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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