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Inspection of Solihull local authority children's services

Inspection dates: 31 October 2022 to 11 November 2022

Lead inspector: Victoria Horsefield, His 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	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

Services to children and families in Solihull are inadequate. This inspection has identified serious and widespread failings across all service areas.

Since the last inspection of local authority children's services in 2019, when Solihull Council was judged to be requires improvement to be good, services to children and families have significantly declined. A Joint Targeted Area Inspection (JTAI), undertaken by inspectors from Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in January 2022, identified significant weaknesses in the practice of all partners at the 'front door'. This resulted in areas for priority action, which have still not been fully addressed. In February 2022, the Department for Education (DfE) issued a non-statutory improvement notice, providing additional support through improvement grant funding and guidance from a DfE adviser. During this inspection, the DfE issued a statutory notice of improvement, and the Secretary of State appointed a commissioner.

Children in Solihull are not getting the help they need at the right time. When there is a concern that a child is at risk of harm, the response is too slow. Too many children in need of help and protection are subject to repeat intervention and plans. For too many children, previous interventions had not led to an improved outcome. A delay in response had led to some children experiencing significant harm.

There are significant delays in children achieving the security of permanence, sometimes for several years, due to a lack of understanding and focus. The service for care leavers has declined significantly since 2019 and care leavers told inspectors of their frustration with the lack of support they receive. Insufficient management oversight and scrutiny leads to children experiencing significant drift and delay, before action is taken to make them safer, or before permanence is achieved.

Strategic leaders and partners have overseen this decline in services to vulnerable children and their families. They did not have an accurate understanding of the poor quality of practice and experiences of children. The safeguarding partnership and the improvement board have not provided sufficient scrutiny and challenge and the pace of change in response to the serious failings identified in the JTAI and national panel recommendations has been too slow. Leadership and partnership arrangements have not demonstrated an ability to develop a shared vision and strategy to make the required changes. Instability in the workforce at all levels has had a significant impact, resulting in frequent changes of workers, inconsistent planning and drift and delay for children. A significant number of cases remain unallocated or are held on duty or with managers. This has led to some children being harmed and others to remain at risk.

What needs to improve?

- Senior leaders' recognition, understanding and ability to address the quality of social work practice, through an accurate evaluation of performance information and implementation of an effective quality assurance framework, and a credible and resourced improvement plan.
- The timeliness and quality of decision-making in relation to concerns received about children and allocation to a social worker to ensure that children are seen without delay.
- The quality of practice for all children, including assessments, plans, planning and purposeful visits that identify and analyse risk and are responsive to need.
- The sufficiency and stability of the social care workforce, so that children experience fewer changes of social worker.
- Partnership arrangements to enable effective working together to both protect and support children.
- Permanence planning, to ensure that the full range of permanence options are achieved in a timely way for all children in care.
- The impact of independent reviewing officers to ensure that children's plans are progressed, that drift and delay is challenged, and that escalation is effective.
- Corporate parenting responsibility for children in care and care leavers, including consultation and partnership with the children in care group, OVOS (Our Voice, Our Services), to ensure that this is prioritised and embedded across the council and all partners.
- Timeliness of safeguarding checks for children in private fostering placements.

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

1. There are serious and widespread failures across services for children in need of help and protection. Significant delays in responding to and assessing children at risk of harm mean that some children have suffered significant harm.
2. When a decision is made that a child would benefit from early help support, there are significant delays in their needs being assessed and support being provided. The early help offer is underdeveloped and under-resourced by all partners, with a lack of services available to address domestic abuse, substance misuse and mental health. While waiting for early help support to be offered, risks remain, and for some children, concerns and harm escalate, requiring statutory intervention.
3. An increase in capacity from all partners in the multi-agency safeguarding hub (MASH) has not led to a corresponding increase in timely and effective identification and response to risk. There are significant delays and risk is not considered at the earliest opportunity, meaning that some children wait too long in situations of harm to receive an appropriate service. Managers at the front door do not maintain sufficient oversight of the progress and timeliness of referrals, causing further delay.
4. The response from out of hours is not sufficiently strong. A lack of capacity in the service means that not all urgent child safeguarding concerns can be responded to promptly, leaving children at risk of harm.
5. When risks to children escalate, strategy meetings are held. Not all take place promptly, leading to further delay. A lack of attendance, participation and contribution by key safeguarding partners hinders effective information-sharing and decision-making to inform next steps. This contributes to the high numbers of child protection investigations being undertaken.
6. Too many vulnerable children who require statutory assessment and intervention wait too long to be seen by a social worker, with the service holding large numbers of unallocated cases. This leaves children in unacceptable situations of unassessed risk and harm. There is a lack of effective management oversight and guidance and a lack of clear safety planning for these vulnerable children. Children subsequently experience further delay in progressing to initial child protection conferences, leaving them without the necessary multi-agency plans to keep them safer.
7. The quality of assessments is too variable. Most assessments are overly descriptive, superficial and adult-focused. They do not reflect the level of risk and need of the child. Poor analysis in the assessment leads to poor planning for children. Ineffective management oversight, a lack of reflective supervision and a lack of focus on the child has led to a systemic lack of impetus to improve children's situations.
8. Child in need and child protection planning is ineffective for most children. Plans, including those for disabled children, are mostly poor. They lack clarity about who

