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Dear Alison

**Monitoring visit of Kingston Upon Hull City Council children's services**

This letter summarises the findings of the monitoring visit of Kingston Upon Hull City Council children's services on 14 January 2020. The visit was the second monitoring visit since the local authority was judged inadequate in May 2019. The inspectors were Caroline Walsh and Neil Penswick, Her Majesty's Inspectors.

The local authority is making insufficient progress in improving services for children in care that were judged to be requires improvement at the last inspection. The progress and experiences of children in care have significantly declined and many children receive poor responses to their needs. Some children in care were found to be at risk of harm during this visit.

## Areas covered by the visit

During this visit, inspectors reviewed the experiences of children in care, including disabled children, with a focus on the quality of matching, placement and decision-making, the quality of management oversight, and the effectiveness of corporate parenting. Inspectors also considered whether performance management information and quality assurance activities provide managers and senior leaders with an accurate view of social work practice and children's experiences.

A range of evidence was considered, including electronic case records, performance management information, case file audits and other information provided by senior managers. Inspectors spoke to an array of staff, including political members, managers, independent reviewing officers (IROs), social workers and practitioners. They met with a small group of children and care leavers, who shared their experiences.

## Overview

Services for children in care have deteriorated since the last inspection. Leaders and managers have failed to appreciate the scale of the weaknesses and the resultant impact on children. Shortfalls identified at the time of the inspection have not been properly rectified.

The number of children in care has been rising very quickly, at a rate more than double the national average. Leaders have not analysed this rising trend to help them to respond appropriately and address the underlying issues. Too many children come into care in an emergency even though many of these children are known to services. Some children do not come into care quickly enough, leaving them at risk at home. Managers took immediate action to protect children when inspectors raised concerns about their welfare during the visit.

Caseloads have increased for social workers, and they are now higher than they were at the last inspection. There are not enough local homes for children in care to suit their needs and, as a result, some children live in unsuitable and unregulated homes. Brothers and sisters are not always able to live together as resources are not available, and too many children have lots of placement moves as a result of poor-quality matching. This does not provide them with stability or help them to form good relationships with their carers.

Corporate parenting is not strong enough, nor sufficiently focused on what it means to be a child in care in Hull. Issues raised by inspectors on this visit were not known about, and there has been insufficient challenge by senior leaders to drive improvements and ensure that services for children are properly funded and supported.

Performance reporting and quality assurance arrangements lack focus on the things that matter most to children, and there is too much emphasis on process and compliance.

## Findings and evaluation of progress

Children in care receive highly variable and at times inadequate responses to their needs. Managers and IROs have failed to identify and escalate issues of concern. This has contributed to the decline in the quality of social work and affects the experiences and progress of children who recently came into care, as well as children who have been in care for a long time. Concerns about the quality of practice are widespread across a range of teams and services.

There is insufficient management oversight to challenge drift, and to ensure that all children receive effective care planning and appropriate responses to their needs. Managers at every level have been ineffective in recognising the extent of the weaknesses and impact on children. Inspectors identified children in care who were at risk of harm during the visit, and this required senior managers to take immediate protective actions.

Children come into care too late in Hull, and they are left for too long in situations where they experience harm from longstanding neglect. Social workers and managers are unrealistic about parents' ability to change or the sustainability of family arrangements. As a result, many children come into care in a crisis, and poor initial placement planning and matching decisions mean that many children experience several moves before they settle.

Assessments are not regularly updated, even when there are significant changes in children's lives. Chronologies do not provide an understanding of children's experiences to help meet their needs. Children's records do not clearly capture the rationale for decision-making about significant events. Too many changes of social workers mean that children must tell their story repeatedly, and social workers do not always understand children's histories. Children's plans are not sufficiently specific and do not always identify actions to make progress and avoid delay.

Life-story work is not routinely completed or updated. Children told inspectors that a lack of focus on updating and supporting life-story work means that they do not have the answers to all their questions about who they live with and what has happened to them.

Risks to children are not well identified or well managed. A poor understanding of child exploitation and risks outside the family, and an absence of multi-agency strategy discussions result in weak responses to children who are vulnerable to exploitation. Children who have gone missing multiple times continue to be at risk of harm, and there is insufficient use of risk assessments and safety planning.

Increased caseloads and limited contact with children have hampered the ability of IROs to oversee children's lives and escalate issues of concern. This includes serious issues where children live in unsuitable homes, where children are out of education or where there is drift in permanence planning. Although their reviews are timely, children's involvement in these is low and there continues to be very low take-up of advocacy.

Permanence is not established in Hull. Tracking mechanisms are ineffective, resulting in children experiencing drift as permanence planning takes too long or is not considered. Systems for approving permanence lack clarity, and there is not enough challenge by managers or support to achieve this for children in a timely manner.

Placement choice and sufficiency is a real challenge for Hull, and too many children are not being offered the right home when they first need it. Placement matching decisions are not based on strength-based assessments of children's needs and too many children experience changes in placements, creating uncertainty and instability. Weak assessment and monitoring of family placements mean that some children live in situations of high risk, where parenting concerns are not properly addressed or supported.

The recently refreshed sufficiency strategy is ambitious for Hull to continue to develop local homes. Leaders have been successful in developing local homes for children who were placed at a distance and have invested in provision for children aged over 16 years. However, the strategy does not take into account the increasing diversity of the children in care population in Hull, nor does it provide sufficient investment to deliver its targets.

Fostering recruitment targets have not been achieved, and the service has seen a reduction in the number of foster carers because larger numbers are leaving the service than are being recruited. Leaders do not have a good understanding of the demographics of their children in care population and, therefore, are not using this important information to forecast future needs. The fostering service does not have the resources to invest in marketing campaigns or provide the right support to compete with the independent market. Recruitment lacks a targeted focus to ensure that the more specialist needs of children, including sibling groups and children with complex and challenging behaviour, are met.

The fostering service does not meet minimum fostering standards. Children describe a lack of choice in their new homes; many experience poor introductions and are provided with little information about where they are going to live. Too many unplanned endings in foster care mean that children experience instability, and there are missed learning opportunities to understand why children's placements end prematurely. There are not enough foster homes for children to live with their brothers and sisters when appropriate, or for those children with more specialist needs and complex challenging behaviour. Consequently, children are living further away from Hull and the specialist support needed to meet these children's needs is commissioned alongside their care needs. This is not always successful and not all children in therapeutic homes receive the right support.

Children are increasingly moving to semi-independent homes without enough consideration of their individual needs. Some of these children are under 16 years old when offered this accommodation and continue to have care needs.

Unaccompanied asylum-seeking children benefit from a specialist team that is improving their experiences and supporting stronger multi-agency engagement in identifying risk to inform placement decisions. Children and young people are supported to take part in regular celebrations of different cultural events, and effective use is made of interpreters. Strong support is given to enable young people to attend college and develop their skills and experiences.

Education support for children in care is mostly effective and children are supported to remain in their schools when placements are chosen. The quality of personal education plans remains too variable and is not consistently helping children to make progress. Leisure interests and hobbies are supported.

The health needs of children in care are prioritised, but performance has deteriorated in the last year, with fewer children having timely health assessments

or dental checks. Investment in the dedicated looked after children and adolescent mental health services has reduced waiting times for those children with emotional and mental health needs, but there is no service to support foster carers to respond to the needs of children with complex needs. Therapeutic care is not always considered even when children's needs appear high.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Caroline Walsh

**Her Majesty's Inspector**