Inspection of Redcar and Cleveland local authority children's services

Inspection dates: 20 June to 1 July 2022

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	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

For most children in Redcar and Cleveland, their experience of services has been sustained since the last full inspection in 2017, although there are some areas of practice which remain in need of improvement. Leaders have ensured that children are seen regularly and that most children have assessments and plans which lead to them being provided with the right support to meet their needs. However, the impact of this work and the quality of manager oversight are not consistently effective for children in need of help and protection, and children in care and care leavers, which requires improvement to be good.

The local authority's plans to improve services for children were stalled in some areas by a council-wide cyberattack in February 2020, followed shortly after by the national COVID-19 pandemic. The scale and pace of improvement were affected by leaders' focus on emergency planning and business continuity. This has been compounded by the acute capacity issues across some areas of the service and, more recently, in the assessment teams. The quality of the immediate response in the multi-agency children's hub (MACH) to help and protect some children has deteriorated. Senior leaders were not aware of some of the shortfalls found during this inspection. There remains more work to do to improve some key areas of practice for children who are living in situations of neglect for too long, and children who live in homes with connected carers that are not safeguarded through regulation. The services provided to some particularly vulnerable children, including children in care, have also declined.

Senior leaders have achieved improvements, for example to the management of allegations against professionals, for the small number of children who are privately fostered, in the quality of assessments, plans and direct work, and in implementing initiatives around edge of care and foster care. There is a clear model of practice so that social workers know what is expected of them. Developments to the quality assurance framework have accelerated during the last six months, but remain too compliance-focused to be driving improved practice for all children effectively.

What needs to improve?

- The effectiveness and consistent recording of management oversight, decision-making and quality assurance at all levels of the service.
- Work with the local safeguarding children's partnership to address their understanding of threshold to improve the quality of referrals which meet the threshold for statutory services.
- The quality of written records including timely assessments and decision making to demonstrate impact for children.
- The response to neglect, homeless 16 to 17-year-olds and return home interviews with children who have been missing.
- The use of unlawful and unregulated placements and the application of the correct legal framework around the child.
- The corporate parent response to care leavers.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children and their families benefit from a comprehensive offer of early help services. Multi-agency discussions ensure that thresholds for children to step up and step down are mostly consistent and enable children to receive the right help at the right time. Children's early help assessments are well informed and lead to comprehensive plans. Early help workers know children well and reflect persistence in their work when families are struggling with multiple and complex issues. However, there is variability in how partners engage in some plans, which leads to actions not always being followed up and some children's plans drifting.

2. Redcar and Cleveland experiences consistently high numbers of referrals to the service. Additionally, the service is inundated with inappropriate contacts from the police which do not meet the threshold for early help or statutory services. The quality and volume of information provided by the police to the MACH are hindering the efficient and timely response to screening. There are also delays in referrals being sent by the police to children's social care, including concerns relating to domestic abuse and where there are high risks of self-harm for children, leaving them potentially at further harm.

3. Consequently, senior leaders have recently revised their triage process in the MACH. This has led to a lack of transparency and, as a result, some children were found not to have a contact record when they should have. In addition, a recently introduced professional helpline was observed, during this inspection, to provide inappropriate advice in one instance. Therefore, in a very small number of cases, professionals are not taking the right actions to safeguard children. Moreover, the service does not have an effective system to follow up with professionals when children require a service. Leaders accepted these practice shortfalls during the inspection and responded appropriately to cease these practices.

4. Social workers thoroughly screen the majority of contacts which are recognised and created as contacts by managers. Multi-agency information and the history of children's social care involvement are well considered. Social workers consistently apply a strength-based model in analysing the information to support decision-making. However, the initial screening by managers does not consistently consider the poor quality of information received from partners or the repeated patterns of harm and the effects on children. Parental consent is correctly obtained by the referrer for the vast majority of children. Where consent has been unable to be secured, social workers are proactive in seeking consent for information-sharing from the family.

5. The emergency duty team (EDT) is responsive to risk for children and there is effective communication and follow-up between the EDT and day social work teams. Duty social workers visit children out of hours to monitor children's welfare and provide a continuity of support to parents.

