COVID-19 series: briefing on children's social care providers, November 2020

Evidence from assurance visits to secure children's homes and independent fostering agencies between 1 September and 4 December

Ofsted is carrying out a series of assurance visits to children's social care providers as part of a phased return to routine inspection. These visits aim to provide reassurance to parents and carers, the public and professionals that children are safe and well cared for and that leaders and managers are exercising good leadership. The visits follow existing principles for inspection. They result in a report that gives no graded judgement but does highlight any serious or widespread concerns and includes requirements or recommendations for improvement.

Data summary

This is the third briefing on our assurance visits to social care providers. Findings are based on visits to 161 providers, as shown in the table. Due to the further national restrictions in November, assurance visits to some providers and local authority focused visits were paused.

This briefing concentrates on the experiences of children in secure children's homes (SCHs) and those in independent foster care. Although we analysed evidence from children's home visits, the findings did not add to what we reported in our previous briefings. We have reported only by exception to help put these findings into context.

Table: Number of visits in this analysis by most recent inspection grade*

Provider type	Outstanding	Good	Requires improvement to be good	Inadequate	No previous grade**	Total
Children's home	4 (3%)	33 (26%)	73 (57%)	5 (4%)	13 (10%)	128
Secure children's home	1 (8%)	7 (58%)	4 (33%)	0 (0%)	0 (0%)	12
Independent fostering agency	0 (0%)	2 (10%)	9 (43%)	4 (19%)	6 (29%)	21
Total	5 (3%)	42 (26%)	86 (53%)	9 (6%)	19 (12%)	161

* Only includes children's homes not covered in previous briefings. Analysis is only reported by exception.
** Providers that have no previous grade are usually new registrations.

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Main findings

Secure children's homes

- Children moving into SCHs generally have multiple highly complex needs, including mental and emotional health needs. They had to isolate for 14 days as required by Public Health England (PHE) guidance. This has increased anxiety for children and staff. In some cases, it resulted in children physically attacking others or self-harming.
- Staff shortages because of COVID-19 (coronavirus) had an impact on children's feelings of safety.
- Some temporary staff did not have experience of SCHs. This led to a reduction in their confidence.
- Children received individualised support to continue their education, including during isolation. In some cases, children were more engaged in education than before the pandemic.

Independent fostering agencies

- When children in foster care responded negatively to COVID-19 restrictions, supervising social workers helped foster carers to understand how children's fears and anxieties might influence their actions.
- Independent fostering agencies (IFAs) were sensitive to carers' own needs. They tailored help and support to meet these.
- The decisions about whether children in foster care attended school were taken on an individual basis. IFAs worked closely with foster carers and virtual school heads to ensure that children's education continued.

Both types of provision

- Children were helped to understand what was happening because of COVID-19. This helped to reassure them and keep themselves and others safe.
- Foster carers and staff in SCHs responded sensitively to children's anxieties arising from the pandemic.
- Leaders in SCHs and IFAs worked hard to keep children and staff safe. They quickly adapted practice as national guidance changed.

Methodological note

Information on social care providers in this briefing is based on assurance visits to SCHs and IFAs. Assurance visits lead to a concise narrative report, with no graded judgement.

We prioritised visits based on a risk assessment of each provider, considering:

- the most recent inspection judgements

- when it was last inspected
- whether the provider is newly registered and so has not yet been inspected
- any other information that we hold about a provider.

Assurance visits focused on social care providers considered highest risk. Findings may therefore not be representative and general conclusions should not be drawn.

Overarching questions

This briefing covers **four** broad questions based on evidence from the visits:

1. To what extent are all children safe and protected from harm?
2. To what extent are children in care well looked after?
3. How are leaders and managers exercising their responsibilities?
4. How financially sustainable are SCHs and IFAs?

Are children kept safe and protected from harm?

SCHs

SCHs look after vulnerable children with complex needs. They give them the care, education and help that they need when they are a significant risk to themselves or others, and no other setting can keep them safe. Courts ultimately decide whether a child will live in an SCH and for how long. Some children living in SCHs have been remanded to custody by the courts or are serving a custodial sentence. There are currently 13 secure units operating in England. Around 180 children lived in them at the end of March 2020 (0.2% of all children in care).

