Solihull Metropolitan Borough Council

Inspection of children's social care services

Inspection dates: 11 November 2019 to 22 November 2019

Lead inspector: Peter McEntee
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement
The experiences and progress of children who need help and protection	Requires improvement
The experiences and progress of children in care and care leavers	Good
Overall effectiveness	Requires improvement

The local authority has made some progress in improving the quality of services for children and families since its inspection in 2016. Senior leaders, elected members and managers prioritise children's services, and this is evidenced by further development despite financial pressures. However, services are not yet good and not all areas of concern identified at the last inspection have been addressed. The local authority's self-evaluation does not provide a clear picture of practice quality.

A strengthened front door multi-agency response and a reconfigured early help response are making a positive difference at an early stage for many families. Children who are at immediate risk are responded to quickly, and, in most cases, receive timely, effective interventions. Experiences for children who need to be cared for by Solihull are enhanced by living in stable long-term homes with their carers. Children who have a plan for adoption are adopted in a timely manner. Young people who are preparing to leave care or who have left care get good levels of support and guidance in preparation for their adult lives.

For some children, plans are not progressed quickly enough and, in a few cases, there is drift and delay. There is little challenge and reflection in the supervision of social workers, and this is a barrier to better practice. The local authority has not ensured that its quality assurance framework is sufficiently robust or that it provides an accurate view of practice quality. This means that it does not always know its weaknesses. Partnership working is not universally strong. Child protection strategy meetings are subject to delays, mainly due to a lack of police availability, and the local authority has yet to remedy this. Not enough is done to ensure that children who go missing are interviewed on their return. This means that managers are missing opportunities to gain important information that could contribute to protecting children. Connected carers are not made sufficiently aware of the same opportunities for training and skills enhancement as mainstream foster carers. As a result, they are not fully supported to help the children placed with them. Homeless 16- and 17-year-olds are not always informed of the option of local authority care, and assessments of need in these cases do not always consider whether entry to care may be of benefit.

What needs to improve

- Quality assurance and audit arrangements to improve practice so that leaders are aware of strengths and weaknesses.
- The timeliness of strategy meetings and inclusion of all relevant partners, including the police.
- The practice and impact of 'threshold' visits on children and families should be reviewed.
- The offer and take up and analysis of return home interviews following episodes of going missing.
- The clarity of children in need and child protection plans so that parents and carers can more readily understand what is expected of them and why.
- The timeliness of reviews of children in need of services at level 2 in the disabled children's team.
- Levels of awareness and access for connected carers to training opportunities that will enhance their skills in caring for children and in strengthening placements.
- Timely progress in the making of special guardianship orders where these are set out as the plan for permanence.
- Consideration of the need for homeless 16- and 17-year-olds to be cared for, and to be made aware of that option, by the local authority.
- The focus on and response to private fostering arrangements.

The experiences and progress of children who need help and protection: Requires improvement

1. Solihull has recently reorganised its early help provision, creating a family support service that undertakes assessments of need and provides families with help at an early point. This area of provision is a strength. Family support and sensitive direct work with children are making a positive difference to their lives. If improvements in children's lives are not made, or if levels of risk increase, family support workers promptly escalate their concerns so that statutory intervention can commence.

2. All referrals for early help, statutory support and protection are made to a newly designed single front door, where they are considered by a stable group of team managers. Decision-making, understanding of thresholds for further work or stepping down to family support are appropriate in the majority of children's cases. In some cases, the decision to close a case is reached without sufficient information being gathered. This means that potential and unassessed risk remains unexplored or not fully understood.

3. The quality of referrals from partner agencies is too variable, and some referrals are poor. Failure to include sufficient relevant information and detail leads to additional work for local authority staff and can add to delays in deciding on the appropriate next steps.

4. The need for consent is understood and sought or dispensed with appropriately. For those families needing help at weekends and overnight, the emergency duty team provides effective responses.

