

# Medway Children's Services

## Inspection of children's social care services

**Inspection dates: 15 July 2019 to 26 July 2019**

**Lead inspector: Brenda McLaughlin  
Her Majesty's Inspector**

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

Services to help and protect children in Medway are inadequate. Most areas have deteriorated since the single inspection of services in 2015. Many vulnerable children who have experienced long-term neglect, and those at risk of exploitation and who go missing from home or care, live in situations of actual harm or are at risk of harm for too long. Senior leaders have sustained improvements in the 'front door' single point of access (SPA) and the multi-agency safeguarding hub (MASH) following the priority actions identified in the 2018 joint targeted area inspection. However, they have failed to recognise or address the serious and widespread concerns identified by inspectors in the early help hubs and the assessment and longer-term team 'pods'. Attempts to drive improvement in these areas have had little impact, and the pace of change has been too slow.

Dedicated staff and frontline managers across teams are not being supported to practise safely. Caseloads in the assessment service are exceptionally high, with most social workers who met with inspectors being responsible for over 40 children, and some as many as 55 children. Services for children in care, for children who need to be adopted, and for young people leaving care are not good enough. Although, overall, children in care do well in their placements, permanence planning

arrangements are significantly underdeveloped. Access to health services for children experiencing emotional and mental health problems is not timely, and health provision for care leavers is a substantial concern. cursory scrutiny by senior managers for children who are subject to the public law outline (PLO) means that children spend extensive periods of time at continuing risk of harm when they meet the threshold for care.

Leaders and elected members are cognisant of the challenges within the service, but their understanding is not based on a systematic analysis of weaknesses. The primary focus of these leaders has been on process and compliance. Ineffective and uncoordinated systems impede the local authority's ability to track and evidence progress. Despite the improvements found during a focused visit in February 2019, a lack of critical enquiry, combined with an over-reliance on unreliable audit findings and an over-optimistic self-assessment, means that senior leaders and politicians have failed to evaluate and understand children's lived experiences across the wider service. These are serious shortcomings, as senior leaders did not know about the extent of the failures to help and protect children until this inspection. In the very high number of cases brought to their attention by inspectors, managers and leaders had to act to ensure that children's needs were met, or that plans to protect children from harm were progressed appropriately.

## **What needs to improve**

- Senior managers' oversight and understanding about vulnerable children's experiences, including through the quality, accuracy and effectiveness of audits.
- Staffing capacity across children's social care, early help hubs and leaving care teams.
- The response to risk for children who have experienced neglect, those exposed to parental domestic abuse and young people in danger of exploitation.
- The coordination and management oversight of early help services to support children to receive the right help at the right time.
- The quality and effectiveness of management oversight and supervision to make sure that children are protected from significant harm.
- The effectiveness of managers' formal permanence planning and decision-making at every point in the child's journey.
- The system for tracking children who go missing from home, care or education.
- Services to help care leavers access suitable accommodation, education, employment and training and to understand their rights and entitlements.
- The strategic relationship with health services, and operational delivery across a range of health functions, to support children and young people in care and care leavers.
- Leadership direction and assertive action to improve and develop the services to foster carers and prospective adopters.

## **The experiences and progress of children who need help and protection: inadequate**

1. A significant increase in referrals and high staff vacancies have reduced the ability of dedicated early help staff to provide a timely and consistently reliably safe service. Delays in the provision of early help vary in length from initial contact to allocation and first visit. Caseloads are much too high within early help and within assessment teams. Consequently, staff are unable to provide the right support to children in order to reduce the harm that they face. Supervision by managers is regular, but in too many cases it is ineffective in providing case direction and in identifying the need for different action to reduce these risks.
2. Risks for some children who require statutory help and protection are not recognised soon enough by early help managers. Many children step down too soon from children's social care when their needs and risks have not been understood or fully assessed, and change has not happened or been sustained. This is particularly prevalent in cases where vulnerable children have experienced neglect over a long period of time, sometimes over many years, and have been the subject of multiple assessments and interventions. For too

many children, the help provided has not made a difference to their challenging and difficult lives. The recent restructure of separate early help assessment and intervention teams has created further delays for children.