As we have seen in other children's homes, leaders of SCHs have shown a good understanding of the risks associated with the pandemic. They have implemented guidance from PHE to manage infection risks.

At the start of the pandemic, healthcare professionals in SCHs carried out COVID-19 assessments and designed bespoke COVID-19 strategies. SCH leaders were tenacious in securing personal protective equipment and they did regular risk assessments to ensure the ongoing safety of children and staff. Leaders ensured that children were tested for COVID-19 when they were symptomatic and that they went into isolation as required by guidance. For children who had serious underlying health conditions, staff worked in bubbles and children's contact with other staff or professionals was limited. Additional measures that were put in place were generally proportionate to the risk.

When children arrived at an SCH, they had a compulsory 14-day isolation period, in line with PHE guidance. This had a negative impact on many children's well-being.[1]

[1] See also 'Childhood in the time of Covid', Children's Commissioner, September 2020; www.childrenscommissioner.gov.uk/report/childhood-in-the-time-of-covid.

In some cases, this also undermined the child's safety, and that of others in the home, because children's anxieties sometimes resulted in physical attacks or self-harm.

Staff in SCHs generally showed an in-depth understanding of each child's behaviours, risks and vulnerabilities. Children had risk-management plans that had been developed together with mental health professionals to help them manage risk-taking behaviours, such as self-harm.

IFAs

IFAs recruit, support and supervise foster carers who care for children looked after by local authorities. The majority of children in care in England live in foster homes and IFAs account for approximately two fifths of approved places.[2]

As we have seen in previous briefings, some children struggled with COVID-19 restrictions. This sometimes led to changes in their behaviour that could be challenging for foster carers. For example, one child who had not gone missing before the pandemic went missing from home regularly during periods of restrictions. Despite help from several agencies, the child had to move out because the risks to the child became too much for the foster carer to manage. It was sometimes difficult to help foster carers with these issues through virtual methods.

In another case, a child experienced an increase in self-harming incidents. The planned therapeutic life-story work was delayed because it was difficult to do virtually with no prior relationship with the child.

Some agencies reported that the tighter restrictions had a positive impact on children because they were able to develop stronger relationships with their carers and felt more settled. One social worker reported that children had become more unsettled when school and contact with their families resumed.

Are children well cared for?

SCHs

Relationships

Children in most SCHs had positive and nurturing relationships with staff, who provided much-needed reassurance. If children contracted the virus, staff looked after them safely and with care. As we have seen in other social care providers, the pandemic provided an opportunity to strengthen relationships between some children and staff.

[2] 'Fostering in England 2019 to 2020: main findings', Ofsted, November 2020; www.gov.uk/government/publications/fostering-in-england-1-april-2019-to-31-march-2020/fostering-in-england-2019-to-2020-main-findings.

However, due to the 14-day isolation period, some children did not find it easy to form new relationships when first arriving at SCHs. Similarly, increased staff absences and the use of temporary staff have meant that some children were unable to benefit from secure and lasting relationships. Occasionally, children struggled to communicate with staff wearing masks because they were not able to lip read or interpret facial cues.

National PHE guidance has meant that children's families have not been able to visit them. Having their liberty restricted, possibly being placed significant distances from home and not being able to see family and those important to them have all had a significant impact on children. Despite restrictions, staff in SCHs worked hard to ensure that children kept in contact with their families and people important to them. Children generally had no face-to-face contact because PHE deemed that the risk of infection from families coming into the SCH was too great. Staff arranged for children to speak to their families remotely through video technology and provided technical advice to families.

Children were given increased access to phones and other communication devices. As restrictions were relaxed, outside spaces were used more often. One home purchased a marquee to facilitate face-to-face contact outside. Another allowed visitors to use an outside secure area where children could see their families and talk through a baby monitor. Leaders were also planning for the Christmas period. One home described making changes to its layout to allow children to have safe family contact.

Children's views

Across the SCHs, staff were committed to encouraging and respecting children's views and ideas and acting on them, often regularly meeting with groups of children to do so. In one SCH, there was a weekly bulletin based on what children had said. A regular request was for more access to fresh air, physical activity and the community.

