Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

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

17 November 2021

Mil Vasic
Strategic Director, People
Halton Borough Council
Rutland House
Halton Lea
Runcorn
WA7 2EU

Dear Mil,

Focused visit to Halton children's services

This letter summarises the findings of a focused visit to Halton children's services on 13 and 14 October 2021. Her Majesty's Inspectors for this visit were Lisa Summers, Rebecca Quested and Lisa Walsh.

Inspectors looked at the local authority's arrangements for children in need, including those who are subject to a child protection plan.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. The lead inspector and the strategic director for people agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19. This visit was carried out fully on site. Inspectors used video calls for some discussions with social workers.

Headline findings

Halton children's services were last inspected in March 2020 and were judged requires improvement to be good. Since then, there has been a deterioration in the quality of social work practice for children in need of help and protection. On this visit, inspectors identified significant weaknesses in social work practice and deficits in management oversight and supervision that have failed to safeguard and promote children's welfare. Too many children are living in situations where there is unassessed risk and there are delays in taking timely action to reduce risk.

There are some significant challenges for the local authority, with high levels of deprivation and large complex families of children where neglect has been magnified as a result of local and national lockdowns. These challenges are compounded by difficulties in staff recruitment and retention, leading to high and demanding caseloads. Case records are not supporting accountable practice. Quality assurance

processes are not helping managers to have a clear line of sight to frontline practice and, as a result, senior managers were not aware of the extent of these shortfalls and what they mean for children.

Areas for priority action

- The assessment and management of risk to children, including the frequency of visits to children, in line with assessed risk and needs.
- Management oversight and supervision to provide effective support and challenge.

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

- The quality of assessments, so they are child focused and use history to inform an understanding of children's experiences and decision-making.
- The quality of plans and planning, to support a timely, multi-agency response, including decisive escalation to pre-proceedings when children's circumstances do not improve.
- The quality assurance of social work practice.

Main findings

Halton continues to have high rates of COVID-19, significantly exceeding national averages. There was prolonged use of lockdown restrictions and Halton was designated an enhanced response area. Senior managers responded to the pandemic, including prioritising the safety of staff, while establishing a framework for the identification and monitoring of vulnerable children. Children in need of help and protection were risk assessed to inform visiting patterns. Social work teams have continued to work in bubbles in offices. They appreciate the ability to keep connected with peers and frontline managers and the flexibility to work from home. Social workers were helped to feel safe by accessing protective equipment.

Despite maintaining low levels of staff absence, senior managers recognise that COVID-19 has significantly impeded service improvement since the last inspection. Additional funding was identified to support the improvement in the quality of practice. Senior managers created an additional duty and assessment team to alleviate the workload pressures on the children in need teams. Despite this, and high social worker commitment to delivering good help and support for their children, most described feeling overwhelmed by the high demands of their caseloads. This is limiting social workers' ability to work proactively with children to make their lives better. Senior managers are currently working to strengthen their recruitment and retention strategy.

The roll-out of the local authority's chosen model of social work practice and the restructure of services to enable greater and clearer management accountability

have been delayed. Senior managers know that areas of weak practice identified at the last inspection continue to be a feature of current practice. However, senior managers were not aware of the extent of the serious weaknesses found at this visit or the significance of this for children. During this visit, senior managers acted swiftly to take remedial action where appropriate, and immediate additional funding was agreed to secure additional social work capacity and expertise, including across management levels.

While the local authority has refreshed its quality assurance framework, and managers access a broad range of performance information including routine audits, this is not supporting improvements in the quality of practice. Audit judgements are inflated and do not consider the impact for children, nor do they identify all necessary corrective actions. Moderation processes bring a sharper focus on unacceptable standards of practice when this has not been picked up by the initial auditors. However, moderations are not being consistently used and social workers are not engaged in audit activity to inform their learning to make a positive difference to children's circumstances.

Social workers report their supervision is regular, however, the quality is highly inconsistent and mostly lacks reflection on understanding the impact that interventions are having on children's lives. Actions are task focused and many lack timescales, with poorer practice and uncompleted actions going unchallenged. Supervision is not helping social workers identify risks to children or think through next steps to improve their practice.

Case records are not supporting accountable practice nor are they contributing to a comprehensive record of children's experiences. There are many gaps in records and despite senior managers' best efforts to improve timely recording and functionality of the system, social workers described the system as difficult and time consuming.

Children are not visited in line with assessed risk or changes in their circumstances. Most visits are not purposeful and direct work to understand children's experiences and test the impact of plans is absent. Some children experience too many changes of social worker, limiting their ability to form meaningful and trusting relationships. It is too early to see the impact of the recently delivered direct-work training.

Assessments are not dynamic and are not updated following significant events, which means that risks for some children remain unassessed. Although most assessments gather information from a broad range of agencies and children's views are actively sought, history is not routinely used to understand their experiences and the harm they have suffered. Most are adult focused; all risks and needs are not always explored. Important decisions to step children down to lower levels of support from child protection plans are not informed by up-to-date assessments. This does not give assurance that risks are reduced and safe decisions are being made. There are a small number of stronger assessments that are thorough and identify risk and understand children's experiences. The voice of children is clear in these

assessments through the provision of more focused direct work, enabling children to inform the social work response.

Children and families experience delays in accessing the help and support they need because the quality and impact of plans and planning is mostly poor. There is significant drift because most plans are too broad and many lack timescales to support accountability and inject pace. There is a lack of clear contingency planning, which means that parents do not understand what will happen if progress is not made. Some core groups and child in need meetings are not frequent enough to support the safe monitoring of children or enable a timely response to changes in circumstances. Although meetings are well attended by partners, this is not resulting in an effective multi-agency response to review progress and improve children's lives. Senior managers have recently implemented greater scrutiny for these children through a dedicated overview panel, however, it is too soon to measure its impact.

Senior managers report a high prevalence of neglect in Halton. There is currently no clear and consistent approach to managing this. As a result, some children are involved with statutory services at different levels of intervention for a significant proportion of their lives. Too many children experience second or subsequent periods of child protection planning, as a result of recurring concerns. This has been identified by senior managers through a thematic audit, the findings of which are shaping the revised multi-agency neglect strategy.

When children's circumstances do not improve, there is not always a timely escalation into pre-proceedings, leaving some children in risky situations for too long. Legal advice meetings provide consistency of decision-making, identifying additional assessments to better understand risk and needs. This is enabling some families to appropriately step out of pre-proceedings or to support more timely court applications when necessary. Reviews and tracking of children in PLO (Public Law Outline) are not sufficiently robust to minimise potential delay. Letters before proceedings are mostly poor and use professional language, limiting parents' understanding of the local authority's concerns and what needs to change for children.

For children who are privately fostered, assessments do not sufficiently consider how carers can meet children's needs, and necessary checks to ensure placements are safe are not always completed. Children are regularly seen and targeted work is helping staff and partners better identify private fostering arrangements, with numbers increasing since the last inspection.

Since the last inspection, improvements have been made for children aged 16 and 17 who present as homeless. Clear pathways with the housing department are being implemented and children are enabled to quickly access accommodation with

appropriate support. Children are supported to return to their family home when it is safe to do so or to enter care when this is required.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to these areas within 70 working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Lisa Summers
Her Majesty's Inspector