will be doing what, and by when. As a result, it is not easy for parents to understand what they need to do to improve their children's circumstances. Core groups and child in need meetings take place but are ineffective at measuring the progress of the plan. Children's plans are closed without any evidence that sustainable progress has been achieved.

9. For the majority of children with a child in need and child protection plan, when the plan ends, there is only a short period of ongoing support provided before the child's case is closed. There is lack of a clear step-down process and a lack of consideration of what this means for children. Some children are closed to services prematurely, with no evidence presented of a sustained reduction in risk. This leads to repeat referrals to statutory services for the same reasons, and for some children, repeated episodes of harm and multiple interventions.
10. High staff turnover, unallocated cases and children being held on duty, or by a manager, across the help and protection service means that many children experience frequent changes of social worker or do not have an allocated worker. This inhibits their ability to form stable, trusting and meaningful relationships with a consistent worker and this further contributes to delay in improving children's circumstances.
11. Escalation to pre-proceedings is not always timely when children's circumstances do not improve, meaning some children remain at risk for too long. When the decision is made to initiate pre-proceedings, recent improvements in process mean that help and support are becoming more focused and effective. Recently developed tracking systems for children when in pre-proceedings is resulting in more timely case progression, which means some children's lives are improving and they are able to remain safely living with their families.
12. Workers in the exploitation and missing team undertake some valuable and effective relationship and trauma-based work with children who are being exploited. This is making some children at risk of exploitation safer. A lack of capacity in the service prevents the significantly increasing numbers of children identified as being exploited in Solihull receiving the timely, specialist support that they need. Daily missing triage meetings have increased oversight of children who go missing. The offer and quality of return home interviews have improved, which is informing planning to help reduce risk. While these improvements are having a positive impact, further work is required to improve the timeliness and take-up of these.
13. The local authority has systems in place for both those children who are electively home educated and those children missing from education. Robust systems to track and monitor these children ensure that they are safe and accessing suitable education. The local authority is prioritising attendance, with a focus on those with the lowest attendance rates, in recognition of the importance that regular attendance can have on keeping children safe and enabling them to achieve to the best of their abilities.
14. The response to the very small number of privately fostered children is poor. Assessments are not timely; they focus on the adult's capacity to care and there is a lack of focus on the needs and views of children. Children are not visited at a

frequency that meets their needs and so there is a lack of assurance that they are happy and being well cared for.

15. Some children aged 16 to 17 presenting as homeless receive an effective response. However, this is inconsistent, with some children not being fully informed of their rights and options to address their homeless situation. This means that they are not informed of the support they would receive as a child in care.

16. The recent appointment of a dedicated designated officer to respond to allegations of abuse by professionals has strengthened the local authority's response. Arrangements to manage allegations are timely and effective. Actual and potential risks are identified well with proportionate actions taken to protect children.

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

17. There are widespread and serious failings for children in care and care leavers and services have declined significantly since the last inspection in 2019. This means that children are not being safeguarded effectively and their welfare promoted.

18. The lack of recognition of the need for permanence and the poor quality of permanence planning are widespread. A lack of urgency and ambition for children to be in a permanent, stable home means that many children wait too long for this security. The delay for children is further compounded by frequent changes of social worker and inconsistent management oversight and irregular supervision. Senior leaders and managers' oversight of children's permanence plans is ineffective due to poor monitoring and performance systems. This is leading to poor outcomes for children.

19. Although most decisions to take children into care are appropriate, not all are timely or well planned. Some children do not come into care at a time that is right for them and have remained in situations of harm for too long. Some children enter care in a crisis when earlier intervention could have prevented this; others experience multiple moves. A lack of a dedicated edge of care service means that intensive work cannot be undertaken either to support children to remain or return safely to their family or support care placements that are at risk of breaking down.

