Additional / To Follow Agenda Items
This is a supplement to the original agenda and includes reports that are additional to the original agenda or which were marked 'to follow'.

Nottingham City Council
Children and Young People Scrutiny Committee

Date: Wednesday, 15 May 2024

Time: 9.30 am

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Governance Officer: Damon Stanton **Direct Dial:** 0115 87 64345

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People Directorate

Meeting Title	Children and Young People's Scrutiny Committee
Report Title	Children's Services Improvement
Meeting Date	15th May 2024

Corporate Director(s)/Director(s):	Catherine Underwood, Corporate Director for People Ailsa Barr, Director for Children's Integrated Services
Portfolio Holder(s):	Councillor Cheryl Barnard
Report author and contact details:	Sam Morris, Head of Children's Strategy and Improvement Ailsa Barr, Director for Children's Integrated Services

Summary of issues:

In July 2022 Nottingham City Children's Services received its full Inspection of Local Authority Children's Services (ILACS), which led to an inadequate judgement. As a result, Children's Services have now entered a monitoring visit regime.

On 3rd and 4th April 2023, a fourth monitoring visit with a focus on Children in Care (planning and achieving permanence) took place. This report provides some context to the monitoring visit regime and presents the findings of the narrative letter published by Ofsted of its fourth monitoring visit of Nottingham's Children's Services.

Recommendation(s):

1. Children and Young People Scrutiny Committee consider the findings of the Ofsted's 4th Monitoring Visits of Children's Services.
2. Children and Young People Scrutiny Committee note the progress made and further areas for focus since the full inspection and the next steps
3. Children and Young People Scrutiny Committee confirm its commitment to improving Children's Services and its ambition for Nottingham Children's Services to be delivering consistently good social care services to children and young people

1. Background

1.1 Committee will be aware that Nottingham City Children's Services received an Ofsted ILACS inspection in July 2022 with the report being published in September 2022 (appendix 1). The outcome of the inspection was:

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 (limited by the grading within the domain of children in need of help and protection).

1.2 The inspection identified 8 specific areas for improvement:

- Effectiveness and timeliness of responses to children's needs when first presented to the multi-agency safeguarding hub (MASH).
- Management oversight and direction of front-line work and the local authority designated officer (LADO).
- Social work capacity so that social workers and first-line managers can respond effectively to children in need of help and protection, and that children in care have greater consistency of social worker.
- Placement sufficiency for children in care and those with complex needs.
- The service response to care leavers aged 21 and over.
- The service response to young people who are aged 16/17 years who present as homeless.
- The quality and timeliness of return home interviews.
- Oversight of children missing from education and those who are electively home educated.

1.3 On 12th December 2022, the local authority submitted an action plan to Ofsted which addressed the inspection findings. Ofsted formally responded on 19th December 2022 confirming that the action plan accurately reflected the findings of the inspection. The Ofsted Action plan is monitored through the Children's Improvement Board, which is chaired by an independent Department for Education Improvement Advisor. The Children's Improvement Board has been restructured to form a monthly Executive Improvement Board and quarterly Partnership Improvement Board.

1.4 The monthly Executive Improvement Board focusses largely on improving the performance of the Council's Children's Services following the Ofsted inspection. It supports the work of the Board in delivering children's services in Nottingham that result in consistently good outcomes for children, young people and their families. The Executive Improvement Board membership includes the Portfolio Holder for Children, Young People and Education as the statutory Lead Member, the Chief Executive as well as senior leaders, ensuring robust monthly senior leadership oversight of progress improvements. The quarterly partnership board has oversight of the progress being made by internal services as well as in the broader children's partnership. The Partnership Board is made up of senior partnership leaders in addition to the Executive Improvement Board members.

1.5 In addition to the monthly monitoring of the Ofsted improvement plan through the Improvement Board, the division has an internal process to ensure robust delivery and accountability. Programme management support and resources are being provided to each Head of Service to support delivery of the plan and ensure deadlines are met and evidence of impact is being gathered. Internal monitoring of progress of the Ofsted action plan and wider transformation plan is delivered through a monthly

portfolio board, which is chaired by the Service Director for Children's Integrated Services. This reports to the Corporate Director through a monthly Oversight and Assurance Meeting which she chairs.

1.6 As a result of the inadequate judgement the Local Authority has entered into a period of Monitoring Visits. These are 2 day on site visits focused upon a specific area of practice. Judgements are not provided, but a narrative letter of findings is produced. The first letter is not published, but all subsequent letters are published on the Ofsted Website. To date the service has received 4 Monitoring Visits:

- The Front Door (MASH, Duty and EDT) – February 2023.
- Children in Need and Children with a Child Protection Plan – July 2023
- Care Leavers aged 18+ - November 2023
- Children in Care – April 2024

1.7 A full report detailing the progress the service is making in its improvement and transformation journey was presented to Scrutiny Committee in January 2024. The information below will detail the key themes from the previous 3 monitoring visits before detailing the findings of the current visit.

