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Ms Alison Murphy
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Dear Ms Murphy

Focused visit to Kingston upon Hull children's services

This letter summarises the findings of a focused visit to Kingston upon Hull children's services on 6 and 7 February 2018. The inspectors were Graham Reiter, HMI, and Matt Reed, HMI.

Inspectors looked at the local authority's arrangements for the front-door, the service that receives both single and multi-agency contacts and referrals.

Overview

There has been a significant step change in the understanding and progress of required improvements since the arrival of the current director of children's services (DCS) in May 2017. Until that point, progress against the improvement requirements relating to the front-door that were identified through the single inspection in 2014 had been too slow. A strong focus on front-line practice and the systems which support this has ensured that senior leaders now understand these well, and this accords with the findings of this visit. Senior leaders have consulted with staff and developed clear plans to enhance the capacity of the workforce and improve and make consistent the quality of practice. These plans were being implemented at the time of the visit and inspectors saw evidence of improved practice and positive changes being made. Much work remains to be done to ensure that all of the

workforce has sufficient capacity, skills and support to deliver consistently good quality and timely practice.

What needs to improve in this area of social work practice

- All work should be progressed in a timely way. In particular, ensure that all assessments are completed within the timescales for the child and that the good practice seen is applied consistently.

- The quality and frequency of case management oversight needs to be improved, made consistent and embedded. Managers should ensure that there are clearly recorded reasons for decisions made, that regularly reviewed case analysis is undertaken with workers and that planning and task direction, with timescales, are clear for workers.

- Senior managers should embed the use of comprehensive performance management information and quality assurance work, in particular audit and user feedback, to support ongoing improvement.

- Senior managers should review cases of children becoming looked after in an emergency, including the use of police protection powers, to consider whether more planned or less intrusive approaches could have been used.

Findings

- Contacts and referrals are progressed in a timely manner. In all cases seen, relevant information, including historical information, was gathered and considered and the decision to progress was appropriate, with clear management oversight. Consent was actively sought and where the need for consent was overridden, an appropriate rationale was recorded.

- Referrals from partner agencies do not consistently deliver clear information and succinct direction on what services or interventions are being requested. As a result, front-door staff have to spend more time than necessary on gaining clarification before these can be progressed.

- Senior managers responded promptly to on-site findings about an email box which contained referrals. They put in place management tracking and oversight systems while waiting on further information from partner agencies.

- The co-location of early help within the early help and safeguarding hub (EHASH) supports the timely progression of work to those services. There is good management oversight of requests, and the early help allocation meeting shares multi-agency information effectively, to ensure the allocation of the right service. This good partnership engagement would be further enhanced by a dedicated education link.

- The early help system is not as efficient as it could be due to providers having different electronic recording systems. This results in a duplication of some tasks when facilitating allocation.

- Decisions to step up work to social care from early help and to step down work from social care were appropriate on cases seen on this visit.

- Immediate risk of harm to children is promptly identified and responded to. In the vast majority of cases seen, strategy meetings were held in a timely way, with attendance of social care, police and health professionals ensuring that information was shared and that children were seen promptly. While the outcome decisions were appropriate, for example resulting in a joint S47 enquiry with police and social care, the rationale and analysis for the threshold of likely significant harm being met was not clearly recorded. The planning was not sufficiently detailed to ensure that clear responsibilities and timescales were allocated for all required actions, nor was interim safety or contingency planning consistently or clearly recorded.

- The rationale for decisions about the outcomes of S47 enquiries do not consistently evidence consideration of all risk factors that inform that outcome decision, but overall decision-making on cases seen was appropriate. However, given the high percentage of S47 enquiries which do not progress to initial child protection conference, this is an area of practice that senior managers should keep under review.

- There is inconsistent practice in the quality and timeliness of assessments. Too many assessments are not completed in a timely way, although available performance information does indicate that this is improving. Management oversight at the start of assessments does not clearly or consistently set timescales for completion in line with the needs of the child, and where these have been set, they have not been reviewed in line with that timescale. Of the cases sampled that were out of the 45-day timescale, children were not seen to be in situations of unacceptable risk. However, delays in completion mean that some families are unclear about whether they will receive support or what support they should receive and, indeed, whether they are still subject to social work intervention. Management oversight had not been sufficiently frequent or effective to identify and rectify the delays.

- Good, thorough assessments were seen, encapsulating effectively the voice and experiences of the child, and appropriately balancing and analysing risk and protective factors to underpin decision-making and future planning. There is clear management sign-off and rationale to support decision-making in those cases.

- In all casework seen, clear efforts were made to directly engage with the child to gain their wishes and feelings and to understand their experiences.

- Senior managers have introduced additional resources and have further plans to enhance capacity and reduce case and workloads for frontline staff and managers. This is crucial to support ongoing improvement.

- The capacity of consultant social workers (CSWs) and their teams to work effectively is compromised by high workloads. Management oversight is not sufficiently regular on all cases to drive timely progression of work, and recorded supervision does not consistently analyse or direct the work effectively.

- When consultant social workers undertake direct work, including S47 enquiries arising from rota commitments, there is no consistent management oversight or support for them on this difficult work unless they request it. While the work seen was effective, more systematic oversight would ensure appropriate support and decision-making, pending planned changes to the role.

- The decisions for children to become looked after were appropriate, although in the majority of cases seen, this was done in an emergency or unplanned way. The decisions were reactive to circumstances rather than being undertaken in a planned way to safeguard the children as no improvements had been made in their circumstances. This limits children's preparation for a change in their living arrangements.

- A high number of children were subject to police protection powers in the three months before this visit, and in the cases seen, the decision to take immediate action to ensure the safety of the child was appropriate. However, the recording of those circumstances does not consistently or clearly identify what alternative courses of action had been considered or discussed with parents, including potential use of accommodation under S20.

- The out of hours responses were timely on cases seen and, where required, strategy meetings were held promptly with police to support coordinated approaches. A small number of assessments held by the service were not completed in a timely way.

- Recording by social workers and managers does not consistently reflect all the work that has taken place, the rationale for decisions or the detail of actions required, and is not consistently entered contemporaneously onto the case management system. This means that if staff are absent, key information may not be available if responses are required.

- Performance management information is underdeveloped and a performance management culture is not embedded with frontline staff and managers. Recent developments have supported better understanding of, and improvements in, practice. A more comprehensive performance framework is planned to be implemented in February 2018.

- Similarly, quality assurance work, in particular the systematic use of a range of audit approaches, is not embedded or effective in supporting and developing the quality of the work. The implementation of this is a key element of the local authority's improvement planning.
- The stability of the workforce is a strength, and staff who spoke with inspectors during the visit were positive about the support that they received. They were clear that senior managers were improving the capacity for them to deliver good quality work and understood the plans to further support this.

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

Yours sincerely

Graham Reiter
Her Majesty's Inspector