Kingston Upon Hull City Council

Inspection of children's social care services

Inspection dates: 14 January 2019 to 25 January 2019

Lead inspector: Jan Edwards
Her Majesty's Inspector

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

Since the last inspection in 2015, the local authority has failed to deliver the improvements needed, specifically to children's circumstances and experiences. A new director of children's services (DCS) was appointed in May 2017. While some important aspects of leadership have strengthened, the actions that leaders have taken have not sufficiently addressed the weaknesses in frontline practice and management oversight, in particular for children in need of help and protection.

There are widespread and serious failures in the recognition of risk and in the quality of social work practice for children in need of help and protection. A lack of authoritative practice by social workers and managers means that risk and need are not identified quickly enough for too many children. Arrangements to safeguard children with specific vulnerabilities, such as disabled children, children living in private fostering arrangements, and 16-year-old homeless children, are ineffective.

There has been very recent improvement to the experiences of children in care and care leavers. However, they are not yet receiving consistently good help to promote

their well-being and improve their outcomes. There is more to do to improve drift and delay in permanence planning, and in improving placement choice, particularly for children with complex or challenging needs.

Improved performance information is helping to secure much greater engagement and understanding of the challenges faced in children's social care from senior leaders and politicians. Priority was given to a restructuring of the social work fieldwork service. However, not all children benefit from safe and effective social work. While senior leaders have focused on these high-level improvements, the experiences of children have not been given sufficient priority.

What needs to improve

- Weakness in social work practice in the identification and response to risk and the understanding of the impact on children of their adverse experiences.
- The response to children with specific vulnerabilities, including disabled children, children in private fostering arrangements, and homeless 16-year-olds.
- Multi-agency child protection work, including strategy meetings, child protection enquiries and the initial child protection plans and core groups.
- The quality of children's assessments and plans.
- Frontline managers' oversight and challenge to consistently drive the progress of children's cases.
- Rigour, timeliness, and senior management oversight of work in pre-proceedings to drive permanence planning for children.
- Scrutiny and oversight of practice by managers and the independent conference and review officers (ICROs) in driving children's plans to improve their outcomes.
- The quality of return home interviews to inform individual planning for children and strategic planning.
- Sufficiency of local placements, to meet the needs of children in care and care leavers.
- Development of quality assurance, including auditing practice.

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

1. Services for children in need of help and protection are inadequate because failure to recognise risk is leaving some children in harmful situations, or at risk of harm, for too long. Too many children do not get the help they need at the right time. Widespread drift and delay in planning for children means that risk and need are not identified and addressed quickly or specifically enough.

2. Referrals for a social work service are made through the Early Help and Safeguarding Hub (EHASH). When contacts are received, EHASH deals with them in a timely way. However, not all professional referrers provide the right level of information to allow for robust decision-making. This results in referral officers spending too much time in clarifying basic details and checking consent. It is not always clearly recorded when consent can be appropriately dispensed with.

3. Manager oversight of the work in EHASH when it first enters children's services is too often vague and lacking in direction, particularly oversight of work undertaken by the referral officers. This results in excessive information gathering that is disproportionate to the level of need and the service request. Although social care history is routinely gathered, it is not always fully considered to inform decision-making. This is particularly the case for cumulative risk in relation to neglect, which means that contacts sometimes close prematurely before checks can be verified or assessments undertaken. Consequently, children do not always get the right help at the right time and there are missed opportunities to offer preventative services and support to children and families.

4. Too many children are re-referred to children's services because risks and needs arising from repeat parental behaviours were not sufficiently identified or met the first time. Consequently, too many children experience intervention that fails to reduce the risks they face and fails to address their needs. Inspectors found that, in some instances, safety plans or agreements made with parents are put in place when children's cases are closed following a referral. These plans do not have continued professional oversight and place an emphasis on parents complying with a set of expectations, without any assessment to inform them of what is required of them or to determine their capacity to carry this out. This means that some children remain in situations of ongoing and unassessed risk of harm.

