East Riding of Yorkshire Council

Inspection of children's social care services

Inspection dates: 2 to 6 December 2019

Lead inspector: Neil Penswick HMI

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

Since the last inspection in 2016, when services were rated as good overall, there has been a marked deterioration in the quality of help and protection support for children in East Riding. Services for children in care and care leavers have remained strong overall, with good strategic and operational management oversight. This is not replicated in services for children in need of help and protection, where management oversight and practice is significantly weaker.

Senior leaders and councillors do not have a wholly accurate understanding of these practice and service shortfalls. Where leaders are aware of the shortfalls, this is not fully reflected in the self-assessment.

Leaders had identified weaknesses at the front door prior to the inspection, and these have not been effectively addressed. This has resulted in children experiencing delays in their needs being identified and remaining in situations of risk. Thresholds for access to children's social care services are not fully understood or applied by partner agencies in the Early Help and Safeguarding Hub (EHaSH). Some children are supported in early help services when the risks are too high. Management oversight of the front door is weak.

While some core social work practice in locality safeguarding teams is stronger and effective, the quality and impact of practice for specific groups of children has deteriorated since the last inspection. For instance, aspects of the practice in pre-

proceedings work, services for disabled children, children in private fostering arrangements and children at risk of exploitation are poor. High caseloads in some teams and weaknesses in the quality of oversight and decision-making by some managers are leading to drift and delay for children receiving the services they need to protect them and improve their lives. The quality of social work supervision is variable, and, for some workers, there are gaps in individual case supervision for some months. The response by the designated officers to concerns is not effective.

Services for children in care and care leavers have remained strong overall. There is a marked difference in management oversight in this part of the service. Robust management arrangements and lower caseloads have resulted in workers being supported to work tenaciously to improve children's experiences and their progress. The care leavers' service continues to provide an excellent service for this vulnerable group of children. Young people in care report very positively about the support they receive as part of corporate parenting, from councillors, managers and staff across the East Riding of Yorkshire.

What needs to improve:

- The accuracy of the self-evaluation in order to ensure that senior leaders and members have a clear understanding of service strengths and what needs to improve.
- The understanding and application of thresholds to children's social care by partner agencies and the EHaSH, to include the appropriate seeking of parental consent.
- The quality and consistency of social work assessments and children's plans.
- The quality of risk assessment and planning where children are at risk of exploitation.
- The quality of analysis and action planning following strategy discussions.
- The timeliness and effectiveness of pre-proceedings work.
- The timeliness and quality of assessment and planning for disabled children.
- The effectiveness of scrutiny and management oversight by leaders at all levels of help and protection work to enable a better understanding of practice.
- The effectiveness of quality assurance arrangements.
- The effectiveness of the designated officers.
- The quality of assessment and planning for children subject to private fostering arrangements.
- Availability and access to training for all social work staff and foster carers.

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

1. The quality and impact of practice have deteriorated for specific groups of children since the last Ofsted inspection in 2016. Despite a strong network of early intervention services to support children and their families in their own communities, and some effective core social work practice in locality teams, there are widespread weaknesses in practice and management oversight for children in need of statutory help and protection services.

2. Thresholds for access to children's social care services are not fully understood or applied by agency partners or by some staff in the Early Help and Safeguarding Hub (EHaSH). Some children remain in early help services when the risks are too high. The front door is not currently resourced sufficiently to meet the demand generated by increased contacts and referrals, and management oversight of the front door is weak. This is leading to delays in children's needs being identified and responded to appropriately and to unassessed risk for some children.

3. Contacts and referrals are received into EHaSH through an email inbox system. Due to insufficient staffing, and weak management oversight, this system is not safeguarding children effectively. Inspectors found referrals were not looked at for several days, leaving children at unassessed risk and without timely interventions to help them. Advice being given by EHaSH to partner agencies is not always appropriate to the risks being presented. Consent from parents to generate child in need or early help referrals is not consistently evidenced and, in some cases, referrals are inappropriately classified as child protection, bypassing parental consent.

4. Referrals to children's social care by other agencies, including Humberside Police, most often lack basic information to enable staff in EHaSH to make timely and appropriate decisions to safeguard children. Many lack an explanation of the reason for the referral, lack the necessary consent from parents where needed, and are not made in a timely manner. Delays by Humberside police in referring a child to EHaSH following domestic incidents leave children at unassessed risk and without support.

