Inspection of Halton local authority children's services

Inspection dates: 13 to 24 May 2024

Lead inspector: Lisa Summers, 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	Inadequate
The experiences and progress of care leavers	Inadequate
Overall effectiveness	Inadequate

Since the last inspection in March 2020, when services for children were judged to be requires improvement to be good, there has been a significant deterioration in the quality of practice for children and young people. A lack of stable and effective leadership has led to shifting strategic priorities and an absence of continuous systematic improvement planning. This has been further compounded by weak governance arrangements, limited performance information and workforce instability. There has been insufficient pace in tackling the serious deficits identified at a focused visit in October 2021 for children in need of help and protection, and many of those weaknesses are still prevalent.

There are serious and widespread weaknesses across the service. Risk of harm is not always identified, and when it is, the response for many children is not sufficiently robust. Drift and delay permeate services for children in need of help and protection and for children in care. This is the result of too many changes of social worker, ineffective supervision and a lack of management direction. Too many children live in situations of neglect for too long. Some plans and the resultant interventions are not sufficiently focused on keeping children safer, even while they are subject to protective statutory measures.

The newly appointed permanent director of children's services (DCS) and leadership team now have a solid understanding of many service weaknesses. Recent work has focused on building the scaffolding needed to support steady and sustainable improvement. Staff and partners are starting to be re-engaged. Governance mechanisms are being strengthened and are supported by improved performance monitoring. Plans and strategies to tackle the deficits are either in their infancy or have yet to be actioned. While there are some early signs of progress, it is too soon to see the impact for children and young people.

What needs to improve?

- Partnership arrangements, so that these provide effective governance and lead to effective multi-agency support for children and young people.
- The identification of, and response to, risk by social workers, so that children and young people receive a swift and robust response, including timely, effective strategy meetings and coherent multi-agency work.
- The quality of social work practice, specifically assessments, plans and planning, including for disabled children, and the timely and effective transition planning for young people leaving care.
- The quality of help and support for children with vulnerabilities, specifically children aged 16 and 17 years who present as homeless, the response to children who go missing from home and care, and young carers.
- The identification, assessment and support for those children living in private fostering arrangements and those living with kinship carers.
- The timeliness of decision-making for children and young people, specifically when children come into care, so that children achieve permanence without delay. This includes the effectiveness of independent reviewing officers (IROs), so that concerns relating to care planning are identified, escalated and quickly resolved.
- The sufficiency of suitable placements to meet children's and young people's assessed needs, including increasing the use of 'staying put' arrangements.
- The support for children in care, so that they can safely have family time with those who are important to them.
- The quality of support, advice and guidance for care leavers, including those with additional vulnerabilities, to ensure that this is timely, consistent and responsive to levels of need.
- The quality of visiting and direct work with children and young people, including life-story work.

- Social workers' and foster carers' access to, and completion of, relevant training, so that they are supported to deliver good-quality services for children and young people.

- The quality of supervision and oversight of frontline practitioners so that children and young people receive a timely, consistent service that is responsive to their needs, and meets those needs.

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

1. Services for children who need help and protection have declined and are now inadequate. There are serious failures which leave children at risk of experiencing ongoing harm. Significant harm is not always recognised, and when it is, the response is not consistently robust, including for children at risk of exploitation. The needs and vulnerabilities of specific groups of children are not well enough understood or met.

2. Children in Halton benefit from a broad range of early help support, delivered by skilled workers in the locality service who know their children well. Most assessments are detailed and planning is child-centred, preventing the need for statutory support for many. A wide range of services are improving children's lives and preventing the need for social work intervention. A particular strength is the risk and resilience programme, which is providing dedicated support, helping children understand addiction.

3. 'Front door' services are not always robust in identifying children who need help and protection. Despite strengthened management oversight and direction, screening for some children is not sufficiently effective. In particular, history is not always used well enough to understand children's circumstances to inform decisions about next steps. For some children, this is leading to repeated contacts, as needs have not been met at the earliest opportunity.

4. When significant harm is identified, the response is not sufficiently robust. Some children and/or parents are spoken to regarding the child protection concerns prior to strategy discussions, which could jeopardise the effectiveness of subsequent enquiries and place children at further risk of harm. Practices have developed where managers determine the severity of significant harm, to inform which strategy meetings can be delayed due to limited police availability. For a very small number of children, discussions are not always effective in analysing risks, to inform decisions to progress to child protection enquiries when these are needed. These factors lead to delays in children receiving a multi-agency protective response.

