Inspection of Doncaster Metropolitan Borough Council children's services

Inspection dates: 14 February to 25 February 2022

Lead inspector: Tom Anthony, 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	Requires improvement to be good

Senior Leaders in Doncaster Council and Doncaster Children's Services Trust have together overseen a decline in the quality and impact of services for children, young people and their families since the last inspection in 2017. The contracted arrangements between the council and the Trust have failed to sustain good help and protection, care and support for many children and young people. Corporate parenting has not been effective in challenging and driving the quality of support provided to all children in care.

Leaders and managers' line of sight to practice quality, performance and children's progress and experiences is significantly impaired by the recently installed electronic management and recording systems. Many staff and managers are insufficiently trained to have the confidence or ability to use the systems well. Senior leaders have been ineffective in making improvements, and children's records and many performance reports continue to be inaccurate.

Some children and young people continue to experience drift and delay in their needs being responded to appropriately. This is compounded by the legacy of poor planning and intervention.

The council began to challenge the Trust in July 2020. However, the impact of this challenge has only recently gained traction. A change in leadership at the Trust has begun to address the shortfalls. Current Trust leaders are now more open and

transparent about the significant decline in children's social care. An effective partnership response to the COVID-19 pandemic ensured that services to safeguard children were maintained despite the restrictions. Targeted investment has been made to increase the capacity across early help, the multi-agency safeguarding hub (MASH) and assessment services.

What needs to improve?

- The scrutiny arrangements between senior leaders of the council and the Children's Services Trust.
- The impact of leaders and managers in driving progress for all children.
- A shared understanding and application of child-in-need and child-protection thresholds across agencies.
- The quality and accuracy of children's records and performance information.
- The quality and impact of supervision and management oversight.
- The quality and analysis of assessments.
- The timeliness and oversight of placement with parent and connected persons arrangements.
- The quality of placement matching.
- The quality and timeliness of achieving permanence.

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

1. When children and families are referred to children's social care for help and support, decision-making within the MASH is effective. Senior leaders, through two recent threshold reviews, recognise that the MASH receives too many inappropriate partner referrals. These consume unnecessary social work time. Leaders are working with partners to improve the understanding and application of thresholds.
2. Management oversight of initial contacts where there are significant concerns about children's safety and well-being are timely, well considered and proportionate. The histories of children and families, although usually listed, are not evaluated in all children's cases to consider the implications of repeated patterns of referrals concerning domestic abuse or neglect. There are high re-referral rates and high numbers of police notifications of domestic abuse. This means that improvements in children's lives have not been achieved and sustained over time.
3. For children who are appropriately referred, early help services in Doncaster are effective. Staff are well supported by their managers and work well in partnership with professionals, and extended families are engaged to strengthen families' coping capacities. Effective direct work with children is

visible throughout the involvement of early help services, and many children receiving early help support make progress.

4. The thresholds and boundaries between the Parenting and Family Support Service, who provide targeted support for children and families, and the assessment teams are blurred and overlapping. This results in too much stepping up and down of cases over short periods and changes of social worker for children.

5. Inaccurate and incomplete information about some children held on the children's recording system hinders the ability of out-of-hours workers to fully understand the context and significance of information that they receive. The out-of-hours service is not always sufficiently responsive or proactive in intervening and relies too heavily on passing information on to daytime services.

6. When children's circumstances require child-protection enquiries to be made, well-attended strategy meetings bring together agencies to share information and make the right decisions. Strategy meetings are mostly well recorded and provide a clear account of children's circumstances and the rationale for decision-making. Strategy meetings are reviewed by child-protection conference chairs who challenge decisions to hold multi-agency conferences if they are unconvinced that the threshold has been met. This provides an important degree of oversight, challenge and assurance.