20. For most children when they return to the care of their parents under a placement with parents' agreement, it is the right decision for them. Risks are appropriately assessed, and plans endorsed by senior managers. However, ineffective management direction and lack of oversight by independent reviewing officers (IROs) means that even when there are no longer any risks, the decision to discharge the care order is not made. This leaves children subject to unnecessary statutory intervention and intrusion into their family life for too long.

21. The practice of IROs is not robust enough to identify and challenge when drift and delay is occurring. They do not provide sufficient independent scrutiny and challenge to influence timely and effective progress of children's plans.
22. Most plans for children in care and care leavers are poor. Too many lack focus on the individual child and do not adequately consider what is needed to improve outcomes. Children are not always matched appropriately with carers that can meet their specific needs. Although some children participate in their reviews, this is not leading to the reviews shaping important decisions about their lives. Work to support children's understanding of their lives, including life-story work, is not undertaken in a timely manner. A lack of life-story work means that children may not understand their journey into care or be supported with trauma from early childhood experiences.
23. Where children live in stable long-term foster placements, the majority make good progress. Children are encouraged to pursue their interests and hobbies, leading to an increased sense of achievement and are supported in their education by committed carers. These children have improved experiences and outcomes due to the quality of care and support they receive from their carers.
24. Children are not always seen by their social worker as often as they need to be and in line with their level of need or risk. Frequent changes of social worker prevent them from developing meaningful relationships and having their voice heard. Children in care have access to independent visitors and advocates; however, these services are underused. This means that children are not consistently supported by an independent person to help them understand their rights or to make complaints.
25. Most children in care benefit from timely health and dental checks. Many children in care and care leavers experience considerable delays in accessing emotional and mental health support. Although the local authority funds private therapy for some children, this does not fill the gap of unmet need. There is a lack of bespoke health support for those children with more complex needs, including substance misuse. This means that children who have the highest level of need are not being sufficiently supported by all partners.
26. A small number of children with highly complex needs live in unregistered children's homes. There is a lack of robust management oversight of these placements to ensure that children are being safeguarded effectively and that the homes register, or children move into a registered provision.
27. Most children in care progress well in education. Members of the virtual school have a good understanding of children's needs. The virtual school is focused on providing support to improve the quality of personal education plans (PEPS) and improve outcomes for children. PEPs are reviewed regularly; however, there is variability in the quality and ambition in setting children's targets.
28. There is an insufficient number of foster carers to meet the high numbers of children in care. This means that a significant number of children are placed outside the local authority area. Despite recent targeted recruitment activity, there has been no significant increase in local foster placements. Assessments of

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foster carers are thorough, enabling the fostering panel to make an informed recommendation about suitability. Once approved, foster carers report that they are well supported by supervising social workers.

29. The local authority is part of a regional adoption agency (Adoption Central England). There are arrangements in place to enable children to be placed with adoptive parents, including consideration of early permanence placements. This is not always timely, and some children have experienced unnecessary delay in achieving permanence through adoption.

30. The experiences and progress of care leavers have deteriorated since the last inspection. A lack of effective corporate parenting from all partners has led to a decline in the services they receive. There is a lack of ambition and aspiration for these young people demonstrated through the lack of an overarching strategy and a local offer that provides only the basic requirements. Not all young people understand their entitlements. Young people told inspectors that the onus is on them to ask rather than be told about what they are entitled to.

31. Due to capacity issues in the care leaver service, many care leavers are not allocated a personal adviser (PA) before their 18th birthday. As a result, many do not receive the support they need to prepare them for adulthood at a pace that is right for them. Not all care leavers benefit from having access to a consistent, trusted PA. Care leavers told inspectors that they were frustrated by frequent changes in worker or not having access to a worker at times of crisis.

32. Pathway plans for most care leavers are poor. Some care leavers have an up-to-date pathway plan that has been completed in consultation with them, but most plans do not demonstrate ambition and aspiration to support care leavers to achieve the best for their future.

33. A small number of care leavers benefit from the stability and support of living in 'staying put' arrangements. Some care leavers experience difficulty in obtaining safe, secure accommodation that meets their needs, with some who are homeless, sofa-surfing or at risk of homelessness. Some live at a distance from their support networks and are not provided with the funds or assistance to ensure that they are able to maintain relationships with family and friends.

34. Some care leavers are supported to continue their education by attending college, university or vocational courses. They have access to bursaries and allowances to support them as they study. Care leavers who find mainstream education difficult are not supported effectively to identify their long-term goals and aspirations. This includes a lack of opportunity to access apprenticeships, traineeships and work experience.