5. When children are unable to stay with their parents following serious child protection concerns, some are being placed with kinship carers without appropriate assessments and safety checks being undertaken. This also

happens when police use their powers of protection in an emergency, and they do not always inform children's services.

6. When decisions are made to undertake a social work assessment of need, some parents remove their consent for this to take place or to accept subsequent packages of support. When this occurs, social workers and managers are not considering what action, if any, they need to take. As a result, children's cases are being closed prematurely without the appropriate intervention to meet their needs, as thresholds are not always recognised. There is a lack of challenge and persistence to try and engage with children and their families. Leaders have recently recognised this and have taken appropriate action.

7. The quality of social work assessments is mostly weak. While most are informed by parents' views and wider partner information, there is insufficient analysis of history to fully appreciate children's experiences and cumulative harm. Chronologies are poor and they are not helping social workers identify themes and patterns of behaviour to understand what these mean for children, to inform resultant planning.

8. The quality of plans to support children in need of help and protection is weak and ineffectual for too many. Most plans lack detail and purpose, and do not reflect the changes needed by families. Some planning is not sufficiently targeting identified risks. While plans are mostly reviewed regularly, partnership attendance at review meetings is inconsistent. There is little evidence in the minutes of meetings that the impact of plans on children's lives is being consistently reviewed. Additional actions that are needed to reduce risk to children and meet their needs are not consistently being identified. As a result, too many children live in harmful circumstances for too long before assertive action is taken, particularly when domestic abuse or neglect are a feature.

9. While children are visited regularly, too many experience drift and delay in having their needs met. This is due to too many changes in social worker and/or delays in accessing services, or that children's voices and experiences are not well understood through direct work to inform planning. Delays are further compounded by a lack of management grip, direction and challenge.

10. The response to children at risk of exploitation, including children in care, is weak and underdeveloped. The quality of assessments is inconsistent and there is a lack of cohesive multi-agency response, so most children do not receive tailored support to reduce risks to keep them safer. Leaders recognise this and have recently appointed two exploitation workers to provide targeted support.

11. Specific groups of vulnerable children do not receive good enough help and protection. When children go missing from home or care, return home interviews are not sufficiently robust to support an understanding of why they go missing, what the risks are and how to keep them safer.

12. Arrangements to support and safeguard privately fostered children are not always effective. Assessments are absent or of poor quality, and social workers are not always cognisant of the risks because they do not carry out the necessary suitability checks, including Disclosure and Barring Service checks.

13. Not all children aged 16 and 17 who present as homeless are assessed, or supported to access timely emergency accommodation when this is needed. Assessments are fragmented, as they are completed separately by social care and housing, limiting their usefulness in providing a clear understanding of children's needs.

14. Children who are young carers are not sufficiently recognised as such or supported. Assessments do not reflect on children's roles as young carers and how this impacts on their needs being met. As a result, subsequent plans are not targeted on how best to support these children.

15. The quality of social work support for disabled children is mostly poor. Most assessments do not fully understand children's disability and the impact that this has on them or their wider family. Children on child protection plans are not always seen in line with their plan. Plans are mostly weak, and there is little direct work. Social workers in the child-in-need teams have not received specialist training to work with these vulnerable children, including in effective communication to strengthen the child's voice and experience in assessments and plans. This increases the vulnerability of these children. Despite these shortcomings, a strong short-breaks offer ensures many disabled children receive services which enhance their lives and experiences.

16. Children who go missing from education and those who are home educated are quickly identified and conscientiously tracked and monitored.

17. Allegations against professionals who work with children are well managed. This has improved since the last inspection, supported by additional local authority designated officer (LADO) capacity.

18. Some children continue to experience delay once escalated into the pre-proceedings stage of the Public Law Outline. This is due to a number of reasons, including competence and churn of social workers, and delays in parenting assessments being undertaken as social workers are not trained to complete these. There are inconsistences in progressing family network meetings to consider support and alternative family placements. For many children, there is a failure to regularly review the progress of pre-proceedings plans with parents. More recently, there has been a strengthening of senior manager oversight and grip, but it is too soon to see the impact on children's experiences.

The experiences and progress of children in care: inadequate

19. Decisions to bring children into care are not always in a timeframe to meet the child's best interests or planned, particularly for those suffering ongoing neglect. When decisions to remove children from their parents' care are made, some are not removed soon enough, due to a lack of sufficient placements. As a result, too many children continue to be exposed to harmful situations for too long.