7. Children's needs are assessed by workers who receive initial direction and oversight from team managers. Assessments mainly contain some analysis and lead to proportionate recommendations. Some assessments do not consider parental backgrounds and histories with sufficient depth or curiosity. Weaker assessments do not consider the cumulative harm children have been exposed to, often over periods of many years. Families First meetings, held during assessments, enable multi-agency work and assist with the further exploration of children's circumstances.

8. Pressure in some teams means that some assessments are prioritised above others and timescales delayed. This means some children wait too long to have their needs understood and met.

9. In the Children with Disabilities Team, most referrals are promptly actioned, thresholds are appropriate and assessments are thorough, helping the formation of plans that are effective and timebound. Multi-agency working is strong and there is a real sense of networks working flexibly in children's best interests. Excellent resources enable social workers to make a tangible impact in supporting parents managing challenging behaviours.

10. There is not a consistent response to 16- or 17-year-old children at risk of homelessness. It is not clear that all such vulnerable children are routinely informed of how the benefits of being accommodated under section 20 would mean better support now and into the future.

11. Children who are vulnerable to extra-familial harm are not always identified. For example, very few children are identified as being vulnerable to radicalisation or extremism. Inspectors did not find any children at risk of harm. When children are reported as missing or identified as vulnerable to exploitation, it is not clear how oversight for many of these children is maintained.

12. Those children allocated workers from the child exploitation team and the small numbers who are considered at multi-agency child exploitation (MACE) panel benefit from a high level of support and engagement. For these children, targeted specialist services are used well to reduce the likelihood of harm. However, the work of social workers across the Trust with children at risk of exploitation, despite the new MACE triage providing added guidance to workers, remains disjointed and poor. Not all relevant information on children is fed back to MACE because of poor recording and actions not being completed. This means that multi-agency discussions and contributions to all children's case plans at MACE to ensure that they are safeguarded are not watertight.

13. Children who are missing education are monitored effectively. However, where children are electively home educated, the data does not accurately ensure that children in receipt of statutory or early help support and those with education, health and care plans are identified. When children return to education, they are provided with effective transition support to help them settle into school. The oversight of pupils on part-time timetables is strong.

14. Small numbers of children live in private fostering arrangements. For these children, assessments started several months after the arrangements began. While children have been visited and their welfare checked during these periods by their own allocated social workers, without timely and robust assessments managers could not be assured that these arrangements were safe. Recently, senior leaders have recognised these shortfalls and have taken action to improve practice. Children privately fostered now have their living arrangements assessed and reviewed by a dedicated worker in the newly created kinship and private fostering team.

15. Child-protection conference chairs are providing more consistency in their chairing and decision-making. Fewer children now come off child-protection plans at the first review and fewer are being made the subject of child-protection plans for a second time, indicating recent more consistent and effective intervention with families. Conferences are well attended. Chairs meet parents and, when possible, children are well supported to engage in conferences. They are routinely offered advocacy support if aged over eight. Most decisions about whether children should be supported on child-protection plans are proportionate and evidence-based. However, records of child-protection core group and children-in-need review minutes are not always accessible. Some reviews comprise a review of recent work but not a coherent overview of how effectively, or otherwise, children's circumstances are improving.

16. Some children's cases move too frequently, over short time spans, between different threshold levels. These service-driven changes entail a lot of change for families as new workers are introduced. A lack of a shared understanding and inconsistency in the application of thresholds for early help, child in need and child protection mean that some children are held at the wrong level of risk and support can be inadequate or overly intrusive. This demonstrates underconfident and inconsistent frontline management decision-making for some children and their families.

17. The quality of child-protection and child-in-need plans is mixed and they do not always demonstrably promote timely improvements in children's lives. In some cases, plans are lists of tasks and assessments to be completed, while others feature pertinent safety plans and well-targeted support to help parents improve the care of their children. Stronger assessments seen by inspectors resulted in more focused and effective plans.