2. Themes from previous monitoring visits

2.1 There have been some common themes of progress made across the previous three visits:

- Evidence of tangible improvements being made.
- Investment in posts to increase front line and management capacity, which has helped manage workload and demand, increase management oversight, reduce caseloads and improve staff morale.
- The workforce feels supported by managers and can feel the positive impact that reduced caseloads are having, this is resulting in better practice being more consistently delivered.
- Staff develop strong and meaningful relationships with their children and young people, know them well and act as good parents. This enables them to assess children and young people's needs to offer good support, particularly to our more vulnerable children and care leavers (such as disabled children, care leavers with additional needs and 16- and 17-year olds who present as homeless). Processes (such as child in need review meetings, visits etc) often take place sooner than the statutory minimum to meet the needs of the child, young person or family, meaning that children and young people are seen or have their circumstances reviewed in timescales appropriate to them.
- There is a committed senior leadership team who have clear oversight and knowledge of performance within service areas, and recently developed dashboards are enabling managers and front line staff understand performance and prioritise tasks that need to be completed, leading to timelier responses for children and families.
- The quality assurance framework has been strengthened and is being embedded. This is correctly identifying areas for improvement and development to help further strengthen practice and learning.

2.2 Inspectors noted that there were further common areas for development, which aligned with the service's self-evaluation of practice:

- Inconsistency in quality of assessments or plans.
- Inconsistency in the frequency and quality of supervision to help progress outcomes for children in a timely way.
- Some children and young people experience too many changes of social worker – due to difficulties around recruitment and retention of staff – an issue being experienced not only in Nottingham but nationally.
- Further work with partners needed to reduce delays in assessment and intervention which some children and families continue to experience.

3. Findings from the 4th Monitoring Visit

3.1 As with all Monitoring Visits no grading is given but findings are presented in a narrative report.

3.2 Inspectors noted that despite significant financial challenges and pressures, senior leaders had secured additional funding and management and staffing posts and have continued to build upon improvements made since the last inspection. They noted that there are signs of a stabilising workforce and numbers of children entering care is reducing due to the strengthened support provided to families in their family networks. Many children in care live within 20 miles of their family.

3.3 Inspectors observed that practice across the service is variable. Families receive a more consistent and better planned service from the Fieldwork service but when a child transfers to the Children in Care service the response is more crisis driven and less consistent. This is due to the staffing investment in the service being very recent and so is yet to have an impact. Changes of social workers and higher workloads in this part of the service mean that social workers are visiting in accordance with statutory minimums but that this is not always according to the individualised needs of children. In addition, there are times where this limits Social Workers' ability to complete quality direct work with children, a fact that was recognised by the children that Inspectors met. Inspectors noted that the improvements and developments in other service areas inspires confidence that this will also be achieved in the Children in Care workforce. They noted that there have been improvements in the quality and frequency of supervision and staff feel supported and able to approach managers and leaders.

3.4 As a result practice across the service is currently variable. Within the Fieldwork service inspectors noted creative planning and support to manage risk, with decisions being child centred and informed by a thorough assessment. However, assessments within the Children in Care service are not yet routinely updated upon a change in a child's situation and specialist assessments are sometimes needed to inform risk management and planning. This means that life decisions are being made for some of our longer-term Children in Care without thorough and detailed assessment. Further work is needed to ensure that care plans reflect the longer-term plans to achieving stability for children. This would be better supported by Independent Reviewing Officer's decisions at care plan reviews being sequenced and prioritising the actions to be taken as well as increased management oversight of plans.

3.5 Inspectors noted that at times a lack of suitable foster homes has led to children remaining in an unsuitable family environment for longer than planned or moving into residential care. This is a national issue, and inspectors noted that leaders are working with partners and other local authorities to find creative solutions. The lack of available

homes has meant some children have been placed in unregistered homes, and although there are processes to ensure children are seen within agreed timescales, these are too new to evidence impact. Inspectors also noted that although children were positive about their education and are encouraged to take part in their personal education planning meetings, placement sufficiency impacts upon the ability to prioritise a child's educational placement.

3.6 Inspectors saw that senior leaders have been working with health providers to ensure that children entering care receive a timely initial health assessment but note that further work is needed to ensure this is consistent.

4. Next steps

4.1 As noted within the Monitoring Visit letter, additional resourcing and funding has been approved for the Children in Care service. Recruitment to permanent posts will take place. This will mean that the service will move from 3 teams to 4 Children in Care teams. This will mean additional staffing and manager capacity, and therefore more detailed oversight will be in place to progress children's care plans. It is anticipated that the additional staffing and management support and oversight will reduce caseloads and support stabilisation of the service which will have a positive effect on the quality of practice and therefore will directly benefit Children in Care.