20. There are delays in achieving permanence for many children. Permanence is not considered early enough. Decisions about permanence are mostly not agreed by children's second reviews, and there is a lack of focus from IROs and managers in progressing permanence. As a result, many children are waiting too long to be matched to their long-term foster carers, and there are delays in progressing special guardianship orders for some children.

21. Too many children live with their parents for significant periods while still subject to care orders. This leaves children exposed to uncertainty, and intrusive and unnecessary statutory processes. Leaders have recently introduced permanence panels and trackers to reduce the drift and delay that children experience. It is too soon to see the difference that this is having on children.

22. While assessments of children's needs are usually updated annually, the quality of these is mostly poor and they do not provide a comprehensive review of their needs. This is affecting the quality and impact of planning for children, to be assured that all their needs are being met. Most care plans lack detail, ambition and clarity about who will be doing what and when to help children have positive experiences to reach their full potential. Blaming language is used in some children's records. This demonstrates an insufficient understanding of the trauma that children have experienced. Leaders are currently tackling this.

23. Although most care plans are regularly reviewed, children are not well enough engaged. Many do not attend meetings, and when they share their views, these are not consistently influencing important decisions about their lives. For example, children are not consistently able to spend time with those people who are important to them. While some children have family-time plans that meet their needs, other children do not. A number of children shared with inspectors their upset and worries about not being supported to safely see people who are important to them, despite asking for this to happen.

24. While IROs monitor children's welfare between reviews, and they sometimes escalate areas of concern, this has limited impact on the experiences of children. Children told inspectors that they do not know about the role of an advocate.

25. Most children in care, including disabled children, have experienced frequent changes in social workers and this has affected their ability to form trusting

relationships with them. While children are seen regularly, this is not always by their allocated social worker and there is a lack of direct work. Life-story work is largely absent. This means that some children do not understand why they are in care or have a secure base from which to explore their past, present and future.

26. Some children are thriving and they are making good progress. They are living in stable foster homes with their brothers and sisters. These children have better experiences due to the care and tenacity of their carers in ensuring their needs are met. Children are engaging in and enjoying the richness of family life. Unaccompanied asylum-seeking children live in good-quality homes that are attuned to their diverse cultural needs and they are making progress.

27. Halton does not have sufficient foster placements to meet the needs of its children. Positively, an increasing number of approved kinship carers means that more children are growing up within their extended families, with people that they know and love. Foster carers report feeling well supported by Halton fostering service. They benefit from support groups and a range of activity days. However, foster carers do not always receive the training and development they need to carry out their role safely and effectively. Not all foster carers are up to date with their safeguarding training or first aid, despite having children placed with them.

28. Adopters benefit from high-quality recruitment, assessment and support through the regional adoption agency, Together for Adoption. There are effective lines of communication and accountability in place between the local authority and the regional adoption agency. Effective, child-centred working between children's social workers and adoption workers results in valuable support for adopters and children. Skilled social workers help children to transition to their adoptive placements, resulting in permanence and security.

29. Leaders and the virtual school have a strong sense of purpose and ambition to support children in care to make good educational progress. While personal education plans are improving through a revised format and rigorous quality assurance mechanisms, the variability in quality is still impacting on children and young people's education and achievement. The efforts of the virtual school in ensuring that all children in care are making achievements relative to their starting points are hindered as a result of some children experiencing too many placement moves.

30. Most children have regular and timely health assessments and reviews. Strengths and difficulties questionnaires (SDQs) are also completed to help understand children's health needs. While this is positive, the outcomes of these are not then translated into planning. Children's emotional and mental health needs are largely absent from plans. When these are identified, pathways to access services are overly complex. This is acting as a barrier to children receiving timely support.

31. Sufficiency challenges have remained unaddressed. As a result of this, some children are not living in homes that can meet their known needs. Too many young children live in residential children's homes, due to a lack of availability of foster homes, and some older children, aged 16 and 17, who have a high level of need for care, are living in supported accommodation. Increasing numbers of children are experiencing placement breakdowns and placement moves in rapid succession, causing them instability across all aspects of their lives.

32. There are insufficient quality assurance checks to monitor supported accommodation providers who have made applications to register with Ofsted but who are not yet approved. This means that there are minimal assurances regarding the suitability of such arrangements in meeting children's needs, or to be assured that their welfare is being safeguarded and promoted.