6. Thresholds and decisions are mostly appropriate for those children identified as requiring urgent action in response to immediate risk. Detailed strategy meetings focus on the individual risks and needs of children. These lead to appropriately focused section 47 enquiries with decisions and actions that reduce risk and ensure the immediate safety of children.

7. Arrangements to manage allegations against professionals by the local authority designated officer (LADO) are highly effective. The LADO service provides a timely and supportive response to allegations, with a focus on the voice of the child. A detailed tracker enables the LADO to have a comprehensive overview of patterns, trends and, where repeat allegations have been made, against adults who work with children.

8. The high demand for children's services is reflected in the numbers of children who require an assessment of their needs. The assessment teams are holding a significant volume of assessments which remain open for completion, although children are not being seen or offered interventions. This means that social workers and managers do not always know how children's circumstances may have changed while they await a decision for a service.

9. When assessments are completed in a reasonable timescale for children, they are mostly comprehensive and provide a strong sense of the child's experience. They consistently balance the risks and needs of children and the strengths of the family using the strength-based model. Children are visited at appropriate levels to the risk, with direct work and discussions with children enabling them to share their feelings and what they are worried about. These assessments lead to effective multi-agency plans that are regularly reviewed to help children get the right help at the right time.

10. The threshold decisions to proceed to initial child protection conference are appropriate. Partners contribute to analysis of risk, resulting in a clear rationale for decisions. Child protection plans are comprehensive, with priority actions to improve children's circumstances, and are consistently reviewed and updated at core groups. Core group meetings are well attended by key professionals involved with the family, who are actively engaged in decision-making. Children's plans are reviewed regularly through these meetings and reflect the current situation for the child and lead to plans being progressed. However, child protection plans do not consistently evidence contingency actions should there be limited progress for children. In addition, there is limited evidence of child protection chairs providing sufficient oversight or scrutiny.

11. The edge-of-care team provides responsive support to children and families. Mapping meetings lead to detailed creative packages of support from workers who are skilled in developing relationships and a range of models of direct work. This work is mostly helping children to remain in the family home or in supporting plans for reunification. Workers have 'stickability', building positive relationships and providing a high level of support and challenge to young people and their parents. Work is reviewed regularly to ensure that it remains appropriate and is effecting change.

12. When children's lives are not improving and they are at risk of continued harm, most children benefit from timely senior manager decisions to escalate into pre-proceedings. For most children, pre-proceedings are timely and include interventions that assist families in making sustained changes and that keep their child safely at home, successfully diverting families away from court. Where there is a need to protect children, action is taken through the appropriate initiation of care proceedings. Letters before court proceedings are clear for families to understand, making explicit what support has been offered, why the concerns are escalating and what needs to change.

13. Most children, including disabled children, benefit from consistent social workers that enable them to build positive relationships. Social workers are creative in seeking all children's views, using a variety of tools to support children's communication needs. Social workers access a range of support services and interventions to respond to the needs of children and families. Most assessments for disabled children in need of support are timely and thorough, and lead to plans with time-limited actions which help to improve outcomes for children.

14. The effectiveness of assessment and interventions for children living in neglectful situations is inconsistent. Better examples understand children's experience with multi-agency responses that help reduce harm. However, there are some children who continue to live in neglectful situations for too long, with social workers not having specific tools to assess and understand children's experiences. A lack of a clear analysis of chronic neglect, an understanding of repeated incidents of harm, and the impact of parental behaviours on children result in some children not coming into care soon enough, or entering care in an emergency.

15. There are effective arrangements for the small number of children who are privately fostered. The child, their parents and their carers are regularly visited to monitor the continuing suitability of the arrangements.

16. Children who are aged 16 or 17 years old who present as homeless are not consistently advised of their rights and entitlements. For the majority of these children, the local authority is not proactive in locating and speaking to them, to ensure that they are protected from harm and are living in suitable accommodation. This means there is a cohort of vulnerable children who are not being supported effectively by the local authority.

