Trafford Metropolitan Borough Council

Inspection of children's social care services

Inspection dates: 4 March 2019 to 8 March 2019

Lead inspector: Paula Thomson-Jones
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
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	Inadequate

Since the last inspection in 2015, where services were rated as good overall and leadership and services for care leavers rated as outstanding, there has been widespread deterioration in the quality of local authority services for children in Trafford as a result of failures in leadership. At the start of this inspection, the self-assessment and the presentation from senior leaders made clear that they believed services remained good or outstanding. They had no awareness of the decline in services and no accurate understanding of the current quality of practice. A lack of effective management oversight of practice at all levels had led to leaders and managers being unaware of significant weaknesses, such as those at the multi-agency referral and assessment team (MARAT). Had the inspection not taken place, weaknesses would not have been recognised and no action would have been taken. Given the widespread deterioration of services, and the serious lack of recognition or action by leaders, the overall effectiveness of local authority services for children is inadequate.

Many children in need of early help do not get the support that they need quickly enough, and some children who need social work assessment experience delay before they are passed to teams for their needs to be considered. Children at immediate risk of harm receive timely assessment and intervention that make them safer. All other children receive an assessment of their needs, and for a small number, the quality of this work is good and ensures effective support. For the majority of children, the quality of the assessment and the plan to support them is not good. This variability in response to children's needs leaves some children living in neglectful situations for too long before they come into care.

Once they are in care, most children experience living in suitable placements and get support that helps their lives improve. Children are appropriately supported to live with their families where it is in their interests to do so. However, some children remain the subject of care orders for too long when they are living with their parents or with family members. Although care leavers do get some good support, long-term planning is weak and does not ensure that they achieve the best possible outcomes. Children and young people are not supported enough to offer feedback or take part in the development of the services that they receive.

What needs to improve

- Senior leaders' understanding of the quality of social work practice, through accurate evaluation of performance information, and implementation of an effective quality assurance framework.

- Management oversight at all levels of social work practice with children in order to ensure that work is good and is helping them to achieve better outcomes.

- The response to all children referred to MARAT to ensure timely review and effective decision-making about the help that children require.

- The quality of social work assessment and plans to ensure that they are effective in meeting children's needs.

- The response to children who go missing to ensure that return home interviews are completed and records of these contain information that will help reduce risk in future.

- The way in which all staff and managers listen to the voice of children to inform individual work and wider service development.

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

1. At the point of inspection, the local authority MARAT was not providing a timely response to all children. Initial screening was effective in identifying children at immediate risk, and ensuring that they were passed for timely consideration by qualified social workers. Most other children who met the threshold for social work assessment were also identified and passed for timely consideration. Where children appeared to need support at a lower level of need and further enquiries were required to inform decision-making, this did not take place quickly enough, and nearly all of these children were left waiting for too long for a decision to be made.

2. Written referrals received from partner agencies for children at lower levels of need were not recorded as contacts in a timely way. Although they were read by a senior customer service adviser, many were then left for up to a week before they were recorded as a contact to the service. Once recorded, contacts were passed for further enquiries to be made, or information to be gathered. No timescales were agreed for this work to take place, and many contacts routinely remained within MARAT for up to four weeks before a decision about next steps was made. For many children, this resulted in delays in early help being provided.

3. The service did not have enough capacity, had no practice standards, and insufficient management oversight. Not all decision-making about thresholds was being undertaken by suitably qualified and experienced workers. Thresholds were not consistently applied, with small numbers of children not offered social worker assessments despite their level of need, and many others not passed appropriately for timely early help. Leaders had no systems in place to monitor practice in the MARAT and had no knowledge of the shortfalls that existed.

4. Following feedback from inspectors, the local authority provided more social work and management capacity to review 120 contacts and referrals that were waiting for a decision to be made, and reviewed and re-opened a small number of previously closed contacts. In addition, the local authority implemented new pathways for work within MARAT and established practice guidance about the timescales that should be met. This remedial action strengthened the response for children, to ensure more effective screening and application of thresholds. Had these shortfalls not been highlighted by inspectors, then these changes would not have been made at this time.

5. There are a good range of early help services that support children well, but these are not well coordinated, and systems are not in place to ensure that all children who need early help get it at the right time. This leads to some

children being repeatedly referred to the MARAT before they get support. The local authority has recently located an early help worker in the MARAT, but this has not yet led to effective coordinated arrangements for children.