33. Halton's Children in Care Council is being redeveloped after membership dwindling during the COVID-19 pandemic. The number of children involved remains low. An enthusiastic and recently appointed participation officer has created a welcoming and inclusive space for children to meet regularly. Children told inspectors that they now engage in activities together and have fun, and that they are starting to focus on how they can influence service development. It is too soon to see the impact of this work.

The experiences and progress of care leavers: inadequate

34. The quality of support provided to care leavers is inadequate. Risks to young people are not sufficiently recognised and they are not afforded the necessary support and guidance to help keep them safer. In particular, there is insufficient support for young people who have experienced, or are at risk of, domestic abuse. The most vulnerable young people, who are at risk of exploitation, do not receive an effective multi-agency response to ensure their safety and well-being. There is a lack of professional curiosity to understand their lives, and risks are not fully assessed or acted on.

35. Personal advisers (PAs) are routinely allocated at a time that is right for the child, but the extent of their involvement with children is limited until they reach the age of 18. This is not supporting children to develop and learn the skills that they need to become adults. While most children are provided with the documents they need as adults, transition planning starts too late. It is often fragmented and is not supported by thorough, clear pathway planning. Some eligible children do not have a pathway plan to identify what support is needed and how this will be progressed.

36. Once connections are established and young people engage with their PAs, many care leavers benefit from strong relationships. Young people told inspectors how much they value these bonds, and a small number access the drop-in facility and are enjoying the activities on offer.

37. Many PAs demonstrate commitment to their young people. Most young people are now visited regularly following the significant increase in PA capacity. However, this is not consistently translating into the provision of ambitious and effective support. Most visits are focused on completing tasks. While most pathway plans are regularly updated, they do not fully explore risks and needs. Too often, plans place the responsibility on young people to complete actions, rather than define how and what help is needed to progress these actions. Planning does not sufficiently focus on young people developing the necessary skills to be independent, or on their future career ambitions.

38. Planning is managed in isolation of important people, including wider family and other professionals. As a result, PAs do not capitalise on young people's networks to regularly share information to understand their current circumstances or to formulate a coherent response to meeting their needs to build future resilience.

39. There has been a reduction in the percentage of care leavers aged 19 to 21 who are in touch with the local authority. Efforts to re-engage these vulnerable young people are not creative enough or sufficiently persistent. Often, this is done infrequently through calls or texts. For these young people, the local authority cannot be assured of their well-being or safety.

40. Many care leavers over the age of 21 are closed to the service, with a view that young people will reach out should their circumstances change. More recently, discussions have been held to ascertain young people's wishes and feelings regarding the post-21 support offer. Despite this, young people are not always actively encouraged to accept this, even when it may be needed. Young people are not contacted to inform them of their rights to access ongoing support through annual follow-ups or to check on their well-being.

41. While some young people are thriving in education or employment or training (EET), targeted support to help young people back into EET is limited. A universal offer and strategy are not in place. There are limited opportunities for young people to access advice and guidance to help them understand their options, to explore their goals and to develop plans to help them to achieve their ambitions. There are no apprenticeships in the council that are ring-fenced for care leavers. Leaders are aware of this shortfall and plans are being developed.

42. Most care leavers in touch with the service live in suitable and safe accommodation, but there is a lack of choice, including in staying put arrangements, even when young people want this to happen. Plans are now in place to expand this and other forms of accommodation.

43. Young people do not routinely receive their health histories. Their overall health needs are not consistently explored by PAs, including the impact of past trauma. As a result, their health needs are not consistently fully understood or addressed.

44. Some young people do receive positive help and support. Care leavers who are parents are supported to access relevant services to equip them for parenthood. Young people in custody are visited regularly by their PAs, who show care and concern for their welfare. Planning for release is revisited through regular meetings so that the most suitable accommodation can be identified.

45. Most young people are not aware of Halton's local offer. Although published, information is not routinely available or widely publicised. Leaders are currently reviewing the offer, while working with young people to help shape this and improve its accessibility.

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

46. Halton was inspected in March 2020 and was judged to be requires improvement to be good across all areas of the service. Despite serious weaknesses being identified at a subsequent focused visit for children in need of help and protection, the local authority has not made sufficient progress in tackling the improvements needed. Leaders' line of sight to frontline practice has not been sufficiently well informed until more recently. A lack of stable and effective leadership, with four DCSs and five assistant directors in the last 12 months, has resulted in shifting strategic priorities and approaches. This instability has contributed to staff leaving Halton, which has further impeded the pace of improvements.