SCHs prioritised keeping children up to date with any COVID-19-related changes in the home or in the wider world, to help reduce children's anxiety. This was done in a child-friendly way, for example by using one-to-one work, group work or drop-in sessions. In one SCH, staff used stories to explain to children what was happening and why restrictions were in place. In another, children who had been outside the home were able to tell other children about their experiences.

Involving children in specific projects, especially during this period, raised morale for both them and staff. Examples included personalising a communal area, decorating for Halloween and upgrading the home's hair and beauty room. In one SCH, children were involved in the recruitment of staff.

Children continued to be involved in writing their care plans and were often fully involved in meetings. For some children, this included adding details of signs to watch out for that meant they were struggling, and how they would like staff to

respond when this happened. When children were not able to visit new homes, managers advocated on their behalf to see them through virtual tours, videos or photos. In at least one home, however, projects to involve the children in their plans had been delayed because of COVID-19.

Understanding and meeting children's needs

Children in SCHs sometimes experienced low moods and increased anxiety during periods of isolation or restrictions. At times, this led to physical attacks on staff and other professionals, as well as an increase in self-harm. Leaders remained aware of the potential impact of isolation on children's mental health. Children were given breaks from isolation to get fresh air and exercise.

Disruption to children's normal routines often meant less opportunity to mix in communal areas, go outside to exercise or go into the wider community. Some children also missed having physical contact with staff. One home reported an increase in physical interventions at the start of national restrictions, which they attributed to children needing this physical contact. The use of physical interventions in this home had lessened over time, as staff learned how to help children live with the new rules.

Staff made good efforts to resolve frustrations and ensure that children felt safe. Children were given sensory and well-being packs, particularly for periods of isolation. These included in-room exercise guides (such as dance), sensory toys, books, quizzes and other activities.

When children were isolating, they also regularly interacted with health practitioners. In one SCH, when children had experienced a period of isolation, each child was seen by a mental health practitioner to assess and support their mental health needs. The advocacy service also had regular conversations with children about their health and well-being.

In another SCH, a psychologist assessed each child and provided help for them when they were struggling. This included input from the occupational therapist and helping children to self-regulate using weighted blankets or other means of comfort. Some children, particularly those with autism spectrum disorder, benefited from detailed daily plans with individual goal-setting. Although this help existed before the pandemic, it benefited children especially during this time. For one SCH, COVID-19 restrictions hampered the recruitment of psychologists.

Children's general medical needs were well met. Acute medical needs were prioritised and addressed promptly. In some SCHs, health drop-in sessions occurred regularly for formal advice or well-being discussions. GPs and nurse practitioners provided remote advice to staff, but also attended SCHs when necessary.

Therapeutic activity, including psychological assessments, continued throughout the pandemic, often remotely. However, some healthcare appointments, for example, routine dentist and optometry appointments, were cancelled or access to services reduced. This was particularly the case during the early stages of the first national

lockdown and reflected what was happening in local communities. One child had been granted funding for specialised treatment but was unable to attend their appointment because they required three members of staff to accompany them. Due to COVID-19 restrictions, the hospital would not allow this appointment to take place.

In some SCHs, children's access to careers advice was restricted. However, one home ensured that children received help with creating their CVs and that they did mock job interviews to practise communication skills.

Promoting children's educational needs

Education was a source of stability for many children in SCHs. Staff worked well together to provide individualised curriculums to meet children's needs, including for children with complex educational needs or who were unable to join classes within the home.

In some cases, children were more engaged in education than before the pandemic. This was sometimes because there were fewer children in the SCH and reduced group sizes meant that teachers had more time to spend with children. In one SCH, the education team set up a working party, made up of care and education staff, to promote the importance of education. Within this home, the children's survey indicated that children felt positive about their education. Furthermore, the percentage of children refusing to engage with education had decreased since the last inspection.