5. When referrals are identified as needing an urgent child protection response, this happens promptly. Strategy meetings are convened and, although they are mainly telephone conversations, the relevant professionals participate in those discussions. This is an improvement since the focused visit in October 2018. However, discussions and decisions about further actions needed to safeguard the child are not always thorough or commensurate with the identified risk. For a small number of children, this results in lower-level interventions when a higher-level safeguarding response is needed.

6. Senior leaders identified that there were weaknesses in EHaSH since the Ofsted focused visit. Actions identified have not been effectively addressed. Inspectors found that many of the weaknesses remain, and this is leading to delays in children and families receiving effective help, support and protection when it is needed.

7. When further social work support is needed, children's cases are not always transferred promptly to locality safeguarding teams. This results in long delays before the child is seen by a social worker. While performance information indicates that most assessments are timely, this is not always accurate. In a small number of cases, inspectors found months had passed before the child and family were seen and assessments were started.

8. Inspectors saw examples of strong and effective practice in the safeguarding teams. While some assessments are of good quality, in particular, pre-birth assessments, and lead to effective evaluation of risk and clear appropriate recommendations, this is not the case for all children. Some assessments do not consider all of the relevant issues and they analysis. There is little use of chronologies of the family history, and this results in key historical events not being recognised and being considered in the assessments, plans and future work.

9. A new service, the Multi-Disciplinary Support team (MDST) started in September 2019. It is providing good-quality systemic analysis and help for some families with long-term problems which traditional social work support has not resolved. It is too early to measure the full impact of these services.

10. Senior leaders say that they use a model of social work practice that is embedded across the social work teams. Although evident in recording templates, inspectors did not see the model being consistently used by all staff to identify concerns alongside strengths and prioritising the key concerns. Examples of good direct work, effectively engaging with children and parents, were seen by inspectors, but this is not consistent. Visits to children do not always occur in a timely manner. Some social workers reported that having high caseloads resulted in them not being able to visit and progress the direct work as necessary.

11. Overall, children's plans are weak in identifying what the professionals and others, including parents, need to do to reduce the risks and improve children's progress and experiences. While the response when children go missing is robust and return home interviews are timely, safeguarding risks are not always identified. Inspectors had serious concerns about the response to those highly vulnerable children who were at risk of child sexual exploitation. Good strategic planning is in place by partner agencies, including the local authority. However, this does not always translate into adequate safety planning for individual children, by children's services, to protect children.

12. Inspectors referred children's cases back to the local authority because of concerns about social work practice and weak management oversight. Senior leaders did not dispute any of the inspectors' findings. In the vast majority of cases, this has resulted in senior leaders taking remedial actions, and immediate safeguarding action for some children.

13. The pre-proceedings stage of the public law outline (PLO) is not effective in ensuring that the children's lives improve. Overall, despite senior leaders considering this work to be strong and effective, management oversight of the quality of work, planning and decision-making for children subject to PLO is weak. It does not ensure that the escalation into court proceedings is timely or effective, and does not prevent PLO work ending before any effective change is achieved for children in all cases. Having been made aware of these issues, senior managers are now carrying out an urgent review of all PLO work that has been carried out over the last six months to ensure that processes are robust and have progressed care proceedings in one child's case because of these findings.

14. The disabled children team is not ensuring that children receive a timely and appropriate service. In some children's cases reviewed by inspectors, it was clear that children's needs had changed some time ago and that their current needs are not recognised or met. Inspectors were alerted by managers to a backlog of children's cases awaiting review. This team had only recently transferred to the responsibility of children's services from another part of the council. Senior leaders acknowledged that work needs to be done to improve the quality of help and protection services in the team.

15. Arrangements for the designated officers are not robust. There is a lack of consistency in recording, and weaknesses in the application of thresholds and decision-making, as well as in planning for further actions. Too many cases result in no further action being made by the designated officers without basic information having been acquired to ensure that the children are safeguarded. Other agencies did feed back that the training and awareness-raising by designated officers, including in schools, were positive benefits in helping them further protect children.

16. The response to vulnerable children who are privately fostered is not timely and visits are irregular. Assessments are weak and do not consider all the risks to the children. Senior managers have been aware of the weaknesses, but have not effectively addressed the shortfalls.