6. Once identified, children who need intensive early help support are referred to a dedicated team. They undertake good assessments of need that lead to well-coordinated plans to help children. These are regularly reviewed, and progress is well recorded in a way that families can understand.

7. Children at immediate risk are responded to quickly and action is taken to protect them. When children are identified as being at risk of harm, they are allocated to a social worker within MARAT quickly. Co-location of staff from partner agencies within MARAT leads to well-attended multi-agency strategy meetings. Good information-sharing leads to timely investigations and prompt appropriate action to protect children.

8. Children are seen regularly by their social workers. A minority of children have their wishes and feelings well understood and recorded because of good direct work. For most children, this does not take place, and their views, or the social workers' analysis of their lived experience, are not clear in their case records and do not have an impact on their care planning.

9. For most children, assessments do not fully consider their past life experiences. Chronologies are not routinely used to understand the impact of past events. There is insufficient analysis of the impact of children's experiences, and the views of children are not always recorded. In addition, children's identity needs are not well considered, particularly when children are from a Black or Minority Ethnic background. This leads to ineffective analysis of risk and need for some children. More positively, children do have their needs assessed in a timely way, and for many this results in effective support being provided.

10. Where the assessment of need identifies that social work support is required, children have a child in need plan or child protection plan that is reviewed regularly at formal multi-agency meetings and results in some coordinated support being provided by a range of professionals. For some children, this work leads to a reduction in risk and leads to their circumstances improving. For others, the lack of clear outcomes or timescales within planning leads to a lack of progress. A minority of children spend too long subject to child in need or child protection plans, and others experience repeated periods of child protection planning with little improvement in their lives.

11. The local authority has recently implemented a model of restorative practice. This has started with some changes in the way that child protection conferences are conducted, with more emphasis on an asset-based or strengths-based approach. Workers have been on training, and some were starting to try and use the principles learned in their work, but it is too early to

see evidence of widespread or systemic change in the approach to work with families.

12. Management oversight takes place but is poorly recorded and does not ensure good-quality social work practice. In most teams, staff undergo regular supervision and discuss their case work. Managers' case recording is limited to one-line statements, which do not offer any evidence of discussion, reflection, or rationale for decisions. In addition, in a small number of cases managers record an observation of lack of progress for children without recording what action is going to be taken to address this.

13. When child protection planning is not making a difference, the local authority reviews this, and makes appropriate decisions to consider legal action. For some children, this leads to decisive action to help them, and pre-proceedings work identifies alternative plans to protect them. The quality of this work is not consistent, and for some children, particularly those at risk from neglect, there continues to be delay in decision-making and action. A small number of children experience neglect for too long before any action is taken.

14. Most disabled children receive a strong multi-agency response from the specialist complex needs team. The integrated service ensures that professionals communicate well so that they have a good understanding of children's needs. Assessments for most of these children are good and lead to effective plans of support. For the small number of children in this team who are subject to child protection plans because of neglect, work is not effective. They are the subject of plans for too long without any improvement, with professionals unclear about how they will measure change, and what action they will take if things do not improve.

15. Children who go missing are referred quickly to independent workers for a return home interview to be undertaken. Insufficient efforts to make contact and meet with young people to speak to them about their missing episodes lead to interviews being carried out with only half of the number of children who go missing. The offer of interview is made only once, sometimes inappropriately by phone or letter, and is not followed up again by workers. When they are completed, the records of these meetings are often too brief and do not provide information that would assist in helping to inform the response or the planning to support a child in the future.

16. The local authority and partners identify children who are at risk of exploitation, providing them with extra support. Children at risk are discussed at locality meetings to try and ensure that plans are in place to help them. For some children, this leads to effective joint working that reduces risk. For other children, this scrutiny has little impact, and actions are not implemented or followed up over a period of several months.

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

17. Because of the delay in action taken for children in need of help and protection, some children wait too long before they come into care. They become children in care in an emergency when further incidents take place, rather than in a planned way. Once in care, children live in suitable placements that keep them safe and meet their needs. Children are supported to maintain family relationships and they have appropriate contact with their families, which is informed by their needs.