5. When children are at immediate risk of significant harm, the response is timely and proportionate. Most strategy meetings effectively share multi-agency information to inform decision-making. Decisions to proceed to child protection enquiries are appropriate and clearly recorded. However, they are not specific enough in detailing what immediate and short-term action is

required to support the child and to specify who will do what, and by when. The police do not always participate in child protection strategy discussions. In some instances, police interview children alone, outside of strategy recommendations. As a result, children unnecessarily repeat their story of traumatic events to different professionals at different times. This practice has until recently gone unchallenged by children's social care. Senior leaders are beginning to address this with senior police leaders.

6. Senior leaders have recognised that social work practice across teams varies in both quality and impact. However, leaders have not sufficiently addressed weaknesses in social work practice and management oversight at the frontline. These practice weaknesses are widespread and undermine children's experience and progress. Inspectors saw numerous examples of poor-quality assessments which fail to identify the child's lived experience, are overly adult focused and are too descriptive. Inspectors noted that more recent assessments undertaken in the assessment teams are more proportionate and individualised to each child. These assessments also include management oversight and provide direction, including clear timescales for completion. A concerted effort to engage with fathers and other males, which is a learning point from serious case reviews, is starting to be evident in some assessments and planning.

7. The lack of child focus in assessments results in written plans that fail to improve children's situations. Plans do not always distinguish between the individual needs of brothers and sisters. They lack clarity about what is needed and who is doing what. This means that they are limited as a tool for identifying the right support and measuring change and progress. Most planning is over-optimistic and lacks professional curiosity in testing out parental self-reporting. Contingency plans are too vague, and they are not individualised enough to the family's specific situation to help them to understand what will happen should improvements not be made.

8. Domestic abuse features significantly in social work caseloads. Referrals are progressed appropriately where there is information about immediate risk of significant harm. Value is added in the EHASH by the presence of the Domestic Abuse Partnership (DAP) workers to provide information or take referrals for early help. Children and adults benefit from services when domestic abuse is a feature of their lives.

9. When children's risks escalate to child protection case conferences, effective multi-agency representation results in detailed discussion about risks and how they affect individual children within the family. However, the quality of these discussions is not always reflected in the adequate completion, by the ICRO, of an initial child protection plan for the multi-agency core group to take forward. Most core group meetings are timely and regular. However, the plans developed from conference are not specific enough to enable the core group to focus on the child and what is needed to improve their situation.

10. When children's circumstances do not improve, assertive, timely action is not always taken to escalate to pre-proceedings under the public law outline (PLO). For those children who are appropriately escalated to pre-proceedings, some do not have their circumstances effectively reviewed and they remain subject to pre-proceedings in neglectful and potentially risky circumstances for too long. Tracking of PLO is only completed on individual cases through the core group. This means that senior managers do not have an overview of the drift and delay in this part of the service. Letters before proceedings are very lengthy and do not clearly detail the local authority's concerns, making them less accessible by families to understand what needs to change.

11. Some children and families who require low-level or targeted support are benefiting from effective early help delivered through locality-based services, including children's centres and targeted youth services. Effective decision-making about thresholds for intervention is supported by early help action meetings (EHAMs) and children in need (CIN) panels. These consider when families may need help from a social worker or when they can be stepped down to early help services.

12. The strength of early help is in relationship-based practice. However, the quality of written assessments and plans is weak. Assessments are almost always adult-focused, and there is a lack of attention given to the impact of parental problems on the child. Despite this, the intense practical and emotional support offered, alongside a range of parenting interventions and services, is improving outcomes for some children and their parents or carers when they receive early help.

13. Vulnerable, exploited, missing and trafficked (VEMT) meetings are held regularly and these are effective information-sharing forums. The meeting collates multi-agency intelligence on children who are at risk of exploitation and going missing, identifying places where, and persons with whom, children could potentially be found. This approach has been successful in helping the police to find children and reduce risks. The child sexual exploitation team provides effective direct support and intervention for children who are at risk of sexual and criminal exploitation.