4.2 Work remains ongoing with Human Resources to support robust recruitment and retention activity to make Nottingham City the Authority of choice for Social Workers to create stability in the workforce.

4.3 The findings will be incorporated into the service improvement plans with clear actions and timelines for completion set.

4.4 Work will continue with health partners to ensure that children receive timely Initial and Review health assessments to ensure that their meets are being fully met.

4.5 The Children's Improvement Board will continue to meet monthly and will review progress made across the service, including specific focus in relation to Children in Care services.

4.6 Two further monitoring visits are anticipated to take place by the end of the year which we can expect to revisit to the Front Door (to follow up on further progress since the monitoring visit in February 2023) and a revisit to the Children in Care Service. It is anticipated that the next full Inspection of Local Authority Children's Service (ILACS) will take place at some point during 2025.

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Inspection of Nottingham City local authority children's services

Inspection date: 11 – 22 July 2022

Lead inspector: Andy Waugh, 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

Services for children who need help and protection are inadequate because there are serious failures, leaving children at continued risk of harm when they are first presented as in need of support.

In February 2020, a focused visit found there were areas for priority action in Nottingham around support for children with child protection or child-in-need plans. Since that visit, progress has been slow and uneven, hampered by the impact of the COVID-19 pandemic and the tragic death of a senior manager. There has been some improvement in the areas identified for priority action, although practice remains too inconsistent. Other services have deteriorated, particularly responses when children are first presented as potentially in need of help and protection. These services are too slow to identify and respond to risks of harm to children. Management oversight and supervision remains inconsistent and is not supporting social workers effectively. There has been a high level of staff turnover for children in care. Children aged 16 and 17 who present as homeless do not always have their needs met by the local authority.

In the last six months, a new senior management team has been established for children's social care. This team has a sound understanding of the challenges it faces and has already delivered some improvements and positive culture shifts. Senior management oversight of vulnerable children has been strengthened through a

range of panels and monitoring systems. A quality assurance framework is embedded across the service, with an understanding of what constitutes good practice. Early permanence for children through adoption is a significant area of improvement. The recruitment and retention of workers is being appropriately prioritised.

What needs to improve?

- Effectiveness and timeliness of responses to children's needs when first presented to the multi-agency safeguarding hub (MASH).
- Management oversight and direction of front-line work and the local authority designated officer (LADO).
- Social work capacity, so that social workers and first-line managers can respond effectively to children in need of help and protection, and that children in care have greater consistency of social worker.
- Placement sufficiency for children in care and those with complex needs.
- The service response to care leavers aged 21 and over.
- The service response to young people who are aged 16 and 17 who present as homeless.
- The quality and timeliness of return home interviews.
- Oversight of children missing from education and those who are electively home educated.

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

1. Weaknesses in the MASH are significant, widespread and systemic. Risk of harm is not always recognised, leaving too many children with insufficient protection. Some children who have met the threshold for social care intervention wait up to six weeks to be seen by a social worker. The majority of contacts in the MASH are delayed and not processed within timescales appropriate to the risks and needs of children.
2. Management oversight is not effective when applying thresholds to safeguard children, and it is not providing social workers with direction or overseeing how quickly contacts are progressed. However, once children are allocated, most social workers understand thresholds well and apply them appropriately for the majority of children.
3. Parental consent is not consistently obtained by partners in order to allow safeguarding information about children to be shared. Complicated systems in the MASH contribute to delays because partners do not respond to social workers' requests for information in a timely way. For some children, this takes up to 16 days. A significant number of children experience repeated contacts and referrals before they get the help they need.