18. The number of foster placements has increased. The local authority has used independent assessors to complete foster carer assessments in a timely manner. The quality of assessments is good, and foster carers speak positively about the support they receive.

19. The virtual school works well with a range of professionals to meet children's education needs. The quality of written personal education plans (PEPs) is improving, but more than half are not yet meeting the revised higher standards that the local authority demands. The process of discussion and the robust challenge from the virtual school about PEPs is driving better provision of support for children. The use of pupil premium is well managed, with funding only released once appropriate provision is identified by school leaders. For some children, this has been very effective and pupil premium is used well to meet children's educational and emotional health needs.

20. Children have their needs assessed, but records are not always updated to reflect changes in circumstances. For some children, this means that records are not always helpful in informing future care planning.

21. Most care plans are well written and identify key areas of support needed, with measurable outcomes to measure progress. Review meetings take place regularly to consider progress. The views of children and parents are sought by their independent reviewing officer (IROs), who ensure that children's voices are heard and are well recorded as part of the review.

22. The local authority has a large number of children in care placed with connected carers or placed with their parents. Many children have achieved permanence through special guardianship with connected carers. For children living at home with their parents, progress has been slower, and many remain the subject of care orders with unnecessary intrusion into their lives that may cause them anxiety and uncertainty about the future. There has been insufficient progress in implementing permanence plans for these children since the focused visit in July 2018.

23. The numbers of children placed for adoption by Trafford is small but increasing. Identification of children who need adoption at an early stage ensures timely progress for most children. Children's permanence reports effectively outline their history and the impact that this has on their current needs. Information contained in the reports does not always give a sensitive or detailed description of their birth families that would support them to fully understand where they come from.

24. Thorough, timely family finding and matching leads to most children in Trafford being placed with adopters who have been appropriately trained and approved by the regional adoption agency (Adoption Counts). Decisions by the agency decision-maker are clear and well recorded and offer a rationale to support the plan for adoption or the match with adopters. Children receive appropriate adoption support, including specialist input for adopters where this is required.

25. There has been a deterioration in the quality of service for care leavers since the last inspection. The number of care leavers in Trafford has increased by 11% since April 2018. This has resulted in high caseloads, with workers responding to immediate need but being unable to spend enough time with young people who are not in crisis.

26. Care leavers have their needs assessed as part of timely pathway planning. Assessments and plans are completed with young people, but the way they are written up by workers results in confusing, descriptive documents that are difficult to understand. Many are too focused on the immediate presenting issues, rather than on a wider, long-term view of how the young person is going to achieve successful independence. Plans often lack ambition about long-term goals and the steps needed to get there. They do not consider contingency planning about what will happen if something goes wrong.

27. Young people have recently fed back to the local authority that they do not have copies of their pathway plans, and they are not used as a helpful tool to support them. The local authority is aware that the way in which the progress of pathway planning is reviewed needs to improve. Reviews are currently very brief and do not reflect effective scrutiny of the service being provided.

28. Despite an increase in the number of care leavers needing support, the council is in touch with the vast majority of its care leavers. Many young people get some good, practical, financial and emotional support from workers to keep them safe. Nearly all care leavers live in suitable accommodation. There has been improvement to the numbers of 17- and 18-year-olds in education, training and employment, with performance higher than comparators. For 19- to 21-year-olds, performance has declined since the previous inspection, with just over half currently in education, employment and training.

29. The influence of care leavers on corporate parenting or service provision is limited. Although historically there has been work with care leavers to consult

with them about the service, this has not become part of regular practice. Very small numbers of young people have been part of wider children in care groups, and the local authority has only recently re-established a care leavers' forum to start discussions with young people about the service they receive.

30. The long-established children in care group attracts a relatively small number of regular attendees. This is recognised by the local authority and there has been a recent push with foster carers and IROs to encourage more attendance, but it is too soon to see any impact from this. Young people have taken part in some recruitment and some good creative work to support employment. There has been insufficient focus by the local authority to ensure that the views of children and young people have an impact on the way in which services are provided.

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

31. Since the last inspection in 2015, strategic leaders have not maintained an accurate understanding of the quality of social work practice. They have not ensured that there are effective plans in place to maintain and develop the standard of services. The self-assessment provided as part of this inspection process was weak and inaccurate. Senior leaders in children's social care stated in the self-assessment and at the start of this inspection that all services remained good or outstanding. Only when presented with findings during the inspection did they acknowledge that practice across the service had declined and required improvement.