18. Social workers visit children in need of help and protection regularly. However, some records demonstrate brief and cursory observations, particularly with larger sibling groups, capturing brief episodic snapshots rather than fully conveying the day-to-day experiences of children. Some individual work is undertaken, and some very good attempts are made to access the voices of disabled children using creative and innovative tools that workers have developed themselves. In some cases, this is not done, and the child's voice is not as clear.

19. Recently increased oversight and tracking mean that families in the pre-proceedings stage of the Public Law Outline receive details, in letters before proceedings, about the concerns professionals have for their children's welfare. Early legal advice, expert assessments and tailored support are made available to families to help them improve the care they provide to their children. When progress is not made, assessment and reports are completed ready for proceedings, to prevent avoidable delays in proceedings.

20. Edge of care staff are well led and they bring considerable knowledge and expertise to their roles. There is no regular management reporting on the family group conferencing service, which means that the effectiveness is not captured. The senior line of sight is not sufficiently secure to assess the impact for children and families.

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

21. Decision-making for children to come into care is mostly appropriate, but not all children enter care in a planned or timely way. This reduces the chance to place children with well-considered and carefully matched carers and contributes to rapid placement moves for children placed in short-term arrangements.

22. Care planning for children is variable and for many children is characterised by multiple changes of social worker, and in some cases changes in independent reviewing officers. Weak management oversight and an absence of management challenge result in poor-quality planning for many children in care. The progress that children make is not consistent enough and is too dependent on which social worker and team the child is supported by.

23. Permanence tracking is improving the oversight and drive to achieve permanence for children from a low base. However, managers do not go far enough to check and ensure that children have been told about their long-term plans or to check that children have been supported through life-story work to help them understand their care journey this far. A lack of attention to case recordings and the failure to keep children's records up to date undermine the impact of permanence tracking.

24. There is an insufficiency of homes for children when they come into care. Some children have experienced multiple placement moves without achieving permanency. This is not just the experience of older children. Leaders know that, for some children, the legacy of frequent and numerous moves and poor matching means securing well-matched placements for these children is now even harder.

25. The recruitment and training of foster carers has not been effective. Assessments of foster carers and connected persons are of variable quality. Poorer assessments have significant gaps in information, lack analysis and are not supported by up-to-date medical information and Disclosure and Barring Service checks. Panel has, on occasions, made decisions to approve carers without the fullest information available. Leaders have now appointed a new agency decision-maker, who provides a more rigorous and focused additional layer of scrutiny.

26. Only five children have been adopted within the last year, but 17 children are now in new adoptive homes, waiting for an adoption order to be made. As part of the regional adoption agency (One Adoption South Yorkshire), there are plans to increase the numbers of children achieving permanence through adoption.

27. When care proceedings are issued, work progresses effectively. This is strengthened by effective case tracking of children within the court arena through the legal gateway panel. The Children and Family Court Advisory and Support Service and the judiciary are positive about the planning and preparation of work with families in pre-proceedings and the quality of planning and evidence provided during proceedings.

28. There has been a significant increase in the numbers of children placed in connected care arrangements. While some arrangements are well assessed, supported and meet regulation, for other children there are significant delays in connected carers being assessed, approved and supported, and some children experience instability, insecurity and placement breakdown.

29. When children are placed with parents at the direction of the court, their experiences and the quality of the social work response are generally appropriate. However, outside the court arena, oversight is often weak and too many children experience delay in the completion of assessments and sign-off by senior managers. In some children's cases, the delay has been several years. This means that some children are living in placements that do not comply with regulations. Leaders cannot therefore be assured that the care provided to all children placed with parents or with connected carers meets children's needs or that these placements are safe. Leaders recognised these shortfalls prior to the inspection and have recently taken action to ensure regular tracking of the progress of assessments of these children.

30. Children's records are not all kept up to date, making it more difficult for leaders and managers to monitor children's care arrangements and their experiences and to understand their story. Changes in placements, and the reasons for them, are not always noted in the appropriate section on case records. This also makes life-story information inaccurate and incomplete.

