienced team manager has been appointed and additional capacity has been provided with the number of personal assistants (PAs) increased. This is providing a much-needed focus on the specific needs of care leavers, who were previously incorporated into the permanence service.

34. Young people leaving care have good relationships with their PAs and receive an effective level of support once they reach 18. Although some young people are allocated a PA at 17, and there is an aim to extend this further to young people once they turn 16, this ambition is yet to be achieved, which means that some young people do not receive a PA as soon as they need it.

35. PAs see young people regularly and use a range of contacts to keep in touch, such as emails, text and telephone calls. This means that young people are receiving the appropriate level of support. If their PA is not available, the team duty system supports young people well. Young people are offered and provided with an advocate when appropriate. There is evidence of young people being supported to understand their identity in terms of their gender, ethnicity and sexuality.

36. Most young people have a pathway plan to ensure that direct support is provided. The quality of pathway plans is inconsistent, and not all are up to date or provide enough detail to reflect the young person's current needs.

There is limited evidence that pathway plans are being utilised as a way of effectively preparing young people for independence. A revised pathway plan template was recently implemented in September 2019, but this is not yet fully embedded.

37. Care leavers have access to accommodation options post-18 in St Helens, although the options and offer for those who reside out of the borough are less clear. The number of care leavers aged 16 to 18 in education, employment or training is an improving picture, with employment and training opportunities increasing to meet the variety of individual needs. There is more work to do to engage 19- to 21-year-olds, where the number of care leavers not in education, employment or training is high.

38. Young people are now appropriately supported through the local offer, with driving lessons and tests, leisure passes, and other support. However, care leavers spoken to during the inspection were not always clear about the details of the local offer.

The impact of leaders on social work practice with children and families: requires improvement

39. Although there have been some improvements for children in need of help and protection since the last inspection, there remain significant inconsistencies in the quality of practice across the service, and unnecessary delays in achieving permanence for children in care. This is in the context of a significant increase in demand at the front door, high caseloads in some teams and workflow issues that have contributed to further drift and delay.

40. During the last 12 months, the local authority has understood the need to take urgent remedial action and has recognised that children's services require more effective prioritisation within the wider corporate agenda. A new DCS was appointed in June 2018 and, since then, significant financial resources have been identified to enable progress to begin. Funding has also been identified to create additional social work capacity within a new restructure and to establish an edge of care service, but many of these developments are not yet fully in place or are too new to have made any significant impact.

41. An independently chaired children's improvement board was set up in September 2018, and this has led to a detailed plan of improvement across the strategic partnership. A new model of practice is in the early stages of implementation. Such developments are enabling the service to be driven forward and to begin to make progress. However, considerable cultural barriers to practice improvement remain, particularly in relation to embedding effective management oversight at all levels to challenge the too variable standards of social work practice.

42. A new senior management team has been established in recent months by the DCS, who has played a critical role in ensuring that frontline services are now overseen by experienced managers with a social work background. However, these appointments have taken over a year to recruit to and are still very new. This has slowed the trajectory of change and has yet to deliver the level of sustained improvement required.

43. The service operates within an environment in which there has been much change at a corporate level, and this creates additional pressures for the senior leadership team. The new lead member is well informed and keen to hold senior leaders to account but has only been in the role since August 2019. The chief executive has changed in recent weeks, and this has led to some instability as new arrangements are put in place.

44. The local authority has welcomed external scrutiny through a range of peer reviews focused on the front door, care leaver service and corporate culture. This has led to greater self-awareness and the local authority now knows that more needs to be done to improve the quality of practice to ensure more robust management oversight, greater consistency and a much sharper focus on permanence.

45. The local authority's evaluation of the effectiveness of its work is detailed and honest, and it acknowledges inconsistency of social work practice and the need to improve. This demonstrates that senior leaders now have a better grasp of what needs to change. There still remain significant service deficiencies and not all the tools or systems are in place to ensure that there is an effective overview of practice. Staff do not yet understand what needs to be done to ensure that permanence is progressed at the earliest point that a child comes into care. Senior leaders acknowledge this, and recently started to develop new arrangements to support more effective permanence planning, but this has been too slow and has not led to sustained improvement.

46. Key partners are engaged and have helped to deliver a stronger MASH at the front door and early help service. This has led to more effective arrangements that protect children and deliver timely support.

47. Corporate parenting is more of a priority than it was 12 months ago, and there is an increased focus on this area of activity. The care leaver service, for example, has been restructured and is improving in response to a very critical diagnostic exercise of the service earlier this year.

48. Cafcass and the judiciary report positively about improved relationships with the local authority and the work that comes before the courts. The children with disabilities team is no longer a service in crisis, as it was reported to be by the peer review in October 2018, although there is more work to do to ensure consistent improvement.

49. A sufficiency strategy and action plan are in place, but this lacks analysis to inform future capacity needs. With no edge of care service in place, the local authority is constrained in its efforts to prevent children coming into care and to adequately support them to safely return home without delay. This critical gap has been well known to the local authority for a number of years, and despite securing resources to take action, it has taken too long to develop a clear approach and implement the service development required.

50. Monthly performance clinics provide a forum for scrutiny and challenge. The DCS assurance clinics maintain an appropriate focus on frontline practice. All of these new developments have not yet had the desired impact on the quality of management oversight in teams, which is still too variable and leads to inconsistency in social work practice. There is more to do to ensure that frontline managers monitor performance more effectively and are robustly held to account to drive up the quality of practice.

51. The quality assurance framework has been revised and is a comprehensive tool with clear objectives designed to ensure greater consistency, but it is not fully implemented. Audits are completed regularly, incorporate external moderation to enhance learning and accurately indicate that some of the work is inadequate. This is leading to the further development and embedding of practice standards, overseen by a new senior assistant director for social work, who understands what needs to be done to improve. This work has been stalled by frequent changes of social worker and caseloads that remain too high in some teams.

52. There has been a high level of turnover of team managers in the last year as a result of leaders and managers challenging the quality and standards of practice and making new appointments. A restructure of the service is still embedding. Although turnover of permanent staff has slowed down more recently, there is considerable reliance on agency staff, and this has led to instability and has hampered the pace of change and the quality of improvement required. Senior leaders have acknowledged the need for the workforce to develop new skills, including frontline management, particularly in key areas related to planning and permanence, but this work has been too slow to progress.

53. Despite these challenges, most social workers were positive about recent changes and valued the visible support received from managers. Social workers in their first post qualifying year of practice, however, do not yet have an established, protected learning environment in which they can develop in their role fully supported. Their caseloads are too high, the support they receive is fragmented and the local authority needs to do more to ensure that less experienced staff receive an effective package of support.

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