5. Strategy meetings in the multi-agency safeguarding hub (MASH) are held promptly, but do not always involve all relevant people, including workers from the receiving team, who will be undertaking the next steps. Some strategy meetings in assessment teams are delayed, sometimes by more than a week, due to a poor and slow police response. Most meetings lead to appropriate decision-making. However, inspectors identified examples of delays in decision-making, or actions being taken promptly, leaving a few children at risk for longer than necessary.

6. 'Threshold visits' are undertaken when children are not deemed to be at immediate risk and managers need further information in order to make a decision. This practice means that some children have to repeat their stories on multiple occasions and in a small number of cases there are delays of up to two weeks before a final decision is made about what needs to happen next.

7. When children and families require further assessment of their needs, social workers in family support teams complete thorough and timely child in need and child protection assessments in most cases. Assessments take into account a

family's previous history. Most children are seen quickly as part of the assessment process. However, some children experience delays before they are seen.

8. Children in need and child protection plans are variable in quality. Better plans are comprehensive, with a mix of tangible and practical actions that support children and their parents. Some plans are very lengthy and without timescales for actions to be completed. This can make it difficult for parents to understand exactly what they need to do, and by when, to improve their children's lives.

9. Child protection conferences, core groups and child in need reviews are timely, and are well attended by partner agencies, parents and sometimes children. Child protection case conferences use a scaling of risk model, but core groups do not, and this is a missed opportunity to be able to further measure progress in reducing risk. Children are offered the support of an advocate to help them express their views to conferences and reviews. This is empowering for them and helps to ensure that their views are fully heard in order to inform planning.

10. If safeguarding concerns either continue or escalate, legal advice is usually promptly sought to consider whether pre-proceedings should be initiated. Letters before proceedings are clear, and examples were seen where pre-proceedings work resulted in parents making the necessary changes to enable their children to stay safely with them.

11. A largely stable and consistent workforce in family support teams, court and child protection teams allows children to build positive and trusting relationships with their social workers. Children's views, wishes and feelings are sought and understood. Many social workers know the children they work with well. They spend time with them alone to ascertain their views and use a range of age-appropriate tools to help develop an understanding of what life is like for children. This is helping to inform assessment outcomes and plans.

12. A less stable workforce in the disabled children's team means that it is more difficult for children to build relationships with social workers. Some children have experienced several changes in social workers. For some, this, and a lack of effective management oversight and good quality supervision for social workers has contributed to drift and delay in their plans being progressed. Poor practice has meant that over 200 children in need assessed as being at level 2 in the disabled children's team are not having their needs and circumstances regularly reviewed. As a result, managers cannot be assured that these vulnerable children are receiving a service commensurate to their needs. However, inspectors did see some examples of skilful work being done by individual social workers, and of family support workers having a positive impact on children's lives.

13. Solihull is currently remodelling its strategic and operational responses to child exploitation and missing children. At present, services are disjointed, making it difficult to provide an effective multi-agency response to child exploitation. For example, social workers must currently work alongside three different police

teams to respond to different forms of child exploitation, making communication and collation of information more complex than is necessary.

14. The local authority has oversight of and information about children who go missing. A monthly meeting considers the circumstances of these children, but it is not clear how this influences children's plans or improves their situation. Return home interviews are offered to the vast majority of children who go missing, but in many cases, these take place outside of the expected timescale of 72 hours. The service commissioned to undertake these interviews is not sufficiently creative or proactive in promoting children's take up of these interviews. This means that, in the majority of cases, the local authority has no information from these young people about what happened when they were missing. When children go missing frequently, strategy meetings are convened, but few have resulted in purposeful action that reduces the frequency of further missing episodes. Multi-agency child exploitation meetings are well attended by partners, but, in some cases, agreed actions lack clarity. For example, agreements to take action without any timescales for completion make it more difficult to hold agencies to account and to measure progress.