Staff absences at the beginning of the first national lockdown adversely affected the provision of education in some SCHs, for example by reducing the number of education hours offered. Despite this, care staff provided additional educational resources and activities designed to promote well-being and personal development. These included a summer Olympics event, physical activity, completing a walk with staff equivalent to the length of the country and learning a new musical instrument. This was for a short period of time and children quickly returned to their full education.[3]

IFAs

Relationships

In most IFAs, supervising social workers kept in direct contact with children and foster carers when possible, though this was more difficult under COVID-19 restrictions. They used a variety of methods, including home visits, telephone calls, text messages and video calls. They would see children on their own when appropriate.

[3] See also 'Childhood in the time of Covid', Children's Commissioner, September 2020; www.childrenscommissioner.gov.uk/report/childhood-in-the-time-of-covid.

Foster carers worked hard to minimise the impact of the restrictions on children by encouraging physical activity and education, and arranging contact with family and friends. Children's positive relationships with their foster carers meant they were able to go to them for help and guidance.

In some cases, children grew closer to their foster family by spending more time together. Foster carers in one IFA received extra money to help fund activities for the children. For others, relationships became strained when children's normal routines were unsettled and they remained inside the house for long periods of time, particularly during the summer holiday period. Supervising social workers helped foster carers to understand children's experiences.

Similarly, foster carers played an important role in maintaining children's relationships with family and friends. Contact, which was often remote, took children's views and wishes into account. It focused on fun activities, such as playing a card game with a relative using video technology.

We saw examples of the wishes of children in foster care being listened to and influencing decisions about where they would live in the context of the pandemic. For example, in one IFA, a child chose carers after a video call and meeting them at the foster home before the match was agreed.

Promoting children's educational needs

The educational needs of children in foster care were carefully considered during periods of restrictions. Decisions were made on an individual basis as to whether children should attend school. IFAs, alongside foster carers, worked closely with the virtual school to put appropriate arrangements in place, including when children wanted to return to school. Some IFAs had specialist education workers who helped foster carers ensure that children remaining at home engaged in learning and returned to school at the appropriate time. In another IFA, education ambassadors, who are foster carers with an education background, helped provide peer support to other foster carers.

Children moving from primary to secondary school were helped through an art therapy group in one IFA. This helped them make a positive transition when visits to the new school were not possible.

How are leaders and managers exercising their responsibilities?

Leadership and management in SCHs

Leaders and managers in SCHs worked hard during the pandemic, focusing on minimising the impact on children of changes in restrictions and guidance.

Staff in SCHs require a high level of expertise to be able to meet the complex needs of children in the home. Many of the SCHs were severely affected by staff absences

due to positive COVID-19 tests, periods of isolation due to contact with an infected person or staff being in the vulnerable group. Two homes reported that 30 staff had been off sick at one point. In some cases, these absences included senior leaders, which contributed to a lack of stability in the home.

Absences were sometimes covered by agency staff, or those from other services or children's homes, who had little knowledge or experience of working in a secure environment. This impacted children's care, because staff were not always equipped to deal with situations as they arose. Some staff described feeling frightened and this led to a reduction in their confidence and morale. The 14-day isolation period for new children entering SCHs similarly impacted morale for some because it contributed to disputes and a tense atmosphere in the home.

Some leaders and managers were proactive in planning their staff resources as a contingency before national COVID-19 restrictions were first introduced. Some SCHs made plans to pre-empt large numbers of staff being off sick, for example by reducing occupancy levels. In some SCHs, fewer children moved in as a by-product of courts closing. This meant higher staff-to-children ratios and an improved atmosphere in the home. In some SCHs, staff were organised into bubbles containing a mix of skills and experience, so that if one bubble had to self-isolate, children's needs were still met throughout the isolation period.

In SCHs, there has been good joint working between health professionals, care staff and education staff, as well as with external partners. In particular, teaching and care staff worked across roles to maintain both care and education. In one SCH, greater flexibility in team roles meant they did not have to draw on any external support and the children were looked after by a stable and consistent staff team.

