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Dear Amanda

Monitoring visit of Lancashire local authority children's services

This letter summarises the findings of the monitoring visit to Lancashire children's services on 25 and 26 July 2017. The visit was the fifth monitoring visit since the local authority was judged inadequate in May 2015. The inspectors were Susan Myers HMI, Paula Thomson Jones HMI and Shabana Abasi HMI.

The local authority is making some progress in improving services for its children and young people.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of children looked after and care leavers, with a particular emphasis on the quality and timeliness of planning for permanence. A range of evidence was considered during the visit, including electronic case records, supervision files and notes, observation of social workers and senior practitioners and other information provided by staff and managers. In addition, we spoke to a range of staff, including managers, social workers, other practitioners and administrative staff. We also met with a group of care leavers.

Overview

The inspection in 2015 identified specific areas requiring improvement. This visit found that some progress has been made in a number of areas. You recognise that, while some progress has been made against your action plan, there is a considerable amount of work to do before you can be confident that children looked after and care leavers receive a good service.

Actions taken to support improvement include securing additional staffing, improving the quality of your audits and ensuring that compliance with basic standards of social work with children are met. There has been a strong focus on creating the right structure and culture to enable good practice to develop. Managers have worked hard to create this environment, and staff feel positive and well supported. There is now evidence that the new arrangements are beginning to support improvements in practice as well as compliance.

The quality of practice provided to children and their families remains too variable. For example, assessments lack thorough analysis of children's cultural and identity needs, and plans are not yet specific enough to ensure that progress can be measured. Adoption is not considered for all children, and permanency planning does not start quickly enough. There is more to do to ensure that managers and independent reviewing officers (IROs) are not overly dependent on self-reporting from social workers during audit activity. Managers have not yet developed robust systems to ensure that sufficient oversight of practice is provided at all levels in the organisation. Increased IRO capacity and the addition of advanced practitioners in social work teams have not yet addressed this shortfall, which was an issue at the time of the last monitoring visit.

Findings and evaluation of progress

For the vast majority of children looked after, statutory requirements are completed in a timely way. Visits to children are taking place regularly, and children are seen alone by their social workers. Most social workers know the children on their caseload well and have taken time to discover their wishes and feelings. However, for the majority of children, these positive relationships have not resulted in purposeful plans for children that lead to improved outcomes.

Some children experience too many changes of social worker. This means that they do not have the opportunity to build long-term, trusting relationships. Some children have a change of social worker every six months. Care leavers who met with inspectors said that they had grown tired of having to get to know so many new social workers.

Social work caseloads are mostly manageable, and staff feel well supported by their managers. However, workloads for some of the newly qualified social workers are too high, both in number and in complexity. This means that they do not have sufficient opportunity for continued learning and development of their social work skills. Some newly qualified workers are not receiving enough support, direction and challenge when they are undertaking complex assessments.

Supervision files and case records evidence that most staff receive regular supervision. Records since March 2017 are appropriately detailed and contain evidence of discussion about casework, regular training and social workers' development needs. Managers now provide challenge about compliance issues, and actions and directions are well recorded. However, timescales are not set and it is

sometimes difficult to see whether actions have been completed. Managers do not always provide sufficient challenge about the quality of assessments and plans.

Assessments and case summaries for children looked after are now updated regularly. The vast majority of children have been subject to re-assessment in the last six months to ensure that there is a current understanding of their needs. Although the quality of assessments remains too variable, several good pieces of work were seen by inspectors and no assessments were deemed to be inadequate. The justification for completing a re-assessment is not always clear, and staff are not routinely analysing information or looking in sufficient depth at some of the most important issues for children. Children's views are recorded, but social workers do not always describe children's lived experiences in assessments and case notes. Stronger practice is evident in teams that have more stable and experienced staff.

All children looked after have a written care plan, and some staff have received training in the importance of purposeful planning for children. However, almost all care plans sampled lacked specific, measurable outcomes against which progress can be monitored effectively. Furthermore, care plans do not sufficiently reflect the assessment of children's changing needs. For example, a young person who is almost 18 years old, and is supported by the special educational needs and disabilities team, does not have an up-to-date pathway plan that reflects a coherent agreed plan for their transition. This is in spite of two years of discussion.

Reviews take place regularly and IROs speak with children prior to review meetings. Children are increasingly more involved in their reviews, both through attending in person and writing part of their own review notes. However, reviews fail to challenge any drift or delay in children's plans. Reviews are not routinely used to ask critical questions about the decisions made about children, or to consider their future needs.

Many staff are unclear about how and where decisions about children looked after are made. Staff are unsure about which individual managers or different panels and groups are responsible for making decisions about plans for children. They are unclear whether reviews, for example, are meetings in which decisions are made or are meetings that simply record the decisions. Some staff are unsure about which cases are considered at permanency panel and which are not. Informal systems have been adopted across different teams, which adds to the problem of inconsistency. Crucial decisions for children, such as achieving permanence, or being separated from brothers and sisters, are agreed by individual team managers. However, the rationale for these decisions is not clearly recorded on children's files.

For most children, permanence is not considered soon enough. Many children achieve permanence by staying in their short-term foster placements for several years, without robust assessment of need or evaluation of options. Although these children are often described as being settled and happy by their social workers, these placements have not been considered carefully and deliberately enough to ensure that they are the right placements to meet the children's current and future needs.

Special guardianship orders (SGO) are not routinely promoted as a way of achieving permanence for children in long-term foster care. SGOs are not regularly discussed with foster carers during statutory visits.

Inspectors saw a number of cases during the visit in which cultural needs, family history and identity needs had not been well considered for children who had drifted into permanence with their foster carers without appropriate consideration of matching. It is unclear how short-term foster placements are converted and formally agreed as long-term placements. Life story work is not routinely completed with children who are in long-term foster placements.

Adoption is not routinely considered for all children who would benefit from it. Inspectors saw a number of very young children who were not being progressed for adoption, and there was no clear rationale for this. There is evidence of stronger practice for relinquished babies who are swiftly placed with foster to adopt families and progressed through adoption processes in a timely way.

Improvements that have been achieved in other parts of the service have not been realised in the SEND team, which has not been as engaged as other teams in auditing and other quality assurance activities. This means that the quality of assessments and care planning for children who have complex needs is not as strong as it is for other children looked after. For example, a child who has complex needs and has been allocated to the SEND team has not had a re-assessment of his needs since 2015.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Susan Myers

Her Majesty's Inspector