35. Care leavers spoke to inspectors about their experiences and much of what they shared reflected what inspectors had seen during this inspection. The young people spoke openly and honestly; the majority of them were disappointed with the service they had received. They spoke of difficulty accessing support and of a lack of transparency in respect of what their rights and entitlements were. They reported that a lack of support left them vulnerable, isolated and having to make

decisions unaided at key points in their lives, such as transition to their own tenancy.

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

36. Children's services in Solihull were last inspected in November 2019, with a judgement of requires improvement to be good. Since that time, the quality and impact of social work practice across all areas have significantly deteriorated. Serious failings identified in the JTAI in January 2022 and the National Panel report published in May 2022, following the death of Arthur Labinjo-Hughes, have not been responded to with sufficient urgency and rigour. Corporate leaders and senior managers have overseen this decline in services to vulnerable children and their families.
37. There are widespread and serious failings across all areas which have a profound impact on the experiences of children. Corporate leaders acknowledge the need for services to improve. An improvement board, 'improving outcomes for children in Solihull', has been established. Although this has streamlined improvement priorities, and established workstreams, the pace of change has been too slow. The local safeguarding children partnership has failed to provide sufficient oversight of safeguarding arrangements and partners have not worked effectively together to meet the needs of the children of Solihull. A review of these arrangements following the Local Government Association peer review in June 2022 has only just commenced. There is insufficient independent scrutiny of how partners work together to safeguard, protect and support children.
38. The self-assessment provided as part of this inspection process was weak and inaccurate. It was not reflective of the poor quality of practice inspectors have seen and does not provide leaders with an understanding of the urgent improvements required. Although leaders were aware of some of the shortfalls, they were not fully aware of the systemic and widespread concerns until this inspection. This was particularly the case for services to children in care and care leavers.
39. Children's services have not had the benefit of a stable, experienced senior leadership team for a significant period. There has been a very recent appointment of a permanent director of children's services. Although new in post, he accepts the significant improvements that must be made to ensure positive outcomes for children.
40. There is significant instability in the workforce, with the loss of large numbers of permanent workers and managers. While there has been financial investment resulting in some success at recruiting agency and interim staff, key services, including the MASH, assessment teams, the 16-plus team and the care leavers service remain fragile, with an over-reliance on this temporary workforce.
41. There has been a lack of focus on preventative work, with an under-resourced early help offer that cannot meet demand, leading to children being re-referred to the front door as risks increase. Specialist resources for those children at risk of

exploitation and going missing are overstretched. There is no dedicated edge of care service that can undertake intensive work with children and families to support children to remain safely with their families or to support rehabilitation from care. This means that too many children experience repeated episodes of statutory intervention with no sustained change in their circumstances being achieved.

42. Managers do not provide consistent oversight of key decision-making for children where permanence and matching are required. This is leading to considerable delay, sometimes of several years, in children achieving permanence.

43. The local authority and its partners do not have a sufficient focus on its corporate parenting responsibilities. Feedback from children and their families is not used to inform service planning or development. Most children and young people who spoke to inspectors about their experiences were negative in their feedback and echoed many of the inspection findings. The children described the OVOS group as broken, with no influence on how services to children should be delivered.

44. Senior managers' line of sight of frontline practice is not sufficiently robust. Performance management arrangements are not effective. Data is not used in sufficient depth to identify areas for further scrutiny, to understand children's experiences. It does not provide senior leaders with an accurate understanding of practice quality, or children's experiences, and does not target resources where needed. Recent work has started to focus on building the processes and systems required to enable improvement, but this is from a very low base. The introduction of an improvement hub has recently introduced practice standards, mandatory training and coaching for frontline managers but it is too soon to assess the impact.

45. Quality assurance processes are ineffective. Auditing does not provide an accurate picture of the quality of practice. A lack of experienced auditors who understand what 'good' looks like has resulted in audits focusing on compliance rather than the quality of children's experiences.

46. Most workers told inspectors that they like working in Solihull, that they feel well cared for by their managers, that there is good focus on their well-being and that their caseloads are manageable. However, managers at all levels do not ensure that children benefit from safe and effective social work practice. There is a culture of high support and low challenge which is not benefiting children. Supervision lacks challenge when progress is not being made and is failing to routinely improve outcomes for children. A lack of visible leadership with a clear vision for how children's services will develop has led to a culture that is failing to place children at the heart of decision-making and practice.

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