3. The co-location of multi-disciplinary staff such as health visitors, midwives, youth and social workers in early help hubs is intended to make sure that children receive the correct level of help and protection. While a wide range of commissioned services for children on the edge of care are in place, they are fragmented. These services lack effective senior management coordination and are not sufficiently amalgamated to address the complexity of older children's needs.
4. Contacts and referrals for children in need or at risk are managed promptly in the MASH. All decisions are made within 24 hours. Consent is routinely sought or is overridden where this is appropriate. Decision-making is well informed by contributions by partner agencies and domestic abuse and exploitation coordinators. Education professionals based in the SPA are helping to build relationships with school staff. There is evidence of management oversight at key points, and this affords additional safeguards. The out of hours service, shared with another council, is responsive, and there is no delay in taking necessary action. Communication with day services is swift and effective.
5. Too many vulnerable children identified by the Medway MASH as requiring statutory assessments and interventions wait too long to be seen. This leads to unassessed risks for many children. A failure to recognise or respond promptly to increasing risk, and an overreliance on parents' own reports of their progress, alongside weak oversight by managers, has led to some children's cases being closed prematurely. These children are often referred again when their circumstances deteriorate.
6. Capacity issues in the assessment teams are considerable, with too few social workers to carry out the work. Caseloads are high and social workers are routinely allocated additional work as they are also responsible for providing a duty service when cases are transferred daily from the MASH. The creation of an additional team with four new social workers starting in August is intended to reduce this pressure. Despite the relentless pressures, staff describe feeling supported by their line managers. Morale is good. Committed workers and frontline managers strive to provide children with a good service, but several reported concerns about their ability to undertake good-quality assessments, make effective plans and take necessary and timely action due to their workload.
7. Despite the high volume of referrals, assessment timeliness has improved, but it is unclear what interventions are taking place to help and protect children during the 45-day assessment period. There are delays in visiting children. Many of these children and their family members have been known to services for long periods and have been subject to multiple assessments. The pervasive impact of

chronic long-term neglect and domestic abuse on children's experiences is not fully recognised or sufficiently addressed in supervision.

8. Better quality assessments capture the lived experience of children and draw on the views of other professionals. They include detailed observations of individual children and clearly record their views. However, most assessments are descriptive and too many do not reflect the level of risk and need. These assessments are superficial and adult-focused. They lack professional curiosity and are rushed through because workers are under pressure to transfer children to the long-term 'pods', to step cases down to early help or to close the case. While most children are seen and seen alone, and there is evidence of some direct work, it is not routine or purposeful.
9. There are also delays in convening some strategy discussions, both in the assessment service and in the long-term team pods. Recent action by managers to convene daily meetings is intended to address this delay. Records do not routinely provide an account of the rationale for final decisions or timescales about single or joint agency child protection investigations. Planned review strategy meetings do not consistently take place to assess progress. When a decision is made that there needs to be a child protection conference, there are often delays in convening these meetings and in developing a multi-agency plan to address risk. The quality of children in need and child protection plans is variable but is beginning to improve. Inspectors saw some good examples of both, but many plans lacked clarity about the actions required and how progress will be measured within the child's timeframe.
10. Although inconsistent, the quality of practice in the long-term team pods is better than in the assessment service, as social workers have more manageable caseloads. In stronger cases, social workers have purposeful relationships with children. They see them regularly and alone, according to assessed needs. They understand their lived experiences and take timely action to make changes that help and protect children and their families. Collaborative professional relationships are helping to safeguard these children
11. Most social workers receive regular supervision, but managers at all levels do not consistently identify or challenge drift and delay. Subsequently, some children who live with serious domestic abuse, poor parental mental health and adult substance misuse wait too long in situations of ongoing harm. For example, senior management arrangements to track and review children who are subject to the PLO are inadequate. Insufficient management oversight and delays in commissioning assessments have hampered timely decision-making about applications for family court orders. Too many children spend an extensive period at the pre-care proceedings stage, with no review or progress against agreed actions. Consequently, some children and young people who may need to be in care wait for too long.

12. The strategic and operational coordination of information and systems in Medway to monitor and assess the impact of work with vulnerable adolescents and children at risk of exploitation is weak. A multi-agency panel is ineffective in systematically tracking and reviewing children who are at risk of sexual exploitation. Minutes of the panel discussion are not routinely available, and actions are not tracked. Inspectors found some evidence of good and effective risk analysis on a case-by-case bases, but this is not underpinned by a coherent strategic partnership approach. Inconsistent responses for some children at risk of sexual exploitation or who go missing from home or care mean that their needs are not fully understood or met soon enough. A daily 'missing' report is produced by the police, but it is unclear how this is used to safeguard children. Management systems to track return home interviews that have taken place with missing children are muddled and inaccurate. The local authority has plans to move the responsibility for completing and monitoring return home interviews to another team.
13. Checks on children missing education are not completed in a timely way to ensure that children are safe. Information is held by different teams. This does not provide leaders with an accurate oversight of children who are not currently educated full time in a school. A small number of children who have been waiting for a school place do not have access to alternative education. The number of children who are electively home educated is rising. Staff take appropriate and proportionate actions to check that these children's needs are met, offering support to parents so that they understand the responsibility they have taken for their child's education.
14. Allegations made against professionals and the associated risks to children are managed well by the designated officer. The response to referrals is both prompt and proportionate. Outcomes are well recorded, with detailed analysis. This is a vast improvement since the previous inspection. Children who are privately fostered are visited regularly and live in suitable and sustainable care arrangements. A joint service with housing to assess vulnerable 16- to 17-year-old young people who are homeless needs strengthening to ensure that young people receive a consistent and comprehensive service. They are not regularly advised of their rights and entitlements, thus their ability to make informed choices is limited.
15. Disabled children in need of help and protection support receive an effective service. Social workers in the children with disability team demonstrate child-centred practice and a good understanding of children's needs. Assessments are comprehensive. The co-location with adult's social care is leading to early and comprehensive transition plans.