17. Relevant partners provide effective oversight and direct support for children at risk of child exploitation through the weekly vulnerable practitioners' group. A revised practitioner toolkit supports robust risk management plans. Social workers evidence their professional curiosity about children's lives, using imaginative ways to build relationships with them. There has been a strong focus on early intervention and prevention, and leaders recognise that there is more work to do for those children at high risk of child exploitation.

18. When children go missing from home or care, return home interviews are not held consistently and are often out of timescales, limiting full information-gathering to enhance safety plans to reduce risk effectively. Key risks and actions identified in the vulnerable, exploited, missing and trafficked (VEMT) group meetings do not consistently align with the child's overarching plan, meaning that risks are not fully understood by all.

19. The local authority has effective procedures to identify and track children who are electively home educated and for the small cohort of children who are missing education (CME). Leaders ensure that appropriate action is taken to track children, for example by checking benefits records and housing. Children are referred to the VEMT if no records can be found. Children are not taken off the CME list until their whereabouts are known, which means there is effective work to find children to make sure they are safe and in education.

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

20. Decisions for children to enter care in a crisis are appropriate. Senior managers have oversight of those children who are in care under section 20, ensuring that the service is proactive in seeking court orders for those children requiring stability.

21. Social workers strive to identify homes for children quickly when family breakdown is considered likely. Where it is appropriate and safe to do so, children are placed with family members. However, there are at least 20 children placed with family or friends who are not approved as carers, meaning that these arrangements are unlawful, being outside the safeguards provided by regulation. In some instances, minimal checks are completed before requests for viability assessments, and there is delay in progressing carers to receive full connected carers' assessments. Thus, the ability of carers to meet children's needs is undecided and children are not being secured timely care arrangements. This also affects what children are entitled to as care experienced children in the future. While senior managers have oversight of these arrangements, it is not leading to appropriate action to expedite legal security for many children.

22. Most children in care live in stable placements with carers who meet their needs. However, there are some children who have experienced multiple moves in a short period of time, affecting their ability to form stable relationships with carers. Children's emotional, physical and mental health needs are mostly well addressed within care planning and their health assessments are, overall, timely. Children are encouraged and supported in a variety of hobbies and interests, which assists in developing their confidence and social skills. Most children's review meetings are timely, but children do not consistently attend their meetings. There is a low take-up of advocates and limited evidence of children's views being gathered consistently by their independent reviewing officer.

23. The relationship between brothers and sisters is carefully considered by social workers, who complete timely assessments to inform planning for children. Children are supported to spend time with people who are important to them through carefully and creatively planned family time. Children also benefit from regular visits from social workers, who build relationships through meaningful and age-appropriate direct work and who strongly advocate on their behalf, often leading to positive outcomes. Many children benefit from individualised life-story work or direct work to help understand their history and reasons for being a child in care.

24. For some children who have returned home under interim care proceedings, there is a lack of robust assessment of risk or a level of visiting which reflects children's needs and monitors their progress effectively. However, children who

return to their parents' care under supervision orders benefit from continued support to ensure that change is sustained and that children continue to make progress.

25. Permanence is considered and achieved for most children who are in long-term care. However, permanence decisions are not always made soon enough for those children newly into care. Senior managers are in the process of implementing a more comprehensive overarching system to ensure that they are more sharply focused on permanence planning and timeliness for all children. Effective working practices between the local authority and the regional adoption agency, Adoption Tees Valley, ensure early notification of potential children whose care plan may be adoption. Their combined efforts have increased the number of early permanence carers. There are no children currently waiting for adoption. Adopters value the adoption support offer, which benefits both them and their children.

26. Most children in care live with local authority foster carers. The service has continued to develop its sufficiency by increasing its number of foster carers year on year. Leaders are currently embarked on the development of a specialist model of foster care to improve children's experiences. However, there are a small number of unannounced visits to foster carers not taking place, some reviews out of timeframes and some medical assessments not renewed.