47. The significant churn at leadership level has led to frequent changes in strategic direction, and a lack of clarity about what corporate action is needed to remove the barriers to improvement. More recently, there has been a better understanding of the support required and this is leading to an improving corporate response, including increased financial investment. Enhanced human resource and legal support are being planned for.

48. The current permanent DCS took up post in November 2023 and now there is a better understanding of practice weaknesses. She has recently appointed a suitably experienced and permanent leadership team. There is a more resolute approach to creating the foundations to support steady and sustainable improvement. There is a more systematic approach to addressing weaknesses, including through a refreshed and appropriately targeted improvement plan. Practice standards have been introduced and service structures have been revised. Dedicated services are being created to provide more focused support for children and families. This includes securing funding to develop edge of care services, appointing family networks coordinators, a care order and discharge team, and dedicated support for children who are at risk of exploitation. Plans and strategies to tackle deficits are either in their infancy or have yet to be actioned. Despite this, the pace of improvement activity is starting to increase.

49. Partnerships are underdeveloped and weak governance arrangements have meant that partners are not fully held to account for their role in helping children and young people. This includes children who are experiencing neglect and those who are at risk of exploitation. Governance arrangements are being strengthened so that corporate parents and the safeguarding partnership can provide more robust challenge and scrutiny. An independent scrutineer has been appointed and there are firm plans for an imminent prioritisation-setting day. Corporate parenting meetings have been recently revitalised and these are starting to show increased challenge. These changes are very new. At the time of this inspection, the boards were not sufficiently ambitious champions for children and young people.

50. The local authority has been too slow to address sufficiency challenges, despite this being a recommendation from the last inspection. Leaders recognise there is still insufficient breadth and range of placement choices for both children in care and care leavers. More recently, leaders have developed a new sufficiency strategy, but many actions are yet to be started. Leaders have increased capacity within the placement and commissioning teams to increase pace.

51. Structures to support the monitoring of data have only recently been established. The introduction of regular scrutiny through the 'aiming high' meetings with frontline managers, to support the implementation of a performance culture, has led to some improvements in compliance. This includes improved timeliness of assessments and initial child protection conferences, the frequency of supervision of frontline practitioners and in visiting children. Performance meetings are providing a better understanding of the story behind the data, which is starting to identify areas requiring further scrutiny and appropriate action. Leaders recognise that performance reports are too narrow in their focus and work is ongoing to address this.

52. Auditing is not providing a clear enough line of sight for leaders to understand all service weaknesses, and this is not leading to improved experiences for children. While many deficits are understood, not all were known. Until this inspection, leaders were not aware of the unsafe practice relating to the response to significant harm, including delays in strategy discussions. Leaders took immediate action to ensure that strategy meeting processes were being followed. Staff have been given clear guidance on action that should be taken. Independent moderation has very recently been implemented to improve the quality and consistency of auditing.

53. Leaders have taken swift action to increase capacity where this is needed, for example in the care leavers' service. The number of PAs has doubled and additional LADO capacity has improved the management of allegations against professionals working with children. While social workers reported that there is a breadth of training available to them, some said they did not have time to access this. Not all social workers are accessing the training needed to support their work. Leaders are focusing on strengthening basic social work practice

and providing a range of relevant training. The recruitment of a principal social worker is planned to support practice improvements further.

54. Leaders understand that staffing instability and inexperience across the workforce have been significant barriers to improving the quality of social work practice. Halton is highly dependent on agency workers. While turnover has now reduced and many agency workers have chosen to stay, including converting to permanent posts, this churn in the workforce is impacting on the quality and consistency of support that children receive, and it is contributing to drift and delay because of too many changes in social worker. A workforce board has recently been established to coordinate and strengthen recruitment and retention. The recently developed social work academy is providing social workers in their assessed and supported year in employment with better, more structured support, so they can develop their social work skills more effectively.

55. Leaders recognised that social workers were not receiving regular supervision and have taken action to address this. While the frequency is improving, the quality of supervision is mostly poor. It is not providing challenge or helping social workers to reflect on children's situations or provide guidance to improve children's circumstances. Although targeted training has been delivered, leaders recognised that this was not impacting on the quality of supervision. Further training is planned.

56. Social workers and managers reported that the new leadership team has brought a renewed enthusiasm and optimism about working in Halton. The DCS and her team have prioritised the engagement and communication with partners and staff at all levels, through whole-service meetings and regular communication. Social workers now feel listened to, engaged and supported in their practice, as a result of a kinder and more supportive culture with a clearer direction and ambition for children and young people.

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