4. Where allegations of significant harm are first presented, decision-making within the MASH is not as timely as it needs to be, leaving some children in situations where they are at continued risk of harm and without safety plans.
5. The emergency duty service social workers do not have consistent management oversight and supervision. Social workers mostly respond effectively to the needs of children out of hours, but on occasions lack professional curiosity in order to ensure children are protected.
6. Most children and their families benefit from a comprehensive offer of early help services. However, not all children receive early help support at the right time, with many waiting too long for targeted support. Managers are not consistent in applying thresholds for children to step up and down between early help and children's social care.
7. Despite the delays in transferring from the MASH to duty teams, when children are allocated a social worker, strategy discussions take place when required and assessments are completed in a timely way. Strategy discussions are well recorded, with the right thresholds applied. Multi-agency discussion leads to effective information-sharing and analysis of risk. This includes consideration of family history and the next steps for intervention.
8. Most children are visited at levels relating to need. Outcomes following Section 47 enquiries are appropriate, leading to decisions and actions that reduce risks and ensure children are protected. Safety planning takes place for most children.
9. The majority of assessments have a clear purpose and rationale for intervention. Assessments address the risks and concerns and explore the impact for children. Direct work provides valuable insights into children's experiences. Where children are part of a large family, they are considered individually. Parents' views and family history are understood. Analysis of all the information addresses the concerns and risks and informs what needs to change. For some children, the neglect toolkit informs assessments. However, it does not always result in an overall analysis or contribute to actions.
10. The threshold decisions to proceed to the initial child protection conference are appropriate. Partner agencies contribute to analysis of risk, resulting in a clear rationale for decisions. Most plans are comprehensive, with immediate actions to improve children's circumstances, and are consistently reviewed and updated at core groups.
11. For children who are supported through child-in-need planning, where concerns are escalating, child protection enquiries are appropriately initiated. Children's needs are well considered in child-in-need and child protection plans. These plans include wishes and feelings, and they are written so that the child can understand them. Families have a clear understanding of the support they will receive and how it needs to be sustained. Most plans are reviewed within timescales. However, for some children, delays in circulating initial plans and meeting minutes impact on the new plans being progressed in a timely way.

12. Arrangements to manage allegations against professionals by the designated officer are overcomplicated. The service has an area of vulnerability because non-social work qualified staff are involved in gathering information in respect of child protection referrals in a complex and specialist area of safeguarding. This is further compounded by an absence of management oversight and effective tracking of referrals.

13. The overall quality and frequency of supervision is variable in duty and fieldwork teams. Team managers provide oversight and guidance at the point of allocation. However, for some children, written records are copied from previous supervision sessions, with no reflection on children's circumstances. Actions lack timescales to monitor progress and effectiveness of assessment. Where supervision is better, it is more reflective, detailed and focused on the needs and experiences of children.

14. When children's lives are not improving, children benefit from early authoritative decisions to escalate into pre-proceeding and care proceedings. Senior managers ensure effective review of the pre-proceedings stage of the Public Law Outline (PLO) through panels, which provides tight tracking to minimise drift and delay for children. Letters before proceedings are mostly clear and identify effectively the individual risks to children, as well as their needs.

15. Social workers establish positive working relationships with children and their families and have a good understanding of their needs. They are persistent when engaging parents to build relationships, which enables better participation with plans and improved outcomes for children. Social workers are skilled at gathering the views of children, using a range of age-appropriate tools.

16. The daily domestic abuse triage meeting is well attended by most partners, enabling effective information-sharing and prompt decision-making in respect of next steps. This ensures clear direction as to what needs to happen immediately in order to safeguard children. However, the absence of information from midwifery and schools prevents a full assessment in respect of some children.

17. Workers in the whole life disability team are committed to the children they work with. Child protection work is effective in making disabled children safer and improving their circumstances through multi-agency working, including regular core groups which monitor the progress of the child.

18. Arrangements for children who are privately fostered are managed effectively. Once in placement, children are visited regularly. A dedicated panel provides effective oversight of privately fostered children. This ensures that children continue to live with carers who can meet their needs.

19. Children who are aged 16 and 17 who present as homeless are not consistently provided with appropriate advice or options. Once children have been assessed, there is a lack of urgency from both the social housing provider and the local

authority in providing suitable accommodation that meets their needs. This lack of accommodation increases some children's existing vulnerabilities.

20. Children who are at risk from criminal and sexual exploitation receive detailed assessments in which risk factors are identified and effective analysis of the impact of criminal and sexual exploitation on young people and their families is provided. Multi-agency meetings and subsequent planning lead to plans that effectively reduce risks to children. Plans are reviewed regularly, with actions being updated in recognition of changes in children's circumstances. For some older children who are at risk of exploitation, there are issues of placement sufficiency, which has an impact on the ability of workers to keep them safe. This means that some children are left too long in situations when they have been assessed as needing to enter care.

21. For children who have been missing, return home interviews are not held consistently, or in good time. Return home interviews have often been recorded without sufficient analysis of the circumstances and with outcomes that are not specific to the child. Hence, return home interviews do not contribute effectively to children's safety plans. Children currently do not have access to a wide range of adults who they can relate to and share their experiences.

22. The local authority does not have suitable oversight for all children who are missing from education. Staff are unclear about the whereabouts of young people when attending part-time timetables. There has been a significant rise in the numbers of children being electively home educated, and the local authority has oversight of all these children. However, for some children, risks are not fully understood because safeguarding is not routinely considered when completing assessments.

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

23. Most children only come into care when it is necessary and in a timely way. For others, however, there has been some delay, meaning that some children had been living in neglectful circumstances for too long.