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

16. Decisions to bring children into care are appropriate. However, some decisions are made in an emergency and are not timely enough or effectively planned to respond to significant escalating risks while children remain at home. Several children would have benefited from being in care sooner. Nevertheless, when children come into care they are safer, and the majority make progress in stable homes with the same foster carer. This includes children who returned to the same foster carers following adoption breakdown. This gives children an additional sense of belonging and stability.
17. Children spoke positively about their carers, although some were unhappy with frequent changes in social worker. Others provided examples of how they have been given support in school. Children talked about the opportunities they have had to go on holiday and to be able participate in activities that they were unable to do when living with their parents. Most children live in placements that meet their needs and they are well cared for. Where possible, they live with their brothers and sisters. However, some children experience multiple placement moves or live a long way from their home area, which disrupts their education. This included a small number of cases where risks to children were not understood or acted on.
18. Despite staff changes, most social workers in the long-term team pods visit children in care frequently and know them well. There are some good examples of skilful direct work helping to build strong relationships that are enabling children to feel safe enough to share sensitive information about their lives. Foster carer mentors successfully work with children and carers, helping children to remain with the same carer. Life-story work and 'later life letters' to help children understand their life history are not prioritised for too many children whose plan is not for adoption. This is poor practice because children do not have the opportunity to fully understand and explore with a trusted adult why they cannot live with their parents.
19. Assessments are routinely updated for statutory reviews. Almost all children's care plans are regularly reviewed by independent review officers (IROs), who know children well. IROs routinely carry out midway reviews and provide comprehensive notes that consider all dimensions of the child's life. Concerns are escalated, but there is little evidence that this is driving urgency in permanence planning. Access to health services when children come into care and for children experiencing emotional and mental health problems is poor. Health provision for care leavers is a significant concern.
20. Fragmented systems to track and monitor permanence planning is a key weakness and is leading to avoidable drift and delay for some children. A revised permanence strategy is in place, but is not yet embedded. While improving, planning meetings are not taking place with enough frequency and are

insufficiently focused on timeliness. For instance, ineffective management oversight, tracking and monitoring means that decisions about changes to care plans for children subject to placement orders are not taken back to court as is required legally. It is not clear where the responsibility for pursuing revocation of placement orders lies. The agency decision-maker has failed to effectively oversee this. As a result, birth families are not informed of this significant change to their children's care plans in a timely way.

21. Under new leadership, the virtual school has instigated a strategy for improvement, welcomed by schools. Virtual school staff are now much better informed about pupils' education. Staff are suitably ambitious for children in care and have taken useful steps to improve their academic outcomes. Some children make progress in education when they come into care. Younger children participate in a wide range of enriching after-school and community-based activities. The quality of children's personal education plans is improving from a low starting point. The virtual head's well-founded plans to improve children's academic outcomes have only been implemented recently, so the impact is currently quite limited, particularly for care leavers. Although the proportion of young people staying in education, employment or training post-16 has increased since the last inspection, it remains well below average. Careers information and guidance are not effective enough in inspiring younger pupils and encouraging their future aspirations.
22. In addition to regular visits from supervising social workers, adopters and foster carers are well supported through workshops, training events and support groups. Most foster carers, connected carers and prospective adopter assessments are satisfactory. The quality of child permanence reports is inconsistent. Post-adoption support is comprehensive and is accessed easily. Positive changes brought about by managers appointed in January 2019 have improved the levels of communication and support to foster carers and adopters in Medway. Previously, carers had not been well informed of specific plans and strategies to enable them to manage and minimise risk following serious incidents. New systems and processes are beginning to have a positive impact. Carers reported that communication and support have recently improved. However, while managers can talk about areas requiring improvement, they do not have a clear strategic overview of weaknesses. There is a lack of senior leadership direction on priorities to improve and develop the current fostering and adoption services.
23. An external review of care leavers' services is leading to more investment and the development of a separate care leavers service. Pathway planning currently takes place too late because of a lack of staff capacity. Inspectors met with a large number of care leavers, and the majority reported having positive relationships with their personal advisers (PAs). This includes those care leavers who have been in prison or who are living at a distance from Medway. Young people who have regular contact describe PAs as 'absolutely brilliant'. Other



young people in more settled circumstances are less confident about contacting PAs for support.