17. The support for homeless 16- and 17-year-olds, in coordination with other agencies, is mainly effective, although checks are not always made to confirm that the children are living in suitable accommodation.

The experiences and progress of children in care and care leavers are: good

18. Most children in care in East Riding receive a good service that improves their life chances. The exceptional level of support for care leavers at the last inspection has been maintained. Separate and stronger management arrangements for children in care, including manageable caseloads, support workers well in this area to ensure high-quality support. This is in stark contrast to children in care who are supported in the safeguarding locality teams.

19. Approximately a third of the children in care are supported in the safeguarding locality teams, where practice for these children is not as consistently strong as in the children in care service. This is due to a variability in the frequency of social work visits, assessments not being completed thoroughly and weaker management oversight.

20. Most children enter care when they need to, although they are not always initially placed in homes that meet their needs. Senior leaders are making concerted efforts to improve the availability of local placements, and there are some early signs of positive impact. Arrangements have been agreed and finance has been confirmed by the council to further extend the availability of local residential provision that meets the needs of children with high levels of need.

21. There are a small number of children aged over 16 who are placed in supported accommodation. These are all planned placements organised to meet the young people's wish to stay in specific locations. The commissioning, monitoring and review of those placements is good, and arrangements to further strengthen this work are being rolled out. The young people are visited regularly by their social workers and personal advisers, and coordinated activities continue to help them further achieve in their education and employment. Senior leaders reported that they had no children in unregistered settings at the beginning of the inspection. However, this was not accurate as inspectors found one child in such an arrangement.

22. The Child and Family Court Advisory and Support Service (CAFCASS) reported to inspectors that there is effective court work with well-prepared social workers and good-quality reports, and this ensures timely decisions for children.

23. Social workers and managers know their children well. Sensitive consideration is given to the allocation of social workers to children. When children's workers change, the ethos of a 'whole team knowledge' of individual children helps to provide continuity to the child or young person. Caseloads are manageable and are kept under constant review by effective managers,

enabling good, trusting relationships to develop. This leads to positive and timely direct work with children.

24. In most cases seen by inspectors, there is a strong multi-agency approach to wraparound support for children in care. This is enabling children's needs to be identified and well met. This includes tenacious partnership efforts to sustain and support children where they live when there are issues that could potentially impact on the continuation of an otherwise good placement. Inspectors saw examples of individual crisis management plans that ensured that the school, carers and anyone working with the child were working together in a caring, consistent way. This approach is improving children's stability, experience and progress.

25. Care plans are regularly updated. They convey the children's views and are written directly to them in language they understand. In most cases, children attend or participate in their reviews, which are chaired by independent reviewing officers who know them well. Children's views are independently gathered by the participation officer, ensuring that they are at the centre of the plans for their future.

26. The virtual school champions effectively the educational needs of children in care. Personal education plans (PEPs) have improved considerably since the last inspection. They are consistent in format. The PEPs reflect the voice of the child. Targets are specific and measurable. They focus carefully on the child's next steps educationally. PEPs have been extended to cover children from birth to the start of school. This is a strength and shows a commitment to early intervention. In addition to social workers, education welfare officers (EWOs) attend 100% of PEP review meetings. Their contribution is highly regarded by school leaders. EWOs manage review meetings effectively and in a timely manner. They challenge schools robustly. They respond quickly with extra help when a child is in crisis. The virtual school team ensures that all PEPs are reviewed three times a year.

27. This coordinated approach has ensured that educational outcomes for children in care have been above national figures in recent years. Although each year there is a smaller cohort of children, outcomes were impressive in 2017 and 2018. Educational outcomes were not generally as positive in 2019 as they were in the previous two years. Children in care attend school regularly. None have been permanently excluded, although the number of fixed-term exclusions has been rising. The proportion of children in care who progress into education, employment or training is above average. School leaders praised the support they receive from the pathways team.

28. There is a holistic approach to identifying physical and emotional healthcare needs, including highly effective partnership working with child mental health professionals. Emotional and mental health risks are managed well, in a child-centred and balanced way.

29. Creative approaches to managing family time are underpinned by a clear understanding of the significance of family members to children's attachments, and good analysis and management of risk. Children have life-story work undertaken with them at a level that reflects their age, understanding and needs. Inspectors saw some very good examples of this being undertaken. Leisure and enrichment activities are interest led, and are well-supported financially and practically, and this gives children a good range of experiences.