24. When children are unable to live with their parents or wider family or friends, alternative permanence options are considered concurrently. As a result, children who require permanence through adoption are being matched more quickly than they previously were. Brothers and sisters have been successfully adopted together, and the use of fostering for adoption placements has given some babies stability and security from the earliest opportunity. Sensitive direct work with children and their prospective adopters is helping to ensure positive and smooth transitions to permanence. Some children also achieve permanence through long-term fostering. These children are receiving consistent care from committed carers, and they are experiencing the quality of support as they would from a good parent.

25. Some children are living with their parents under care orders, where there has been drift in planning for the discharging of care orders. Consequently, children have been living with statutory intervention and with a level of uncertainty about their future for too long.

26. Too many children in care have experienced too many changes of social workers, including times when they are visited by duty workers. This has affected children's opportunities to form trusting relationships with their social worker and complete meaningful direct work. Some children have been able to develop positive and trusting relationships when their social worker has remained consistent.

27. Too many children who are in long-term foster homes do not have an up-to-date assessment of their needs, thus hindering effective planning to ensure that children are receiving the right support at the right time. There is not sufficient life-story work being undertaken with children who do not have an adoption plan to help them to understand their journey into care, develop their sense of identity or help them to feel proud of who they are.

28. The review of children's plans mostly takes place within statutory timescales, and minutes are sensitively written to children to help them understand the outcomes and plans. Independent Reviewing Officers (IRO) do not consistently monitor children's circumstances in between reviews. Escalation processes are currently not effective in demonstrating impact or positive change for children because of concerns raised by the IROs.

29. Family time is carefully considered, and takes place based on children's views and an analysis of risk. Children are supported to take part in a range of leisure and social activities. Children told inspectors about the range of fun activities and social experiences they enjoy while living in their foster placements, which have enhanced their confidence and self-esteem.

30. The virtual school is ambitious in ensuring that most children in care make good educational progress at school or other provision. Most children achieve well relative to their starting points. The virtual school works in close partnership with schools to ensure that vulnerable children receive the right provision. For a small number of children, learning takes place full-time in unregistered provision. Sometimes, low levels of attendance are not prioritised as concerns and the voice of the child is not captured fully enough.

31. The emotional and mental health needs of children in care are appropriately met in Nottingham. Many children in care and their carers are benefiting from both direct support and consultation to help improve their emotional and mental well-being.

32. The help and support provided to children in care who go missing and who are at risk of exploitation is variable and is impacted by the quality and consistency of social workers relationships with children. In stronger work, multi-agency

packages of support are safeguarding children effectively. For some children, when practice is weaker, there is a lack of clarity in respect of safety planning and a lack of opportunity to learn and plan from return home interviews.

33. Support for children who arrived in the UK as unaccompanied asylum-seeking children (UASC) is tailored, supportive and recognises their need for a range of practical and emotional support. This includes a specific looked after children's nurse to support UASC.

34 Most children in care live in stable placements that meet their needs. There are sufficiency challenges, particularly for children with the most complex needs. This has resulted in a small number of children under 16 living in unsuitable and unregistered children's homes while placement searches continue. These placements are unlawful. Senior leaders are aware of these children and maintain effective oversight.

35. High staff turnover in the fostering service has impacted on the quality of work, resulting in foster carers having limited training opportunities and inconsistent support from supervising social workers. There is a shortfall in the number of foster carers being recruited, which affects the local authority's ability to be able to provide care for children within the local area.

36. There is effective working together with the regional adoption agency (Adoption East Midlands), which enables effective matching of children to adopters. Adopters are provided with the required training throughout their adoption journey, and post-adoption support is organised and specific to individual need. Adopters are provided with life-story books, which will help them and their children to understand their adoption journey.

37. The Children in Care Council provides some children and care leavers with an opportunity to share their views on services they receive. However, the council is underdeveloped, with only nine children attending regularly. This limits the capacity for children and young people to influence service development and co-production in Nottingham city.

38. Care leavers are allocated a personal adviser (PA) six months before they reach the age of 18, enabling them to begin to build a relationship before they leave care. Care leavers, some of whom have complex needs, are reassured when they transition into adulthood that there is a trusted person who can help and to whom they can turn, if needed. Most care leavers benefit from long-standing relationships with dedicated PAs who establish enduring relationships with them.

39. The majority of care leavers are informed of their rights and entitlements. The offer of support and entitlements are outlined for care leavers, although it has not been updated since 2018. The local offer does not confirm the statutory requirement to provide a PA to support care leavers post-21 years of age. The

local authority is not consistently fulfilling its duty to care leavers post-21 years of age.

40. Risk assessments for care leavers are not consistently reviewed. Some PAs are managing high-risk situations without the benefit of regular supervision, or appropriate staff care, including lone worker health and safety risk assessments.

