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Dear Ms Lewis

Focused visit to Luton Borough Council children's services

This letter summarises the findings of a focused visit to Luton children's services on 12 and 13 June 2018. The inspectors were Anne Waterman HMI and Kate Malleson HMI.

Inspectors looked at the local authority's arrangements for children in need and those subject to a child protection plan.

Inspectors considered a range of evidence, including children's case records, case discussions with social workers and managers, performance management and quality assurance information and supervision files.

Overview

Since the last inspection of children's services in February 2016, there has been a significant transformation programme within the authority. This has included the introduction of a multi-agency safeguarding hub, the introduction of an assessment team and a remodelling of five family safeguarding teams. With support from the Department for Education's children's social care innovation programme, the authority has introduced a whole-family model of safeguarding and is now working to embed this approach.

Despite measures taken to address the recommendations from the last inspection, the local authority recognises it is still on an improvement journey. Leaders have a

good understanding of service strengths and of areas where the quality and impact of practice are not yet sufficient. Through the self-evaluation process, the authority has identified areas it needs to address to improve the experiences of children. It has maintained an improvement board to oversee its plans. Evidence from the focused visit supports the local authority's own evaluation that further work is needed to address inconsistencies in the quality of practice, reduce the turnover of staff, reduce its reliance on agency social workers and ensure that workloads are manageable for all social workers by maintaining the overall downward trajectory in caseloads it has achieved in the last few months.

Areas of strength

- There is a strong commitment by partner agencies to protecting the children of Luton. Most strategy meetings are well attended by relevant professionals who share information to aid decisions about the next steps for children. They are well recorded, with a clear rationale, and result in appropriate actions to keep children safe. Relevant agencies consistently attend core groups, child protection conferences and child in need reviews, which means that information is shared effectively to inform plans.
- Appropriate information sharing through multi-agency risk assessment conferences, multi-agency public protection arrangement processes and, in one case seen, proactive information sharing by the Jigsaw sex offender unit, is reducing risks for children.
- Social workers have a good understanding of Luton's diverse population and are alert to potential safeguarding concerns. In recognition of the multiple languages spoken, social workers can swiftly access an interpretation service whose role is evident in supporting their work with children and their families.
- Where children have had a consistent social worker, their wishes and feelings are fully explored, and work undertaken during visits is well evidenced and demonstrates a good understanding of their lived experience.
- Families experiencing domestic abuse can readily access a wide range of services. Inspectors saw examples of parents accessing the Freedom programme and individual support for anger management, and children receiving support through family workers in schools. These services are helping to reduce risk and build children's resilience to lessen the impact that domestic abuse has upon them.
- The authority has taken steps to reduce caseloads for social workers, and these are beginning to take effect.
- All social workers have received training in the model of practice that the authority is developing, and they are enthusiastic about putting it into practice. It is too soon to evidence the impact of this approach, as it is yet to be embedded, and the recruitment of key professionals to some teams is very recent. However,

in those children's cases where the intended approach is in place, with domestic abuse and substance misuse workers providing direct support to parents alongside children's social workers, it is having an impact on reducing risk for children.

- Staff are enthusiastic about working in Luton. They told inspectors that their managers are approachable and supportive.

What needs to improve in this area of social work practice

- Quality assurance processes are not being used to explore current practice issues clearly enough to enable senior managers to take effective action to secure improvement.
- Case records do not identify clearly enough the needs of each individual child within the assessment, review and plan in cases which involve multiple family members.
- While it is sufficiently frequent in most cases, supervision of practice often lacks challenge and reflection. This has led to social workers not having a thorough understanding of all presenting risks and not consistently progressing children's plans in a timely way.
- High caseloads, particularly within the assessment team, have impacted upon practice. In particular, this is undermining the quality of assessments; in most cases, very little direct work is undertaken with children during the assessment process.
- Chronologies are not being used effectively to inform assessment. Significant events in the individual child's life are often combined with other family members, so are not fully understood.
- Oversight of practice has not been sufficient to ensure that child protection and child in need plans are of consistently good quality. Stronger plans are clear about timeframes and expectations and are updated following reviews about what still needs to happen. However, the majority lack clear timeframes and are overly ambitious about parents' compliance. The use of a statement of expectations with parents in most cases involving domestic abuse is over-optimistic and does not take enough account of the impact of violence on the woman's ability to protect her child/children.
- Delays are evident in work being undertaken with families following assessment, at the point at which children's cases are transferred to the family safeguarding teams. Child in need and child protection visits are not always timely. In some cases, visits are carried out by a duty social worker due to capacity issues and then allocated to a different social worker to undertake actions on the plan. While

immediate risks are addressed, and children are not left at risk of significant harm, this means that not all children receive the help they need soon enough.

- The authority is implementing a strategy to address the high numbers of non-permanent staff within children's services. Nevertheless, the current impact of the high turnover of staff is evident, as some children have too many changes in social worker. This makes it difficult for children to form meaningful relationships and has contributed to delays in progressing plans.
- Case recording is too variable. Where case summaries are up to date, they provide a useful snapshot of the current situation. However, key documents, such as review minutes following child in need meetings, are not being uploaded quickly enough. The child's voice is not evidenced strongly enough, particularly where there are several family members and where the child is pre-verbal. This means that the individual child's needs are not always addressed, and the presenting issue of a brother or sister may receive all the focus.
- Audit activity has largely focused on compliance to standards. While compliance is important, the approach taken is not identifying all the practice issues to address within audited cases, including those of risk. Social workers do not always receive feedback when their cases are audited; this is a missed opportunity for learning. Leaders are aware of these issues. They have been reviewing quality assurance processes, and work is now underway to 'close the loop', in your words, to enhance the effectiveness of audit as a tool and to ensure that risk is fully understood as you further implement your model of practice.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Anne Waterman
Her Majesty's Inspector