30. During 2019, the appointment of new managers and staff in the fostering service led to the successful progression of a wide range of developments. Foster carers receive a timelier response from the fostering team when they first make contact. As a result, there has been a significant increase in the number of foster carers going through the preparation and training process. The quality of assessments is good, and decision-making about foster carers' suitability and ongoing approval is scrutinised independently by a challenging fostering panel. While foster carers have access to a wide range of training, they have not received training about county lines and child criminal exploitation. Some foster carers have also not completed their statutory annual training.

31. For most children, permanence is achieved quickly and in placements suitable to their needs. However, they do not always benefit from early permanence planning. For instance, in the safeguarding teams, parallel planning is not always considered at the earliest opportunity.

32. Adoption performance is improving across all the measures. The local authority is now part of a Regional Adoption Agency (RAA), for the North and Humber, and this has improved the adoption services. Effective work by adoption social workers supports extensive and effective family finding for children, including those with complex needs. Children are appropriately matched, and their needs are well considered by the adoption panel, which demonstrates effective challenge to try and ensure that children's needs will be well met. The children placed for adoption have good-quality adoption support, including intensive therapeutic intervention where this is required. There is close working between East Riding and the RAA, which makes sure that local authority managers have effective oversight of the work of the RAA. There are no East Riding adoption disruptions.

33. There is an established, well-supported and engaged group of children in the Children in Care Council, who have access to a wide range of social and consultation opportunities. They meet regularly with senior leaders and elected councillors, as part of corporate parenting arrangements. They feel listened to and influential in making changes that are important to them, for example revised levels of pocket money and delegated authority for their carers. There are a good number of social opportunities for the group to

meet, including: participation in activities like the Christmas card competition where the winners draw parts of the councils' corporate card; the recruitment of staff to the two children's homes; induction events and training for new foster carers; and the design of a new complaints leaflet.

34. The group has made an excellent animated video that depicts how it feels to be in care, and this has been widely distributed to other local authorities, schools, social media platforms and the children's commissioner's website. The children were well supported to describe their feelings in poetry, and they featured as animated characters in the video. The video includes a powerful message about their wish not to be singled out and treated differently, especially in school, and celebrates their uniqueness rather than their difference.

35. Help and support provided to care leavers by the pathway team continue to be of a very high standard. Basic good practice underpins all the work, and effective and enduring relationships support the improvements in their opportunities, experiences and chances for adult life. All staff in the service know all the young people, and this means they get an appropriate and immediate response to their needs when required. Visits, sometimes weekly visits, are determined by the level of need. When young people have not been in touch, there are persistent and creative efforts to communicate with them.

36. Care leavers who met inspectors were effusive in their praise for the pathway team. They value the high-quality relationships that have enabled them to trust the staff and feel that they are 'a spot-on bunch of people'. They appreciated being able to drop in and the flexibility of the team to work out of hours to meet them.

37. Pathway plans are regularly reviewed with the young people, and their voice is clear. Needs relating to culture and identity are well understood, and the team are sensitive to this. Effective joint work with specialist accommodation and education workers ensures a cohesive and joined-up response to young people's needs. This is enabling them to engage purposefully in education, employment and training opportunities, manage and feel safe in the place they live in, and be ambitious and hopeful for their futures.

The impact of leaders on social work practice with children and families is: inadequate

38. Since the last Ofsted inspection in 2016, when services were rated as good overall, there has been a significant deterioration in the quality of help and protection support for children in East Riding. Senior leaders and members have not recognised the decline, do not have a wholly accurate understanding of practice and service shortfalls and have been ineffective in identifying,

prioritising, and making improvements. Where leaders are aware of shortfalls in practice and services, this is not fully reflected in the self-assessment.

39. Senior leaders had identified weaknesses at the front door since the last inspection, which have not been effectively challenged or improved. The current action plan does not sufficiently address the weaknesses. These weaknesses have resulted in children experiencing delay in their needs being identified and for some children remaining in situations of unassessed risk for too long. Senior leaders only strengthened some arrangements at the front door because of inspectors' findings.

40. Senior leaders have also been ineffective in addressing known weaknesses in practice where children are subject to private fostering arrangements. Senior leaders were not aware that previous management direction given to improve this area of practice had not been carried out until concerns were raised by inspectors.