41. Pathway plans are regularly updated. A new pathway plan template enables the engagement of care leavers in planning next steps, but this is not consistently happening. Some pathway plans are, therefore, completed without the benefit of co-production, and sometimes language lacks sensitivity and empathy.

42. Care leavers are supported to access accommodation that meets their needs. A significant number are benefiting from living in staying-put arrangements. Managers work closely with the housing department, providing appropriate identity documents to create accounts for care leavers to bid for, and, where necessary, they are facilitating direct housing offers. Care leavers can move into their own tenancies; if they encounter challenges, they are supported to return to semi-independent provision, allowing them access to further support.

43. Some care leavers are successfully undertaking university courses. The care leavers team works closely with specialist employment officers to enable care leavers to meet with local employers to discuss their futures. The processes to support young care leavers in post-16 education are inconsistent. For many, the review of their personal education plans does not happen frequently enough, including for those most vulnerable to not being in education, employment or training.

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

44. In response to the areas for priority action identified in the focused visit in February 2020, leaders and senior managers developed a service-wide improvement plan as well as a plan to manage the subsequent pandemic. The service and its members then experienced the impact of the sad passing of their Director of Children's Integrated Services (DCIS). Corporately, the local authority also faced significant financial challenges with the council, being the subject of a section 114 notice (Local Government Finance Act 1988) in December 2021. Within this challenging context, slow progress was made against the areas for priority action and, while some services improved, others deteriorated.

45. A new, knowledgeable DCIS, along with a committed new leadership team, is beginning to have a greater impact on practice. There is clarity on the expectations of all staff, and leaders are developing a culture that promotes good practice through high support and high challenge. However, the scale of required improvements remains substantial, and the pace of change needs to

quicken for all areas of the service to provide safe and consistently good services for children.

46. In November 2021, significant shortfalls were identified in the MASH following a diagnostic report. Backlogs in the system meant that children's needs had not been responded to for significant periods of time, and some children were not appropriately safeguarded. Senior managers responded by altering some systems to improve the timely response to all children referred to the service. This, in effect, created a further backlog in the MASH, as more children were identified whose circumstances needed to be assessed. In May of this year, senior managers responded further by recruiting a team of qualified staff to manage the continuing demand at the front door. However, inspectors found the additional resources, alone, have not been effective in ensuring a timely and safe response to children who have met the threshold for a service. This includes some children who are at risk of significant harm.

47. During the inspection, leaders acknowledged that the level of delay and impact for children was unacceptable at the front door. In response, managers completed a significant amount of audit activity to ensure children's needs had been appropriately assessed. In addition, structural and systemic changes in the MASH, planned for August 2022, have been brought forward.

48. The quality of supervision and management oversight remains inconsistent across services and is not an effective process for the timely progression of children's assessments and plans. The poor application of threshold decisions by some managers leaves too many children in situations of unassessed risk, with their needs not fully understood.

49. Elected members and the chief executive remain committed to improving the quality of children's services, despite the local authority's financial challenges. Further investment has been agreed to increase capacity to manage the demand and improve outcomes for children.

50. There are positive working relationships with partners at a strategic and practice level that work together to achieve the best outcomes for children. The judiciary and the Children and Family Court Advisory and Support Service reported effective working relationships with the local authority, which ensures timely court proceedings and enables children to achieve permanence at the earliest opportunity. The application of the PLO has improved significantly.

51. The corporate parenting board is attended by social care staff and elected members, with partners only attending to share specific information. It is difficult to measure the impact the board has on service delivery and development because children's views are not consistently recorded. Leaders have acknowledged that the board is underdeveloped, and they are currently reviewing its functions to ensure that there is a greater commitment from partners to children in care and care leavers.

52. Senior managers understand the ongoing challenges regarding sufficiency of placements for the most complex children and young people. An ambitious sufficiency plan is in place, with funding secured to recruit more foster carers, along with block commissioning residential and semi-independent placements to increase placement capacity. However, the plan is at an early stage of implementation and is yet to demonstrate the impact it might have for children.

53. Senior managers welcome scrutiny from partners and peers in order to provide opportunities to reflect on current service delivery and make improvements to frontline practice. The chosen model of a strength-based approach has been implemented but requires further embedding for it to be consistently effective in supporting families. A career pathway has been developed for social workers through mentoring with heads of service and encouraging peer support.

54. A performance and quality management framework is beginning to provide managers with an effective oversight of the service. Consequently, managers have an improved grip on the service and a better understanding of practice. Audit activity provides evidence that managers and staff have an understanding of what good practice looks like. However, audits are not consistently used to improve individual practice or learning for the whole service. The local authority's self-evaluation mostly demonstrates a sound understanding of the service's effectiveness and impact on children. However, there remained shortfalls at the front door that were not fully understood.