14. Senior leaders have correctly recognised that practice for children who go missing from home or care is weak. The VEMT considers the most appropriate people to undertake return home interviews in order to improve young people's engagement, but this does not always translate into their successful completion. Missing persons action plans are developed when children regularly go missing but are not consistently completed for all missing children. This limits the effectiveness for individual children's safety planning. This also limits senior managers' ability to respond robustly to emerging risk and to develop a coherent strategic response for missing children.

15. Thresholds for safeguarding for disabled children are not clearly understood or applied. This means that some children are subject to unnecessary statutory intervention where a lower level service response would meet their needs. Conversely, where child protection interventions are required, the risk of harm is not recognised for some children. Inspectors identified one child for whom there had been a risk of significant harm which had not initially been recognised by professionals. Senior managers had subsequently intervened to ensure the child's safety, and a learning lessons review is planned.

16. Many children with other additional vulnerabilities are not receiving effective help. A failure to comply with private fostering regulations means that the small number of children living in these arrangements are placed with carers when there has been no assessment of the suitability of the arrangement. Carers have no support plans and no understanding of their rights to access support if needed. This means that managers cannot be assured that these arrangements are safe for children.

17. Homeless 16-year-olds are not provided with a child-centred response which focuses on risk. The recent development of the 16–25 Vulnerable Young People service is intended to ensure that all children are receiving the right support. However, management oversight of 16-year-olds is very weak. Children's needs and circumstances are not sufficiently assessed or responded to. Consequently, incorrect referral pathways are followed, and there is a lack of urgency to review children's circumstances. A lack of sufficient housing options means that these young people are not provided with appropriate options for security and protection, including the option of entering care. The local authority acted swiftly during the inspection to review these cases and to reassess these young people.

18. By contrast, 17- and 18-year-olds receive a more robust service by the Targeted Youth Support service. However, while 17-year-olds should have a statutory assessment of their needs, an early help assessment is undertaken. These suitably identify the risks and overall needs and young people are supported through mediation to live successfully with family or in alternative accommodation. These young people are advised of their rights and entitlements, including the right to be looked after.

19. Allegations against professionals and the risks posed to children are robustly managed and monitored by the designated officer. Well-embedded systems ensure that children missing education and those electively home educated are safeguarded. In the six months prior to inspection, a small number of children and young people were held in custody overnight while awaiting court hearings the next day. Senior leaders monitor these children and young people, and there has been improved communication with the police to ensure that when custody is used, leaders can assure themselves of the appropriateness of this action.

The experiences and progress of children in care and care leavers: requires improvement to be good

20. Services for children in care had deteriorated following the last inspection. While services have recently begun to improve, there is much more to do to work through a legacy of poor practice. This includes embedding a culture of permanence planning, and increasing the sufficiency of suitable homes, in particular for older children with complex or challenging needs and for 16-year-olds who present as homeless.

21. Senior managers have recognised that there is an increasing complexity in children's needs when they come into care. They also recognise that there were too many older children coming into care in an emergency. As a result, recent investment was made in an edge of care service, and this is starting to make a positive difference. Most children on the edge of care now receive good, intensive support to enable them to remain with their families where it is safe to do so.

22. Most children live in good placements, where their needs are well met. However, there is a lack of local placements to support children and young people with highly challenging and complex needs. As a result, senior managers have agreed to the use of unregulated placements out of area. There were 15 such children in the year preceding inspection, and there is one young person who is currently in this type of placement. When unregulated placements are used, senior managers ensure checks and balances are in place to monitor the placement. This includes independent review officer (IRO) oversight and consultation with parents.

23. Assessments of children after they first come into care are not regularly updated. While social workers know their children well, they do not always ensure that plans for children focus on their current needs, and their plans are not routinely updated following changes to their circumstances. Brother and sister relationships and contact with the people important to children are usually well considered when children enter care.