32. Inspectors identified significant weaknesses that were unknown to the local authority during this inspection, particularly in respect of the response to children in the MARAT. Senior leaders and managers had identified an increase in re-referrals and that the step-down process needed to improve and had taken some action to try and address this. However, they had not identified the level of delay in the response to some children in need of early help, or that threshold decisions in relation to contacts and referrals were not, as they should be, all overseen by suitably qualified staff. There had been no quality assurance work undertaken in the MARAT for over 12 months, and no review of decision-making by middle and senior managers. This was despite very clear performance reporting identifying a continued rise in repeat referrals to the service. Action was taken during this inspection to address the concerns raised, but without the inspection, leaders would have remained unaware of the unassessed risk in relation to contacts, and the delays that many children were experiencing.

33. During 2018, there were changes in strategic and political leadership. A new lead member for children and a new leader of the council have been in place since May 2018. The chief executive role had been covered on an interim part-

time basis from July 2018, until the permanent appointee started immediately prior to this inspection. Following the previous post holder leaving in July 2018, the director of children's and adults' services posts were separated, and managers from within the organisation were promoted to take on the acting roles of corporate director of children's services and director of safeguarding.

34. Despite appropriate governance arrangements and regular performance reporting, senior leaders do not have an accurate understanding of services. Areas of potential weakness had been highlighted by good-quality performance data. Identification of high re-referral rates, high numbers of children on repeat child protection plans, and high numbers of children on child protection plans for over two years had been reported to senior leaders for at least 12 months. This had not led to robust action to determine the cause of these figures. Reports to leaders consistently stated that the majority of practice was good, but this was based on ineffective quality assurance activity, and was therefore inaccurate. This is a failure of senior leaders and managers.

35. During the focused visit in July 2018, we reported that 'Quality assurance activity, through audit, does not currently provide an up-to-date overview of practice'. Following the focused visit, the local authority developed a new quality assurance framework, which included the requirement for managers to complete audits of work with children. The local authority failed to implement this framework.

36. Quality assurance work over the last six months largely consisted of two thematic audits of very small areas of practice. The thematic audits were poor, and, in many cases, did not offer an accurate assessment of practice. Prior to the inspection, audit work had not been subject to any scrutiny or moderation and had been accepted as reassurance that practice remained good.

37. None of the audits reviewed identified areas for learning or development. There was little evidence of any useful evaluation or learning from quality assurance work and no feedback to individual workers or the wider workforce to improve practice.

38. Management oversight of frontline practice does not ensure that work with children is consistently good. Most staff have regular supervision, but the recording of case discussions on children's files is too brief. There is little evidence of reflective discussion or challenge to ensure good-quality work or an opportunity for social workers to learn or strengthen their practice.

39. For most children, their IRO does identify when there is a need to challenge the work of the local authority. This has an impact for some, and action is taken to address the concerns identified. Where this does not happen, it contributes to drift and delay in children's care plans being achieved.

40. During 2018, the corporate parenting board, under new political leadership, reviewed its membership and the structure of how it operates to ensure that the right people are attending. The board has offered challenge to a wide and varied range of topics raised, including performance data, youth offending practice, the role of IROs and fostering and adoption. It is not clear if this challenge has had any impact on improving services for children.

41. Children in care attend the board meetings and provide a link between corporate parenting and the children in care council who have worked together to devise the corporate parenting strategy. The limited number of children involved in the children in care council, and the absence, until recently, of a specific group for care leavers, has prevented the council from having a detailed understanding of the experiences and views of children and young people in their care.

42. The workforce in Trafford is stable, with low rates of staff turnover and sickness. Many staff have worked for the local authority for a long time, and morale in many teams is good. Caseloads remain too high in some teams, with workers struggling to spend enough time with children and young people. Many workers feel supported by managers, but in some teams, gaps or changes in management roles have left them without regular formal supervision. A team of peripatetic staff are used effectively to ensure that they have the capacity to fill gaps when there is an issue of absence or an increase in volume of work.

43. Workers have access to a range of suitable training and development opportunities. Some workers reported that training is helping them and talked about how they had put new ideas into practice to improve their work. A small number of social workers and personal advisers reported not being able to attend training due to the pressure of their workload.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

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