55. The improvement plan implemented in response to the areas identified as requiring priority action has resulted in incremental improvements in the services delivered to children and families. The pace of change is slow, and practice in some areas of the service remains variable.

56. Senior managers are appropriately focused on the need to drive forward recruitment and retention, motivating current staff with an enhanced financial package, and reducing the reliance on agency social workers in order to stabilise the workforce. Although recently reducing, workloads for some social workers remain too high. For less experienced social workers, they have manageable workloads.

57. Team managers do not provide consistent oversight of key decision-making. Supervision is too variable, and there are gaps in frequency. The level of reflection and ability to consider impact on children is inconsistently recorded.

58. The staff that inspectors have spoken to are positive about working in Nottingham City and show a commendable loyalty to the children of Nottingham. Some social workers told inspectors that they feel valued and expressed their pride in working for Nottingham City and their drive to improve children's experiences. Workers remain committed to doing their best to support children in Nottingham.

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15 May 2024

Catherine Underwood
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Dear Catherine

Monitoring visit to Nottingham City children's services

This letter summarises the findings of the monitoring visit to Nottingham City children's services on 3 and 4 April 2024. This was the fourth monitoring visit since the local authority was judged inadequate in July 2022. His Majesty's inspectors for this visit were Margaret Burke and Jenny-Ellen Scotland.

Areas covered by the visit

Inspectors reviewed the progress made in support to children in care planning and achieving permanence since the last inspection. Inspectors focused on:

- The quality of children's assessments, plans and reviews.
- The quality of visits and work with children.
- Where children in care live and the support they and their carers receive.
- The quality of management oversight and supervision.
- Stability and sustainability of the children in care service workforce, including the impact of current caseloads on practice.
- Performance and quality assurance oversight of senior leaders.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

Senior leaders have continued to build on improvements made in their delivery of services to children and families in Nottingham City since the last inspection. Working within the context of significant financial challenges and wider pressures on the council, senior leaders have successfully secured funding for a more balanced base budget for children's services. They have also secured very much needed permanent

additional management and staffing posts in the children in care service to support the oversight of plans and reduce caseloads. There are signs of a stabilising workforce and a reduction in staff turnover in some parts of children's services. The number of children entering care is slowly reducing as support now strongly focuses on supporting children within their family networks. The vast majority of children in care live within 20 miles of the city. Where it has been identified that further support and intervention are required following an assessment, there is evidence of an improved service response for children and their families from the fieldwork services. Once a decision has been made that a child in care will not be returning home, their social work support transfers to the children in care service. Support to children in this part of the service has not seen the improvements evident in other service areas. In this part of the service, many children experience too many changes of social workers and do not get the support they and their carers need at the time they most need it.

Findings and evaluation of progress

Most children who come into care are well supported by the fieldwork service. Careful consideration is given to the child's needs and how best these can be met. Creative planning and support options are considered to manage risk and keep children safe. Decisions are child-centred and for most children informed by a detailed assessment which demonstrates an understanding of the family. There is clear consistent management oversight and legal options are appropriately considered for interventions with a clear rationale for those decisions taken.

The lack of available foster carers and suitable homes for children in the care of Nottingham City Council impacts on the authority's ability to safeguard a small number of children effectively. Some of these children, following a decision made for them to come into care, have remained with parents who have been considered as unable to meet their needs appropriately for longer than planned. The lack of suitable placement options has resulted in higher numbers of younger children being placed in residential children's homes. Leaders are responding creatively to placement sufficiency challenges, working collaboratively with other authorities and partners on both local and national initiatives.

A small number of younger children are placed in unregistered children's homes. There are also a number of older children living in unregistered supported accommodation. New systems have recently been introduced by senior managers to improve oversight of these placements. They include head of service and service manager's scrutiny, supporting providers to seek registration, and additional oversight from the placements contract monitoring service. However, many of these processes are too new to ensure that children in these settings are routinely seen within identified timescales, or to be confident that the homes they are placed in are able to provide safe care.

Children who remain in care long term are supported by the children in care service. Most children in care live in stable homes and have their needs met by their carers. However, for those children whose needs or situation changes, the social work response in this part of the service is often crisis-driven and reactive. Social workers in the children in care service do not routinely update children's assessments, even when children's needs and situations significantly change. Children who have presented with behaviours which adults have found challenging to manage do not routinely benefit from specialist assessment to help understand and inform how best to manage risks and respond to their needs. Stability and disruption meetings are not routinely held, to assist with planning or learning for the child, carers, practitioners or the organisation.