24. There has been a legacy of a lack of urgency to secure permanence for children. Inspectors found a number of children living in long-term placements with connected carers who have not been fully assessed, and with temporary approval. Similarly, there are a significant number of children at home on full care orders where there has been drift in ensuring a discharge of the care order. Frontline manager and IRO oversight and scrutiny have previously failed to prevent drift and delay in achieving children's permanence plans. Recently, some aspects of permanence planning are beginning to show signs of improvement. There has been an increased use of special guardianship for children who cannot live with their parents, and priority has now been given to ensure that connected carers' assessments are expedited.

25. Fostering services are improving from a low base. The new management of this service has driven progress in the completion of fostering assessments which have previously gone beyond timescale, and where appropriate reference and criminal checks had not been undertaken. The fostering panel is still dealing with cases of connected carers who have had lengthy and delayed assessments. There is demonstrable evidence of improved manager grip on the work of the service and its development. Mainstream foster carers' assessments are now generally of a good quality and they are timely. Annual reviews are more robust and clearly inform foster carers' training and developments.

26. There is a commitment to pursuing adoption for children, including those who are considered to have more challenging needs in family finding, for example brothers and sisters together or older age children. This has meant that, while timescales are improving, the timeliness at the family finding stage is still above expected government thresholds. However, a recent restructure in the adoption team has enabled a much clearer focus on identifying children for adoption earlier and family finding to start at an early stage. The local authority is a partner in One Adoption North and Humber regional adoption agency, which provide effective adoption recruitment, training and support. This ensures that adopters have the right information, knowledge and support to secure permanence for children. Adopters told inspectors that they valued the support they receive from their children's social workers.

27. The timeliness of care proceedings has improved but does not meet statutory timescales of 26 weeks in all cases. The Children and Family Court Advisory and Support Service (Cafcass) reports a recent improvement to the quality of evidence, although there is inconsistent and variable practice in the completion of care plans and in capturing the voice of the child. This was identified by the local authority in their self-evaluation and was seen by inspectors. The presiding family judge told inspectors that while practice was improving it remained inconsistent.

28. Family practitioners, based within social work teams, are highly valued by social workers. They undertake direct work with children to ascertain their wishes and feelings, life-story work and parenting interventions. Their work is effective in delivering direct work and in contributing to the plan. There are a range of allied services that support children with issues which are troubling them, particularly their emotional well-being and where domestic abuse is a feature of family life.

29. The IROs have high caseloads made up of both child protection and children in care cases. Senior leaders have recognised that lack of capacity has impacted on the IROs' ability to adequately scrutinise and drive progress in care planning. However, even with improved capacity, caseloads remain too high. The IRO service aspiration is to see children between their reviews, but

this has not been possible due to high caseloads. This means that IROs are not able to establish for themselves, in all cases, children's most up-to-date wishes and feelings. While escalations to social work managers by the IROs have improved when children's plans are not progressing, there remain too many children for whom IRO effectiveness has been limited.

30. The virtual school team has been effective in securing positive relationships with schools, setting high expectations, and scrutinising use of pupil premium funding. Personal education plans are too variable in quality, and leaders are working to improve this. Outcomes for children in care in the early years and key stage 1 are below the national averages. There is a clear strategic priority to improve the education outcomes for these children. Careful and thorough monitoring and tracking of attendance and exclusions by the virtual school and the education welfare service ensure that most children in care attend school regularly. As a result, exclusions for children in care drastically reduced in 2017–2018, and attendance is now in line with the national average. The summer arts college programme, accessible to children in care, has been successful in engaging disaffected young people to return to education, employment or training, to have a positive experience and to achieve awards.

31. Transition planning for older disabled children who are looked after has been negatively impacted by delays in procuring accommodation with adult services. While individual cases had been brought to the attention of senior leaders, who have intervened to progress the plans, the delay has caused considerable uncertainty for these young people, impacting negatively on their emotional well-being. Senior leaders had recognised the deficits in this service prior to inspection and are appropriately embarking on a review of all children's cases in the disabled children's service.