27. Leaders of the virtual school have a good understanding of their strengths and areas to improve. The virtual school works proactively with other agencies to avoid permanent exclusions. However, the number of days lost to suspensions has not reduced and the number of children who receive repeat suspensions remains stubbornly high. Leaders have strengthened the systems for personal education plans (PEPs) and completion rates are high. However, there is variability in the quality of PEPs.

28. Senior leaders have recently introduced an asylum-seeking through care team, and, while in its infancy, is a much-welcomed improvement to services which has increased capacity. Unaccompanied asylum-seeking children are supported through the immigration process and provided with appropriate legal advice. They live in homes which are supporting their cultural and identity needs. There is evidence of the independent child trafficking service and referral to the national referral mechanism where appropriate, to help support those children most at risk.

29. Children in care start to build a relationship with their personal adviser prior to becoming 18 years old. Personal advisers are strong advocates for their young people. Where young people are reluctant to engage, personal advisers show persistence in keeping in touch. Care leavers are exceptionally positive about the support they receive from their personal advisers.

30. Care leavers are informed about the local offer. However, the web-based offer is out of date, which means that care leavers may not be able to easily access the most up-to-date information about their entitlements and financial eligibility. Most care leavers benefit from council tax exemption up to the age of 25 years. However, this is not consistently provided for those who live outside the borough. Senior leaders agreed to address this during the inspection.

31. Most care leavers live in suitable accommodation. The sufficiency strategy has focused plans on increasing the options available, but it is too early to assess the impact this is having. Care leavers have access to an accommodation officer, who explores housing options on their behalf; however, care leavers do not have priority one status, meaning that they are not guaranteed a secure tenancy. Young people are enabled to remain with their carers through 'staying put' arrangements when this is right for them.

32. Most pathway plans are detailed and completed with the young person; they clearly identify the young person's needs for support to enable them to work towards independence. Personal advisers help young people to access support through their GP and adult mental health services, or through funding for psychological support.

33. The education, employment and training (EET) needs of most care leavers are identified, and they are supported to attend university, school, college and apprenticeships, which is enabling them to fulfil their potential. A specific EET worker has been appointed to support the small number of young people who are not in any form of education, training or employment.

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

34. Following the last inspection in 2017 and subsequent focused visits, the local authority developed a service-wide dynamic improvement plan to address the inspection recommendations and areas for improvement. However, the director of children's services (DCS), newly in post in 2019, and the leadership team were significantly challenged by a council-wide cyberattack in February 2020. This was quickly followed by the national pandemic. Improvement has also been affected by significant workforce challenges. A spike in demand has resulted in high workloads across some parts of the service. Despite financial pressures, further investment has been secured to increase capacity in response to this demand. A commissioned project team has been deployed since March 2022 to increase capacity in the locality social work teams.

35. The DCS and her leadership team are aware of the service's inability to complete assessments of all children when first referred to the service, and had, in response, commissioned a team to start in July 2022. However, at the time of this inspection, it was too soon to see any impact to secure manageable

workloads in the assessment teams, to complete work with children and families, and to ensure that risk is managed in a timely way.

36. Senior leaders have made improvements to some specific areas, such as allegations management and the quality of core social work practice. In other areas of the service, improvements have been made, although these have not been with the necessary pace required to secure consistently good service-wide improvement for children. There are gaps in the service's own self-assessment of practice in some specific areas. For example, leaders had not been fully sighted on: the potential serious impact of their responses to the non-screening of contacts in the MACH; of the quality of the advice and the lack of an effective system to follow up with professionals when they have accessed support via the professional advice line; ineffective manager oversight and recording at all levels; the impact for children of the use of unlawful placements; and in the lack of a consistent response to 16 to 17-year-old children who are homeless.

37. The MACH, following disaggregation from the South Tees MACH, had demonstrated a resultant improvement in practice as seen in the assurance focused visit in February 2021. However, more recent spikes in demand have led to senior leaders implementing ill-conceived strategies in the MACH. In the last six months, there have been a significant number of children who have not been screened to identify risk and any services needed to meet their needs. Leaders had not been aware of the impact of this practice, but accepted inspection findings and took action to rectify this. Managers and leaders could not be assured that initial decisions for all children consistently resulted in the right response to risk in order to safeguard children's welfare. In the 2017 judgement inspection, a recommendation had been made to ensure consistently effective management oversight and decision-making of all contacts and that work progresses appropriately to referral and assessment. The focused visit in February 2021 found that this aspect of work had initially improved, but at the time of this inspection has deteriorated.