31. Despite the pressure brought on by the COVID-19 pandemic, the health needs of children in care and carer leavers continue to be well assessed and responded to. Children have swift access to child and adolescent mental health services (CAMHS) and mostly reasonable transitions to adult provision to support their mental and emotional well-being.

32. The virtual school is well led. Recent improvements have ensured that the virtual school is better informed about the progress and achievement of children from early years to key stage 4. The school is less well informed about the progress of children in key stage 5 but is taking steps to address this. The virtual school's actions have secured reductions in the number of exclusions and suspensions for cared for children and improvements in attendance for primary-aged children in care. However, rates of absence and persistent absence for secondary-aged children in care remain high.

33. Most children, including those placed at a distance, are seen regularly by social workers, but this is not always the child's allocated social worker. Persistent efforts are made by social workers and personal advisers to build effective relationships with the children and young people they support.

34. Records for children in unregistered children's homes and those in unregulated placements are not up to date or accurate. This makes it more difficult for leaders and managers to consistently maintain the necessary oversight for vulnerable children.

35. Practitioners' recognition of children's unique identity and diverse cultural needs is inconsistent and, for some children, their ethnicity and disability are not recorded accurately on their records. Inspectors saw rapid sensitive and focused responses being provided to newly arrived unaccompanied asylum-seeking children. Children in care supported by the Children with Disabilities Team make good progress, benefiting from the support of social workers who know them and their families well.

36. Effective relationship-based support is being given to care leavers by the Inspiring Futures Team (IFT) and the benefits to care leavers of partnership working is evident in many young people's experiences. The support that care leavers receive reflects their level of need and all young people are regularly contacted and visited by their advisers.

37. Personal advisers work determinedly and skilfully to build trusting, purposeful relationships with young people, some of whom have had poor and damaging experiences in their birth families compounded by transitory social worker contacts. These positive relationships create a platform for personal advisers to get things done for young people, who can sometimes receive and ask for help for the first time.

38. Persistent efforts are made to contact care leavers who have not been in contact with the service, and this has led to hugely beneficial support and outcomes for some young people. Pathway plans recorded on the 'Leaving Well' app are personalised and set manageable goals, and most, but not all, are updated in line with changing needs.

39. A range of housing options are available and good joint working with housing providers means that there is consideration of young people's safety before the allocation of accommodation. Floating support services help young people to succeed in their tenancies. Although several young people benefit from 'staying put' arrangements with foster carers, 'staying close' arrangements, to promote relationships with care staff, are not yet developed.

40. Support is provided to help care leavers attend and achieve in education. While several young people successfully attend university, the impact of the virtual school is less evident for those aged over 16. Creative solutions are found to engage young people who have had poor education experiences, helping them to build confidence and access further opportunities.

41. Care leavers told inspectors that they value their relationships with, and the support they receive from, their personal advisers. They also said that the transition to receiving support from a personal adviser is not always seamless and timely, and some said that preparation for independence started too late.

42. Children's participation is a developing strength in Doncaster. The Children in Care Council is positive about children's participation, as well as the advocacy support they receive. Care experienced Young Advisors play a prominent role, offering advice to help the development and improvement of services. Children participate in interviews, deliver training to staff and meet with senior leaders and councillors to provide feedback and suggestions about the services they receive. Children in care do not currently attend the Corporate Parenting Board.

43. A well-articulated and clear local offer is known to care leavers, who receive financial support when they move into their own accommodation.

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

44. The service provided to vulnerable children in Doncaster has deteriorated significantly since the last full Ofsted inspection. A previously difficult relationship between the council and the Children's Services Trust, compounded by a lack of accurate performance information available to the council, meant that the council's line of sight to children's experiences was hindered. Following the last inspection, the council was not initially focused and rigorous enough in the challenge it provided to the Trust to ensure that children and families continued to receive effective and appropriate support.

