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Dear Professor O'Brien,

Focused visit to St Helens children's services

This letter summarises the findings of a focused visit to St Helens children's services on 11 and 12 July 2018. The inspectors were Stella Elliott, Her Majesty's Inspector, and Caroline Walsh, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for children in need and children subject to a child protection plan.

Inspectors looked at a wide range of evidence, including case discussions with social workers in the assessment and children with disabilities teams, and meetings with team and senior managers. They also looked at local authority performance management and quality assurance information, and children's case records.

Overview

The Ofsted single inspection in November 2014 found that services for children in St Helen's required improvement to be good. Since that time, despite commitment and financial investment from political leaders, the quality of services for children in need, including those in need of protection, has declined. During this focused visit, areas of significant weakness were identified that are placing children at risk of inadequate protection and significant harm.

The new director of people's services, who has been in post since June 2018, is in the early stages of recognising what is required to improve services for the local authority's most vulnerable children. The director has already revised the children's plan and has instigated a full review of the many policies and procedures that govern the work undertaken by children's social care.

On notifying the local authority of the focused visit, Ofsted was made aware by the director that during her first weeks in post, serious shortfalls in practice had been identified. The focused visit confirmed that entrenched cultural, management and social work practices are negatively impacting on children's outcomes.

There are poor threshold decision-making and delays when escalating children's cases to child protection plans and also to pre-proceedings processes. This was found particularly when children experience chronic neglect. The local authority fails to address poor and harmful living conditions for too many children. This means that children live for too long in circumstances in which they are experiencing ongoing risk and experiencing harm.

Inspectors found that social workers do not always take effective or timely action when children are living in neglectful circumstances with their families. These weaknesses in practice are not tackled because management oversight across all levels in children's social care is poor. Inspectors identified drift and delay for children during this visit and the local authority did not immediately take sufficiently robust action when these cases were first raised with them, despite clear risks to the children.

These areas indicate a systemic failure to address weaknesses that have exposed children to significant risk of harm and to safeguard and promote their welfare.

Areas for priority action

The local authority needs to take swift and decisive action in the following areas in order to address the weaknesses found during the focused visit:

- There are significant delays in escalating children's cases from children in need to child protection and/or public law outline processes when risk increases. This is exposing children to further actual harm, particularly when children are experiencing long-term neglect.

- The deficit in oversight of, and supervision and challenge by, leaders and managers means that children are not being appropriately safeguarded.

- Quality assurance and audit processes do not appropriately challenge poor practice. This means that leaders and managers are not able to understand the quality of social work practice, and, more importantly, means that safeguarding concerns and other actions to promote children's welfare are not identified.

What needs to improve in this area of social work practice

- Social workers, managers and key professionals from other agencies do not demonstrate an understanding of the impact of chronic neglect on children or how drift and delay can compromise children's futures. This means that they do not take timely and necessary action to safeguard children.

- Services do not meet children's levels of need for protection and welfare. Recording of decisions by managers regarding escalation of cases to higher levels of intervention are not clear.

- Assessments of children's needs are not kept up to date, nor do they include clear contingency arrangements should children's needs, or the risks they are exposed to, change.

- Pre-proceedings letters to families do not clearly identify professionals' concerns or provide the details of what needs to change in order to reduce risk for children.

Findings

- The application of thresholds is poorly understood across most levels of children's services and in partner agencies. During the visit, inspectors saw evidence of inconsistent chairing of child protection conferences and the application of thresholds at Section 47. Social workers reported that, despite sharing escalating concerns, the thresholds applied by IROs are often too high, leaving social workers feeling disempowered and unable to ensure the safety of children.

- Although partner agencies' attendance at child protection conference, core group and children in need meetings is appropriate, there is little evidence of them challenging the views of children's social care or the conference chair. This lack of effective partnership collaboration has not been assisted by the inconsistent application and understanding of thresholds by social workers, managers and meeting chairs.

- The recent review of child protection plans, undertaken by the performance unit, identified that, for children who had been on a plan for over 18 months, the rationale for children's cases being progressed was unclear and there were no criteria for stepping down from child protection or commencing pre-proceedings being established. There was also no evidence that the threshold for ongoing work with children and their families was tested at review conferences. This view was confirmed during the visit through discussions with senior managers and social workers. Ongoing actions and work with families are being monitored, but this is happening without a shared understanding of how this lack of up-to-date analysis of threshold was impacting on the plan as a whole. The high number of

children subject to a child protection plan has been significantly reduced over the past year and decisions to step children's cases down to child in need are appropriate. However, there is little confidence expressed by the workforce that thresholds are being consistently applied for children whose needs require an increased level of intervention. This concern mirrors the findings of inspectors during this visit. The local authority is aware that its pre-proceedings work needs development and has identified a relevant action in its improvement plan.