15. The local authority has not had the capacity in recent years to respond to the increase in the number of children electively home educated (EHE). There is a backlog of visits still to be made, and, while the local authority has now responded to this issue with increased staffing, this backlog will not be dealt with until March 2020. Relationships with local EHE community groups are underdeveloped, making it more difficult for the local authority to establish a full picture of home education in the borough. Where children are known, staff have a clear oversight of pupils' individual needs.

16. Young people aged 16 and 17 presenting as homeless are not being made aware of their entitlement to be accommodated and receive S20 support. A small number of cases are closed too early and do not have an adequate overview of the risks that young people face. Not talking to young people about the possibility of care when they are homeless reduces their options and affects their future welfare.

17. The awareness of private fostering remains underdeveloped. No annual private fostering report is produced, and the local authority and their partners have been too slow to develop this area of work.

18. The designated officer service is effective in its response to allegations against adults. Solihull designated officer(s) work well with key partners and neighbouring local authorities, resulting in effective information-sharing and overall swift decision-making.

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

19. Children who come into care in Solihull benefit from dedicated carers and social care staff. Decisions for children to come into care are made in their best interests and in most cases are timely. These decisions are informed by comprehensive assessments that clearly identify a child's individual needs and risks, and they are supported by appropriate plans.

20. The vast majority of children live in good-quality, stable homes for as long as they need to be looked after. Stability for children in care is good and enhances the chances of long-term positive outcomes for children. A range of services are in place to meet children's individual needs, including therapeutic intervention, educational progress and support on leaving care.

21. Children are seen regularly by their social workers, who know them well. They are seen alone, and their views and feelings are considered in planning and decision-making that affects their lives. For those children who live away from Solihull, there are clear improvements in their circumstances after they come into care.

22. Children are encouraged to keep in touch with important people in their lives and they are supported to do this when it is in their interest. Brothers and sisters are placed together whenever possible. Foster carers have good relationships with the children they care for and ensure that brothers and sisters see each other and have fun together.

23. Highly trained and skilled family support workers in children in care teams deliver valuable therapeutic life-story work. Over time, children benefit from trusting relationships with these workers. Children help to create their own good-quality products, such as books, presentations and life journeys. While most children get life-story book work started quickly, some children wait a lengthy time to receive this more specialised and very good service.

24. All children in care have a care plan, although these are not always updated immediately following a child's review. This creates potential for delay in actions being taken to help and support children.

25. Timely children looked after reviews are well attended by young people, who receive good support from advocates to ensure that their voices are heard. Recommendations from reviews are appropriate, but records from reviews are not written in a way that most children can easily understand. Where independent reviewing officers identify concerns, including drift and delay, steps are taken to escalate these concerns. These interventions are not always effective and, in some cases, have not led to a quick enough resolution of the issue.

26. There is effective parallel planning for many children that ensures that adoption plans and most plans for long-term fostering are progressed without delay.

Solihull's children move to live with prospective adopters, including fostering to adopt carers, quickly, and the time it takes to place children continues to improve. For most children, the timescale is better that the national average, and demonstrates strong performance by the local authority.

27. Work to ensure that children who need permanence through special guardianship is not always pursued with enough pace or rigour. Formal matching of children to their long-term foster carers takes too long in some cases.

28. All children in care benefit from regularly updated and reviewed health assessments. Care leavers receive their health histories, meaning that they have the important medical information that will help them as they enter adult life. Initial assessments of children and young people's mental health needs are undertaken in a timely manner. However, the children in care council and care leavers told inspectors that they experienced significant delays in accessing treatment following an initial assessment, and a small number waited longer than 30 weeks.

29. Most children receive appropriate education provision, and their education needs are supported by education, health and care and personal education plans (PEP) plans. Children in care have progressed in recent years in almost every key stage, and they are above national attainment for the same group.