32. Health assessments for children in care are not always timely. Children and young people are given priority for child and adolescent mental health services, but there is still a waiting time of around three months for treatment. Performance is monitored through a shared improvement plan. Furthermore, there is a range of mental health and emotional well-being services delivered through Hull's Headstart programme. These services include universal and early help provision through schools, and targeted support on issues such as bullying, transitions and friendships. New and improved systems to measure effectiveness show that some children and young people are benefiting from the early help support they receive.

33. The participation of children in care in developing services and having their voice heard is highly valued by senior leaders and managers. Children are well represented by the Hull Young Voices in Care (YViC) council. They are involved in a range of opportunities to influence local practice, including training social workers in assessment, in staff recruitment, and have had more recent involvement in the corporate parenting board. Care leaver champions work with the personal adviser lead to develop consultation and

participation with young people, particularly those who are more difficult to reach and engage. This work is in its early stages to be able to demonstrate impact.

34. The care leavers service, including the unaccompanied asylum-seeking children's team, provides an effective service for young people when they leave care. Investment has been provided to enable the service to expand to ensure that young people are helped to build resilience and independent living skills from the age of 16.

35. Considerable value is added by the council's local offer team, which is enabling care leavers to access a wider choice of employment and leisure opportunities. They are well supported in their education, employment and training choices, including apprenticeships in council businesses. Most care leavers are in appropriate accommodation, including staying put with their former foster carers. They are visited regularly and are encouraged to stay in touch with their personal advisers. In addition, a clinician is based in the care leavers service to support young people with their emotional well-being and to provide mediation with family if it is thought that it is possible to support a return to family.

36. The dedicated pathways team, which has been newly formed specifically to undertake pathway assessment and planning, is showing some early positive impact on the delivery of plans, although there is more to do on improving their quality. Funding has been secured for the development of digital pathway planning to further improve meaningful engagement of young people in their own plans. However, there remains an insufficient range of accommodation options for care leavers. The council recognises the issue of a lack of appropriate range of accommodation and is engaged currently in the procurement of new accommodation options for care leavers and vulnerable young people aged 16–25 years.

The impact of leaders on social work practice with children and families: requires improvement to be good.

37. Since the last inspection in 2015, there has been a significant deterioration in performance of children's services. The 'getting to good' improvement plan produced following the inspection did not deliver the level of improvement required. Progress had been negatively impacted by changes to senior management, financial savings and a deletion of posts in safeguarding and other parts of the service. An experienced DCS took up post in May 2017. The DCS appropriately embarked on early diagnostics, including the use of external consultants in auditing practice. This identified the seriousness and scale of the issues. This was followed by a phased restructuring of social work delivery, but this is not yet ensuring that all children benefit from safe and effective social work.

38. The DCS has taken time to get to know the strengths and weaknesses of the workforce, the needs of the local communities and the areas of greatest need. Starting from a very low base, the self-evaluation identifies what has been achieved and reflects very well the large-scale improvements which are still required across the whole service. While the local authority had focused on these high-level improvements, there has been insufficient priority given to the experiences of children. This was not recognised in the self-evaluation.

39. A significant area of challenge for senior managers is affecting the cultural shift within the workforce to create an environment focused on improving basic social work practice. Workforce stability is very strong. Most frontline staff have been employed in the local authority for many years. Consequently, turning around some long-established practices which have previously gone unchallenged remains a focus for leaders. Supervision is now regular, although the quality varies greatly across teams. Not all records evidence reflective discussion to improve practice or demonstrate how discussions are driving progress in children's plans.

40. Early help, EHASH and the care leavers service have been strengthened, and an edge of care service has been developed. Frontline management capacity has increased, and social work caseloads have been reduced. Basic practice standards were introduced, together with an improving quality assurance and performance management framework. Inspectors were able to see that improvement actions have had some impact. There has been a recent improvement in compliance with timeliness, including timescales for assessment, when children are seen by their social workers, and in multi-agency meetings.