- A high proportion of the children's cases that were seen during this visit featured issues of long-standing neglect. Too many children have been left in home circumstances where their health and well-being are compromised. For some children, this was added to by additional concerning factors such as parental substance misuse, domestic abuse, poverty and poor mental health. Considerable drift and delay were seen in a number of cases. The cumulative impact on children is not sufficiently recognised by all workers or their managers, and the high tolerance to familial neglect is neither questioned nor challenged by effective management oversight or reflective supervision.

- Thresholds for escalating children's cases into pre-proceedings or proceedings are set too high. Harmful situations for children are assessed in isolation, and the use of burden of proof, rather than actual or potential risk of harm, results in very few children being subject to pre-proceedings. When pre-proceedings have been instigated, the letters to families are lists of actions and do not clearly state expectations of behaviour with timescales in order to assist families in fully understanding what they need to achieve to prevent further escalation.

- Audits for children who are assessed to be children in need or subject to a child protection plan are variable in quality and are not conducted using a consistent methodology. They are overly compliance-focused, and recommendations from these audits were not routinely incorporated into revisions of children's plans. As the auditors had not benefited from recent training in auditing practice, the value of these audit processes are questionable, and a dearth of commentary on poor social work practice in audits does not support improved practice or learning. Because of poor audit activity, managers' oversight of practice is not effective.

- Supervision, though regular, is poorly recorded. Social workers report that, while monitoring of actions from plans takes place, reflection on what is working well and discussion relating to direct work with children is less common. Children's experiences do not fully inform the evaluation of risks in supervision. This means that necessary actions, and the associated timescales for completion, are not identified to best meet children's needs.

- Contingency planning is weak, with limited evidence of potential support to families being well explored. The lengthy delays in establishing an edge-of-care service has not helped increase or improve the potential to support families in crisis. However, family intervention workers, together with a wide range of

effective targeted services, are having a positive impact for many children and their families.

- Assessments of children and their families vary in depth and quality. A number are well-written, evaluative assessments of parental capacity, and of extended family members' viability. However, some assessments are devoid of analysis of risk and protective factors, and this has impacted on the quality of subsequent plans. Children's experiences do not always inform the evaluation of risks in assessments, nor are their experiences fully taken into account when identifying necessary actions and required timescales to best meet their needs.

- In the previous full inspection, children's wishes and feelings were identified as not being well recognised or responded to. During this visit, inspectors determined that this situation has not greatly improved. While children's wishes and feelings are recorded on most case files, and social workers demonstrated that they know the children well, this does not always convert into child-focused and timely plans to improve children's daily lived experiences. The newly formed young advisers group has yet to demonstrate impact.

- Since a restructure of the service in 2017, and recently improved performance in the recruitment and retention of social workers, caseloads are felt by social workers to have diminished to a manageable level.

- Newly qualified social workers praise the support provided to them during their assessed and supported year in employment by mentors, and their morale is generally high. Their commitment to improving children's lives is very clear.

- The local authority was open with inspectors about the current quality of its services and the challenges that they have to meet in order to improve. The calibre of many of the social workers is recognised. The planned improvements in management oversight, supervision, quality assurance processes and consistent models of social work practice suggest that social workers may be better supported to undertake their roles in the future.

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

As part of our early review of the framework for the inspection of local authority children's services (ILACS), we have decided to amend the framework when we make an area for priority action after a focused visit. In these circumstances, we will now require the local authority to submit its final action plan up to 70 days after receipt of the inspection letter in line with the Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007. We will re-publish the framework in September 2018, but we are implementing this change with immediate effect.

We plan to amend the inspection framework further to request that local authorities share an early draft of the action plan within 20 working days to help us understand the quality of planning.

In making these decisions we took account of our inspection principles (set out at paragraph 4 of the inspection framework), most particularly prioritising our work where improvement is needed most.

We have notified the DfE of the areas for priority action and we understand you will receive separate correspondence from them. In terms of our next steps, we will be considering whether our next activity in St Helen's will be a focused visit or a standard inspection in due course.

So, in summary, you will therefore need to send us your action plan to ProtectionOfChildren@ofsted.gov.uk. You will receive the letter 24 hours before publication on 8 August 2018, so we expect to receive your final action plan on or before 3 December 2018 and your draft plan by 10 September 2018.

Yours sincerely

Stella Elliott
Her Majesty's Inspector