30. The virtual school has a positive impact and tracks the achievement of all pupils. Leaders recognise that tracking needs to more fully demonstrate the progress that pupils make through a school's curriculum. Designated teachers receive comprehensive training that ensures that teachers are clear about the virtual school's expectations. The attendance of children in care is carefully monitored, and cases of persistent absence have fallen considerably.

31. The fostering service is still working to resolve a legacy of shortfalls that are due to there being no permanent manager between 2017 and early 2019. Senior leaders acknowledge that the quality of management oversight and overall standards in the service are not yet good enough. The quality of foster and connected carers is too variable. For example, in some cases, significant adults attached to a family are not interviewed prior to consideration by the fostering panel, and, in some other cases, not all statutory checks have been completed. The fostering panel is effective in identifying these issues, and is providing strong levels of scrutiny and challenge and ensuring that all approvals are comprehensively secure.

32. The fundamental skills to foster course is offered online but connected carers have not, as yet been made sufficiently aware of this. This is a missed opportunity to help provide connected carers with some of the core skills they need to care effectively for the children who will be living with them. The vast majority of mainstream foster carers complete required post approval training, and this contrasts with under a third of connected carers achieving the same

standards. The local authority has recently taken steps to address this shortfall by appointing a specific family support worker.

33. The service for young people aged 16+, care leavers and unaccompanied asylum-seeking children (UASC) is well developed and provides good outcomes for many young people. Social workers and personal assistants (PAs) are committed, caring and competent. They see their young people regularly, know them well and are aspirational for them. The local authority is in touch with almost all care leavers.

34. A high proportion of care leavers live in suitable accommodation, including staying put with former foster carers after they reach 18. Careful consideration is given to young people's level of independence skill when deciding when they can and should move on. When young people live in houses of multiple occupation, these meet their needs and are supported by good liaison with staff on site. Any issues are well recorded and responded to. The vast majority of young people are fully engaged in choosing where they live.

35. Pathway plans for young people are completed regularly and set individualised and appropriate goals. They are undertaken in collaboration with the young person, and, in most plans, the young person's views and wishes are clear. Social workers and PAs have high aspirations for their young people and encourage them to aim high and to achieve their potential. Young people are well supported to access education and training, and the number who are aged 19 to 21 in education, training or employment is above the England and neighbours average in the last full year.

36. Social workers working with unaccompanied asylum-seeking children are experts in their field. They demonstrate extensive, in-depth knowledge of relevant legislation and are highly alert to, and curious about, the issues and vulnerabilities for this group of children and young people. Social workers are effective advocates for their young people and support them well with their immigration status. Sensitive direct work helps young people to share their experiences at a pace that is right for them. Social workers strive to provide children with cultural matches or communities in which children feel at home.

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

37. The local authority has made some progress in improving the quality of services for children and families since its last inspection in 2016. Many, but not all, of the recommendations made at that inspection have been acted on. Senior leaders and elected members are ambitious and have a good understanding of the needs of vulnerable children. Despite financial pressures, there is a commitment to children's services and a focus on ensuring the well-being, safety and outcomes of children in Solihull. Further investment has been made to improve key areas of staffing and to allow a reconfiguration of early help services.

38. Senior leaders have developed and implemented some effective children's services. These include the creation of a beneficial family support service that provides early help and an effective single access point at the front door. Well-resourced plans are in place to expand the use of the Family Group Conferencing service and to develop a Family Drug and Alcohol Court (FDAC).

39. The local authority's updated self-evaluation identifies strategic and service initiatives, as well as areas for further development. However, the self-evaluation does not comment sufficiently on practice quality and on what needs to improve to ensure better outcomes for all children.

40. The local authority has developed and implemented a whole-service management information system that allows senior managers to better understand practice performance. This includes enough information to allow an understanding of, and to track the progress of, children's permanence plans. However, the combination of trackers used does not easily provide an overview of permanence planning and progress, and it is cumbersome and time-consuming for managers to use.