Care plans are often limited to considering the immediate situation and do not fully address longer-term issues or permanence stability for children. Review decisions are often about the here and now. Independent reviewing officers' decisions at best are detailed but they often do not set prioritised timescales for the actions listed. Most targets are set to be completed by the next review, which is often scheduled for several months later. This makes it more challenging for the child and carers or when social workers change to know what the long-term plans and the actions that need to be prioritised are.

With these weaknesses in the service, important life decisions are made about children without being informed by an up-to-date assessment or clear long-term plan. New processes evidence some senior management oversight and steer within the children in care services, but this oversight is not currently effective enough to ensure compliance with procedures and follow up on plans to provide confidence that children are well supported to be successful within their care homes.

Most children with social workers in the children in care service are visited every six weeks irrespective of the child's identified needs. Some of these visits are conducted by duty social workers, who children may not know. Social workers recognised that some children would benefit from being visited more frequently but told inspectors that the demands of their caseloads prevent them from doing this. This makes it more difficult for children to build trusting relationships with their social workers. The children who met with inspectors told us that social workers' caseloads are too high, meaning visits are quick pop-ins where there is no time to get to the bottom of any issues that are arising.

Participation and direct work with children in care is a mixed picture. Social workers in the fieldwork teams demonstrate that they are carrying out this work more effectively and they routinely seek children's views to inform their assessments, court processes and care planning. Social workers in the children in care teams do not consistently undertake purposeful direct work.

Children who leave care are supported when relevant to achieve permanence via formal orders such as adoption and special guardianship orders (SGOs). Support

continues as long as required, with options on an individual case-by-case basis for ongoing support from permanence officers. For children leaving care as part of court processes, senior managers in the fieldwork service maintain oversight to ensure that progress is maintained for children. Leaders have recognised the need to strengthen and formalise the support offer to all SGO carers and plans are currently being developed.

For those children who are returning to live with their parents after a period in care and subject to a care order, there is more variability. Pragmatic support plans are made to support children and their parents. For some children there has been drift and delay in revoking orders, meaning children have unnecessarily been subject to statutory intervention for longer than needed. For those children placed with parents more recently, there is evidence of clearer management oversight and grip. The updated placement with parents policy is now being more consistently applied and legal meetings are held to consider revocation of orders in a more timely manner.

Children are positive about their education experiences and the support they are given by their school. The support of the virtual school is evident, and children are encouraged to take part in their personal education planning meeting, resulting for some children in creative planning. Children's education needs are not always prioritised when securing placements for children, often as a consequence of the challenges of placement sufficiency. This has resulted for a small number of children, particularly those placed out of area, waiting for some time for appropriate full-time education after moving into their new home.

Health performance for children in care has fluctuated over the last year. While most children will eventually have a health assessment, the vast majority of children coming into care do not receive an initial health assessment in the required timescales to ensure that their health needs are fully understood so they can be addressed. Senior leaders continue to have discussions with health providers and seek longer-term solutions for this to be resolved.

Senior leaders have continued to invest in and strengthen quality assurance processes. Findings from individual audits are routinely translating into whole-service learning. Leaders have gained more insight into the quality of their services and now have an accurate overview of their strengths and areas for practice development. This is helping the local authority to better plan, develop and improve the support offered to children supported by the children in care service area. Children told inspectors that they had experienced several changes of social workers. The number of permanent social work staff in the children in care team is gradually increasing, but from a very low base. Over 50% of these posts are currently covered by agency staff. However, this includes temporary cover for the newly established additional posts created within the children in care services while these posts are recruited permanently. Caseloads are variable across the service, with considerable differences between the workload of social workers within the children in care teams and those

in fieldwork teams. While caseloads in the fieldwork teams are now at a manageable level, some social workers in children in care teams still have caseloads that are too high. Senior leaders are aware of these challenges and believe the new funding for additional posts in the children in care service will alleviate some of these pressures.

The work undertaken by senior leaders within children's services to secure service improvements and developments in other service areas has inspired confidence in the children in care workforce. Social workers are optimistic about working for Nottingham City Council and believe that things are getting better and will continue to improve. Staff spoke positively about the changes in the culture of the service, service developments and having access to training. All felt well supported by their line managers; they had easy access to service managers and the head of service, who were described as visible and approachable. Improvements are noticeable in the quality of supervision. Supervision now increasingly takes place monthly. Supervision notes reflect a discussion and checks on compliance. There is still room for further improvement to ensure that these conversations and notes reflect longer-term plans and aspirations for children.

There is a recognition by leaders that despite whole-service developments across children's services, the children in care service remains the weakest service area. Leaders acknowledge that there is much more to do to reach and sustain key service improvements for children in care. They have delivered improvements in other parts of the service and are confident that they now have many of the building blocks in place to do so for children in their care.

I am copying this letter to the Department for Education.

Yours sincerely

Margaret Burke
His Majesty's Inspector

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