24. Not all care leavers are informed of their rights and entitlements. They do not routinely receive their health histories, national insurance numbers or photographic identification before they turn 18 years old. Emotional and mental health support provided to care leavers by the local child and adolescent mental health service and the clinical commissioning group are insufficient and ineffective. Pathway plans are completed along with young people. However, young people are not routinely given copies of their plan, and actions sometimes lack clarity about how identified needs will be met. The quality and choice of supported accommodation commissioned by the local authority is variable and limited. Some care leavers are worried about breaches of privacy and poor living conditions. Senior leaders have not visited all local authority-commissioned accommodation to assure themselves that it is suitable to meet these young people's needs. Staying put arrangements are supported for those young people who are eligible.

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

25. Corporate and senior children's social care leaders were not aware of the widespread and serious concerns experienced by some of their most vulnerable residents until this inspection. Inspectors brought to the attention of the local authority 74 children from 43 families, who were either at risk of significant harm or where there were unacceptable delays in progressing work. Senior leaders and managers had to act to make sure that those children who were at risk were safe, and that plans to help others were immediately reviewed or progressed more quickly.
26. Governance arrangements in Medway are clearly delineated, and links between the chief executive, lead member and the director of children services (DCS) are well established. Medway's corporate transformation team and children's services are working together to identify areas in the service that can be improved or transformed. Objectives and aspirations for vulnerable children are clearly articulated, underpinned by the strategic delivery of children's services, in area-based social work teams, created with the intention of minimising social work changes. Notwithstanding the apparent commitment to improving services for children, there is insufficient analysis and understanding of underlying complexities and continuing risks to children. These are serious weaknesses. Change has not happened quickly enough for too many children at risk.
27. A strategic improvement plan for children's services, developed with partner agencies and monitored by senior leaders in several forums, routinely considers the substantial staffing and high workload challenges in children's social care. However, the plan is perfunctory. Evaluation is not based on a systematic

analysis of the current service weaknesses, or on a full understanding of the present experiences of vulnerable children. Minutes from meetings evidence detailed discussions about current pressures and consider reports on performance and audit findings, but leaders concentrate too much on process and compliance. While the components are in place to deliver safer services, ineffective and uncoordinated systems impede the local authority's ability to track and evidence children's progress.

28. Highly committed and skilled social workers and frontline managers work extremely hard under very difficult circumstances. They regularly work evenings and weekends to see vulnerable children and complete reports. This is not sustainable. Action by leaders has not been successful in creating an environment in which good social work practice can flourish. Senior leaders do not have an accurate view of the impact of high workloads on their staff.
29. Corporate parenting arrangements are being reviewed by the recently appointed lead member for children. Although performance data is scrutinised, it is not clear how effectively the quality of practice is examined or understood by the board. More work is required to ensure that actions emanating from the corporate parenting board are sufficiently tracked to ensure completion. The views of children and young people are well reflected in the minutes, but young people have questioned the board's effectiveness in changing things that are important to them, such as numerous changes in social worker.
30. Performance management information is readily available and analysed by senior leaders and operational leaders weekly and monthly. A comprehensive audit programme underpins the revised quality assurance framework. However, there is a significant disparity between auditors about what good practice looks like. The findings are often overly optimistic, with key areas of poor practice and delays in progressing work being missed in too many cases. These often-inaccurate audit findings are leading to false evaluations about the quality and effectiveness of social work practice. The recent practice of moderating audits is starting to improve the accuracy of audit gradings.
31. A significant challenge facing the local authority is the instability within the children's workforce. A relentless national recruitment campaign has had some success in reducing vacant social work posts from 39% to 25% across children services. Leaders have secured funding to increase the overall number of social workers. However, at the time of the inspection the vacancy rate in some frontline teams was still 35%. A range of training is available to staff, including a compulsory three-day session on 'the foundations of practice' introduced in June 2018, followed by monthly themed workshops which have included learning from audits, external reviews and complaints. The local authority does not rigorously evaluate the impact of training to inform its effectiveness or enable it to focus attention on areas of the greatest priority.



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