41. Leaders have been successful in developing and delivering good-quality services in some key areas. There was no evidence of children being at immediate risk where the authority has not responded. The vast majority of children in care live in safe and secure homes, and, as a result, their outcomes have improved.

42. Despite the local authority improving the quality of practice in some important areas, in other areas there is evidence of too much variability in both quality and timeliness. For example, some referrals are closed too early at the front door and concerns over risk are not resolved, and this contributes to a high number of re-referrals.

43. Some issues have not been resolved since the last inspection. The delay in convening strategy meetings persists, despite ongoing efforts by senior managers to improve the situation. There are still significant delays in the police responding to meeting requests, and, as a result, some children at risk do not benefiting from a timely partnership response.

44. For some children, plans are not progressed quickly enough and, in a few cases, there is drift and delay. For example, some children wait too long to become subject of special guardianship orders. There is little evidence that homeless 16- and 17-year-old young people are being told about or offered the opportunity of care. The recognition of private fostering remains undeveloped, with very low numbers being referred to the local authority. The quality of supervision offered to social workers is inconsistent and lacks the challenge and reflection necessary to improve practice. IROs are getting better at recognising drift and delay in care planning. They do not always escalate concerns effectively and neither do they receive timely responses from managers.

45. Senior managers have implemented a quality assurance framework, but this is yet to realise its full potential to ensure learning and improve practice. Compliance by team managers to complete the desired volume of audits is poor, and senior managers have been slow to remedy this shortfall. Overall, casework audit outcomes are overly optimistic, and, in many cases, are not completed and moderated in line with the local authority's own standards. On this basis, the local authority cannot be assured that it has an accurate measure of its own work. The local authority has not established themed audits to look at specific service and practice areas, and it is reliant on less than half of its planned audit findings to inform its analysis of practice and compliance standards. This is not a sufficiently robust base of management information, and, as a result, the local authority cannot be assured that it has a reliable overview of quality of practice. There is little evidence of any learning loop for staff, and so there is little benefit for staff in the audit activity undertaken.

46. There is established partnership working between the police and social workers for children who are vulnerable to sexual and criminal exploitation and to going missing. The establishment of a child exploitation team that incorporates criminal exploitation is a positive development. The team recognises that further developments, such as developing services for children who are criminally exploited and better collation and use of missing children data, are necessary.

47. Evidence indicates that the service commissioned to provide return home interviews for children who go missing is not making determined or creative efforts to engage with children. To date, senior managers have not been effective in challenging the service to improve its performance and ensure that the rate of completed interviews rises from the less than one third seen in recent months. Current standards of performance do not add value to strategic management of the risks and intelligence associated with children going missing.

48. Senior leaders have strengthened the children's services workforce. Use of agency staff has reduced, and the stability of staff in post has increased. There is an appropriate level of support for newly qualified staff. The local authority has ensured that staff overall have manageable caseloads. Staff are happy to work in Solihull, feel well supported and valued. They benefit from training opportunities.

49. The local authority has both a positive relationship with the Children and Family Court Advisory and Support Service (CAFCASS) and a good reputation with the local judiciary. Both CAFCASS and the courts are positive about the engagement of the local authority and the skills demonstrated by its staff. This includes the good quality of reports and evidence given before the court.

50. The corporate parenting board is an active advocate of young people's needs, and young people are well represented in the membership. At times, attendance by some elected members has been low, and the local authority recognises the need to ensure regular engagement at all levels. The board receives regular performance information and other reports.

51. Senior leaders have strengthened the support for Our voice our service (OVOS), the group that has represented children in care and care leavers since the last inspection. Young people say that they are being heard and that they have been able to influence the local authority on policy making.

52. The local authority seeks feedback from parents, professionals and children by a variety of means, including a well-analysed summary of annual complaints and an associated plan of actions. The views of children in care are made known by OVOS and from an effective annual 'Viewpoint' questionnaire, which is well responded to, and which asks about a wide range of children's experiences, including relationships with their social worker.

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