38. Leaders have also introduced a professional advice line, launched in May 2022. Inspectors found an example of advice provided which failed to recognise risks to the child and introduced delay in a multi-agency response. Senior leaders acted on inspection findings to suspend the advice line, to ensure that there were robust governance arrangements in place with clear terms of reference.

39. Despite financial pressures, there is a commitment from the managing director and elected members to children's services with further investment secured to increase capacity to manage the demand and staff pressures. Partnerships have been strengthened as a direct impact of the response and adaptation to collaboration during the pandemic.

40. The corporate parenting board is committed to the participation of children in influencing service delivery and service developments, although this is not consistently embedded. Furthermore, not all members understand the needs of

care leavers, and the need to be aspirational in planning and developing opportunities for them.

41. The sufficiency strategy is helping to forecast demand and to identify future commissioning intentions to meet the needs of children in care and care leavers. Successful recruitment of foster carers has resulted in a net gain and leaders are engaged regionally in increasing independent foster care capacity and children's residential home provision.

42. The DCS has introduced a line-of-sight meeting in which a range of high-risk and vulnerable children are discussed by the senior leadership team. While this is providing a forum for information-sharing and accountability, it is failing to evidence the difference the leadership team is making to children's outcomes. Furthermore, there is limited evidence of senior and team manager oversight on children's records, which means that it is difficult to understand key decision-making for children.

43. Senior leaders know that there are at least 20 children who are living in unlawful arrangements with connected carers. This means that some of these children are not being secured timely and permanent care arrangements. While these are considered, by leaders, to be in the best interests of children, this response fails to provide children with the legal framework, rights and entitlements of care that they deserve. Following inspection findings, senior leaders agreed to revisit their decisions for these children and to seek further legal advice.

44. The DCS and leadership team have fostered a culture of learning through a process of peer reviews and seeking opportunities for learning from both regional and national practice and programmes. An example of this is the strengthened approach to exploitation following learning from a rapid review. Additionally, in development is a social work academy as a part of leaders' efforts in succession planning. The chosen model of a strength-based approach is improving consistency and effectiveness in supporting families, and leaders are supporting practitioners to increase their skills and confidence in its use.

45. There is a new quality assurance framework and practice standards and a strengthened approach to performance management. Quality assurance through auditing has been a priority area of focus following successive inspection visits. A process of moderation has been recently introduced to provide added assurance. However, audit work does not consistently provide detailed evaluation of social work practice in all areas, as many audits remain too compliance-focused and are not progressing improvement effectively.

46. Performance is also supported through the development of a range of trackers, including those for pre-proceedings and care proceedings. The Public Law Outline tracker is monitoring children's experiences effectively through pre-proceedings. A recommendation from the 2017 judgement inspection had been to ensure that permanence plans for all children in care are systematically

tracked and monitored. Leaders know that there is more to do to improve their monitoring and are currently refining the tracker so that it supports a more robust oversight of children's permanence plans.

47. Many social workers have regular supervision which is reflective and provides clear direction in practice. However, at times, the frequency of supervision does not support a focus on the progression of planning for children. This, combined with some social workers' high workloads, does not always allow for a consistent critical review of work to assess risks to children.

48. Social workers clearly articulate their understanding of children and their experiences. However, this knowledge and their understanding of children's needs does not consistently translate into their recording, meaning that children would not be able to understand why decisions were made about their lives were they to access their records. The quality of recording and management oversight seen across all parts of the service does not enable a clear understanding of the effectiveness of planning for the child or their lived experience.

49. All social workers told inspectors that they feel valued and are proud to work in Redcar and Cleveland. They benefit from a broad range of training opportunities and feel well supported by managers and leaders, and are motivated to do the best for children.

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