45. Since July 2020, council leaders have been more robust in their challenge to the Trust leadership. There have been significant changes to the senior leadership of the Trust. Senior leaders across the council and the Trust are now working together and taking action to establish a clearer line of sight to frontline practice. While some improvement can be seen, too many children's needs have gone unmet and children have experienced drift and delay in their plans progressing. Leaders and managers do not have an accurate and up-to-date understanding of the circumstances for all children they support, nor the quality and impact of the service they provide.

46. Although operational since August 2021, the children's recording system is not being used consistently to maintain up-to-date and accurate records for all children. Many staff and managers remain insufficiently trained to have confidence in the children's recording system. Practitioners are not always able to locate key information, and confidence in using templates that promote the chosen practice model is low. This means that records are often ineffective and lacking in analysis. In many cases that inspectors looked at, important records were absent. Senior leaders have been ineffective in resolving these issues and, as a result, children's records and performance reports continue to be inaccurate.

47. Manual workarounds are being used to monitor visits, reviews and other events for children, but these are not consistent and provide weekly rather than daily monitoring. This additional burden means time is being diverted from supporting children because of the system failures.

48. Case file audits are now being used as a sensible and clear framework to provide a balanced view of the quality of casework. The Trust's new director of children's social care chairs regular moderation meetings, providing her and others with an enhanced understanding of some children's experiences.

49. Leaders have taken action to improve the local authority designated officer service, which has been ineffective in responding to allegations and concerns for a significant period of time, leaving some children at risk of harm. The service is now well led and managed by an experienced new service manager who has a close operational eye and grip on the service.

50. Most social workers and early help practitioners receive regular monthly supervision that is recorded on children's electronic case files. However, records of supervision for MASH practitioners are paper-based, and many are missing. This means staff undertaking critical work to determine the best way to support children and their families are not receiving records of the support and challenge they receive.

51. The pace of progress for some children is too slow. Support is not maintained, for example, when workers are absent for periods of time. Supervision and management oversight do not always ensure that what has been agreed with families and partners happens within acceptable time frames. For some children, this means that significant needs are not being addressed and their lives are not being improved as they should be. Not all frontline managers rigorously check that work is actioned and records are updated.

52. Supervision records and actions are often too generic (for instance, 'do direct work') and managers do not use the reflective section of the format or the child's lived experience to inform the discussion and outcome of supervision. Supervision often lacks challenge and curiosity when progress is not being made. Supervision does not routinely drive improved practice and outcomes for children.

53. Children and parents spoke positively in most cases about their relationships with, and support from, social workers, and especially from personal advisers. The voice of children is captured in some records and, in better work, plans respond to what children are saying.

54. Staff told inspectors that there has been a recent improvement in the support provided to them since the appointment of the new director of social care within the Trust. Workers reported that leaders at all levels are more visible and accessible and there is an extensive range of training available to workers. Good support to social work students and practitioners undertaking their assessed and supported year in employment means that many staff choose to continue their careers in Doncaster.

55. Caseloads are high within the assessment service and area child-protection teams. Personal advisers within the IFT often have too many care leavers to support. This inevitably affects the amount of time they can devote to each young person.

56. A significant number of social workers and early help practitioners have worked in Doncaster for many years. Staff commitment to children and young people, coupled with arrangements that leaders have put in place to improve the oversight and grip of children's progress, provides a foundation for the delivery of more effective and timely support to vulnerable children and their families.

57. Effective partnership and multi-agency working are evident at some levels of the organisation. This has enabled the creation of fast-track access to CAMHS assessment and support for children in care. Communication between the care leavers service and housing department colleagues means that offers of

accommodation are informed by careful consideration of any location risks for the individual young person.

58. Leaders are taking action to increase the number of in-house placements they can provide to children in care and those leaving care, purchasing property within Doncaster to keep children in their own communities and providing intensive wraparound therapeutic support. This is part of a refreshed sufficiency plan, which is appropriately focused on keeping children in care close to home.

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Piccadilly Gate
Store Street
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M1 2WD

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