41. Improved performance information has helped to secure much greater engagement and understanding of the challenges faced in children's social care from senior leaders and politicians. However, progress has begun to stall. The improvement plan has achieved some positive changes to structure, systems and processes, but has yet to make an impact on the quality of frontline practice. There is an urgent requirement to improve the quality of services that children are receiving, and momentum needs to be built in order to do this.

42. Despite considerable investment and the restructuring of frontline service delivery, there are significant weaknesses in the response to children who need help and protection. Frontline managers do not have a deep enough understanding of the quality of social work practice. A lack of management oversight and challenge does not ensure that all risks and needs are identified and responded to quickly or safely. Most children's assessments and plans are poor. The DCS recognises the need to accelerate progress in improving

frontline managers' grip and their understanding of the quality of practice in their teams, but progress is too slow.

43. Starting from a low base, there is now an improved quality assurance and performance framework to provide the context and focus for improvement. However, quality assurance processes do not yet assure senior managers that good decisions are being made throughout the service to improve outcomes for children and families. While auditing practices have improved, there is insufficient understanding and agreement among managers about what good practice looks like.

44. While the training offer has been enhanced and is valued by staff, it is not yet delivering improvements in the quality and consistency of social work practice or management oversight. Some social workers said that they felt safe to practice due to the improved manager oversight and manageable caseloads. Staff value the introduction of agile working, which is improving their capacity to work more directly with families. They are able to talk about children's wishes and feelings better than is reflected in children's records. While improving the voice of children and understanding their lived experiences has been a strategic priority, this is yet to have the impact on practice that is required.

45. Senior leaders are realistic about the challenges and they are clear that while they have invested heavily in restructuring services, in maintaining key relationships with some partners and in engagement with staff at times of change, the pace of improvement for children has stalled. This has been compounded by staffing issues in the integrated looked after children teams. While the experience and progress of children in care and care leavers is beginning to improve, some children continue to be adversely affected by a legacy of poor practice, which has resulted in wide-scale drift and delay in children achieving permanence. Inspectors found a number of examples where a legacy of drift and delay was still being worked through by social workers.

46. Placement sufficiency in the local area continues to be a challenge, particularly for children with complex needs. On occasions, children with complex needs have been placed in unregistered and unregulated residential settings. The DCS has ensured that, where this occurs, appropriate monitoring takes place while a more appropriate placement is found. The development of internal residential services and procurement of accommodation for vulnerable 16- to 25-year-olds, in the third phase of the transformation plan, will address the issue of placement choice and availability for these young people.

47. The DCS has the full support and confidence of the chief executive and politicians. Senior leaders recognise what has been achieved in improving service delivery, but also recognises that there remains more to do. The high-level improvement board chaired by the chief executive ensures that

ownership of the transformation is shared across the partnership. This is exemplified by partners' continuing commitment to the co-location of partners in the EHASH, in the further integration of early help, and in the development of the vulnerable young people's service in the next phase of the transformation.

48. Senior leaders constructively challenge partners when multi-agency practice has fallen below expectations, for example escalation of delays in police notifications to EHASH following a recent police computer failure. Senior managers are working constructively with Cafcass to challenge the courts regarding placement of children at home on care orders when this is against the local authority care plan, and in achieving a timely discharge of care orders where appropriate. Effective work is beginning to take place with adult services to improve transition planning for young people, as well as with the police to ensure that children held in custody are done so under the Home Office concordat.

49. A developing corporate parenting culture is raising the profile of the needs of children in care and care leavers and is resulting in higher aspirations and ambitions than previously. The new lead portfolio holder for children, who is being mentored through the local government association, is putting children and young people at the heart of service development and raising the profile of their voice in scrutiny. The chief executive is also working diligently to ensure a stronger corporate responsibility to children, children in care and care leavers. The development of the local offer team is an innovative approach to developing opportunities and raising standards for care leavers.

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