41. While some core social work practice in locality safeguarding teams is strong and effective, the quality and impact of practice and management oversight has deteriorated since the last inspection for specific groups of children. Practice in pre-proceedings work, services for disabled children, and the operational response to children at risk of exploitation are weak. High caseloads in the safeguarding teams and weaknesses in the quality of oversight and decision-making by managers are leading to drift and delay for some children receiving the services they need to protect them and improve their lives.

42. The recommendations relevant to help and protection services and practice that were made at the last inspection and at the focused visit in 2018 have, mainly, not been fully addressed. This includes: improving the quality of assessments to include better use of chronologies; case recording of social work engagement with children and families; management oversight; and the quality of children's plans.

43. Despite being a recommendation from both the last inspection and focused visit, quality assurance activities are not robust. There is a broad range of quality assurance activities which are monitored across a range of forums. However, they do not sufficiently inform senior leaders and managers about the quality of frontline practice, where there are strengths, and where improvements are needed. Where service shortfalls are identified, senior leaders do not effectively challenge practice and drive forward improvements. There is too much focus on compliance with process, and insufficient focus on the quality of practice and children's experiences. Senior leaders acknowledge that the issues are known about and have very recently identified a senior manager and established a quality assurance and improvement group to improve this area of work, but this is not yet embedded. Performance management information is also not reliably informing key aspects of practice

and had not identified the inadequate practice in help and protection practice and services. There is much data produced, but there is insufficient evaluation of the impact of practice and quality of interventions for children or their progress and experience by senior leaders.

44. There have been very recent changes to the senior leadership team. The current director of children's services and assistant director have been in post for less than three months. Approximately a third of the social work workforce has changed since the last inspection and, reflecting national trends, there has been an increase in the number of newly qualified social workers. Although there is little use of agency and short-term staffing, at key points in children's services, including in the safeguarding teams and at the front door, there are insufficient staff to effectively address the levels of demand.

45. Workloads for social workers vary widely across the service areas. Since the last inspection, there has been a significant increase in the numbers of referrals and families being supported by children's social care. In the help and protection service areas, most social workers have very high and complex caseloads. This is impacting on social workers' ability to carry out tasks in a timely manner and to a good standard. According to local authority information, there have also been periods in which they have had a high number of unallocated cases in these teams over the last few months, contributing to drift and delay for children. In the children in care and pathway teams, the workers have much smaller caseloads, enabling good relationships to be built up and children's needs to be addressed promptly and effectively.

46. Senior managers have recently appointed two managers to each of the social work teams. However, the quality of management oversight and support given to social workers remains variable. Most social workers receive monthly supervision, although this is not consistently delivered across the teams. Other workers report that this occurs every three months. The recording of supervision varies in quality, and too often lacks clarity in decision-making and fails to challenge the weaker practice in the help and protection services. While there were favourable reports from social workers about the quality of training being offered, they also reported that they couldn't always access these courses because of workload pressures.

47. All the workers who met inspectors reported positively about working for East Riding Council. They talked about the peer support from their colleagues and their ability to carry out direct work with their children, resulting in improved experiences and progress for families.

48. Senior managers describe their model of social work practice as being embedded across children's services. However, inspectors did not see evidence of this, either in conversation with social workers or in the daily case

recordings or completion of templates using this methodology. Some workers said that they had not yet been on the relevant training.

49. While political support, high aspirations for children and young people and continued investment by councillors in service developments remain strong, there is a disconnect between strategic planning and the services that children who need help and protection receive. While good practice and services have been sustained in support for children in care, fostering and adoption services and support for care leavers, there has not been enough focus by senior leaders on the day-to-day experiences of children receiving help and protection services.

50. Corporate parenting continues to be a strength. Councillors describe their aspirations to provide the best services for children in care and care leavers. This can be seen in the investment from the council, which has resulted in demonstrably improved experiences and progress achieved by those children. Children from the corporate parenting and care leavers groups reported very positively about the effective support they receive and how their views are listened to, resulting in further improvements in services. Success is recognised and an annual celebratory event for children in care is highly regarded.

51. Commissioning arrangements are good. There has been an increase in the availability of local fostering and residential placements to address the increase in the complexity of needs of the population of children in case. This includes new arrangements being brought in to monitor children in care in unregulated settings and partnership arrangements to support homeless older teenagers.

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