All the homes worked closely with NHS England, PHE, the Department for Education and the Youth Custody Service, and drew on relevant advice and guidance. However, these bodies advised members differently on working practices, leading to some tension. For example, health care staff followed local NHS commissioners' guidance to wear masks when working with children in SCHs, although other staff did not have to. Many SCHs reported that children adapted to these differences, but for some children, the differences and the frequent changes in rules were harder to accept. Similarly, some health staff were advised initially to work from home and for no face-to-face appointments to take place in the SCH.

Managers of SCHs have had to grapple with regional disparities in guidance from PHE. For example, one home was able to access lateral flow testing following agreement with local PHE professionals. This meant that children could be tested for COVID-19 on admission and again on day six and, if tests were clear, the child's isolation period could end. It is not clear why this has not been offered to all SCHs so that no child need suffer a harmful prolonged initial isolation period.

Some SCHs reported positive staff morale because of good supervision and staff feeling well supported. Staff in one home were excited about improvements in the home, were well motivated and were enjoying weekly well-being meetings.

Leadership and management in IFAs

Most IFAs responded well to the pandemic, following guidance and promptly putting COVID-19 safety measures in place, including providing PPE to vulnerable workers. Supervising social workers were able to work from home effectively. They used technology to enable remote meetings and supervision with foster carers.

Supervising social workers maintained good contact with foster carers. They were sensitive to carers' individual needs and tailored help around these. Supervision largely took place virtually but supervising social workers were mindful of some carers' limitations with IT or their communication preferences. Foster carers have continued to provide support to one another. One supervising social worker organised a regular virtual coffee morning for foster carers to stay connected. Some agencies identified the most vulnerable carers and provided additional practical help, such as food parcels or a reminder that they were key workers and could access early opening slots in supermarkets.

One agency reported that there had been no placement breakdowns during the pandemic, despite many challenges. This was due to the supervising social workers' child-focused assistance. For example, the help given to foster carers of one child, who initially struggled with COVID-19 restrictions, meant the family were now doing well. The child was working part time, attending college, had got back to the gym and was back into their routine.

The use of face-to-face visits varied between different IFAs. In most cases, they continued when there were safeguarding concerns. Several agencies used risk assessments to assess whether supervising social workers should visit carers and/or children in person, or whether they should meet remotely instead. Some agencies were reluctant at first for social workers to carry out any face-to-face work, and largely operated remotely. When face-to-face visits happened, precautions were taken, such as using the back garden to hold a review meeting.

Some vulnerable foster carers were concerned about the risk of infection, by foster children or by the supervising social worker visiting the home. In rare cases, this led to children being refused back into the home and placements breaking down. These concerns were generally balanced against the need for face-to-face communication to check on foster carers' well-being and help them understand children's experiences. For example, a supervising social worker arranged a 'walk and talk' supervision outside for one anxious carer.

Foster carers and agency staff were able to access a combination of online training courses and direct training (for example, through video-calling software). One agency started a book club that raised foster carers' awareness about discrimination. However, one supervising social worker reported that they had not had any training for their role since joining their agency, partly because of COVID-19.

Use of permitted regulation flexibilities

Although there were several flexibilities relating to foster care regulations allowed by the Adoption and Children (Coronavirus) (Amendment) Regulations 2020, they were used, as intended, only when absolutely necessary. Examples included initially accepting medical self-assessments to prevent delays in progressing foster care applications.

In most cases, fostering panels continued at their usual frequency and with good representation, but they were completed virtually. Despite initial concerns about holding fostering panels virtually, panel chairs reported that they had worked well and felt robust. For one panel, processes were adapted so that comments and feedback from panel members were received before the meeting. This made it more efficient. In addition, foster carer applicants seemed more comfortable in their own home, and panel members valued seeing them interacting with their own children.

One panel chair reported that the panel was not as representative as they would like, lacking care-experienced members and ethnic diversity. However, progress in achieving this had been delayed due to COVID-19.

How financially sustainable are social care providers?

In our inspectors' survey of visits to all provider types, only around 3% of providers were 'very concerned' about their long-term sustainability.

There were not enough respondents to give an accurate picture of the experience for all SCHs and IFAs. However, some newly registered agencies struggled to get their agency established due to the pandemic. For one IFA that had registered just before the first national lockdown, this meant managers were forced to return to additional paid work alongside running the agency.

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