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Ms Jane Parfrement
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Dear Jane,

Focused visit to Derbyshire County Council children's services

This letter summarises the findings of a focused visit to Derbyshire County Council children's services on 27 and 28 February 2018. The inspectors were Caroline Walsh, HMI, and Ian Young, HMI.

Inspectors evaluated the local authority's arrangements for children who are the subject of child protection plans.

Inspectors considered a range of evidence, including discussions with social workers, senior managers, conference chairs and parents. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Senior leaders have an accurate view of the quality of child protection services for children in Derbyshire, and plans are at an advanced stage in addressing the variability in practice. Leaders are committed to investing in the right conditions for good social work to flourish, although these are not consistently in place across the local authority. Appropriate plans are underway to provide more support to social workers and increase capacity to reduce caseloads for social workers. Staff are positive about working for Derbyshire and value the training and development on offer.

Although no children were found to be unsafe, the quality of child protection work is too inconsistent. The identification of the risk of harm to children when child protection work begins is not clear enough. Reviews of progress are not sufficiently focused on the impact on children, and this leads to drift in planning. Management oversight is not strong enough to ensure that all children benefit from high quality and consistent social work practice that improves their circumstances in a timely way.

What needs to improve in this area of social work practice

- The quality of child protection planning is too variable. Risk for children is not clearly identified in assessments. This leads to a lack of clarity in planning to ensure that actions are appropriately focused on improving children's circumstances.

- Independent chairing of conferences and reviews does not consistently focus participants on the risks of harm to children or ensure that plans help parents and carers to understand what needs to change.

- Management oversight and the supervision of staff does not consistently review progress of plans to avoid drift and delay for all children.

Findings

- Senior leaders understand their service well. A committed and focused director of children's services creates an environment in which staff are valued and listened to. Political support has been provided to significantly increase investment in children's services, with the aim of addressing capacity issues and improving oversight and support for frontline staff. The workforce development plan clearly focuses on addressing capacity issues and supporting the retention of experienced social workers. Plans to introduce practice supervisors have been designed to develop inexperienced social workers' skills and provide career progression opportunities for more experienced staff.

- Leaders are rightly focused on the significant increase in the number of child protection plans in the last three years. This increase in demand has adversely impacted on the timeliness of assessments and initial child protection conferences, as well as on the quality of practice. Detailed performance information enables managers to focus attention on poorer performing areas. This is beginning to reap benefits, and there have been improvements in these core performance indicators.

- A keen and energised workforce is committed to working for Derbyshire county council. Many social workers are still relatively inexperienced, but are positive about the training and development on offer. Morale is generally high,

and although caseloads are high, staff are supported to manage their workloads.

- Social work practice is mostly compliant with statutory requirements and is clearly focused on getting the basics right. This ensures that concerns about children are investigated without delay. Partner agencies are also contributing to the sharing of information and planning of these enquiries. The timeliness of initial child protection conferences is improving, and most core groups and statutory visits take place regularly. Conferences have good multi-agency attendance and partners are contributing appropriately to plans.

- Many families with children subject to protection plans have complex needs, including high levels of parental alcohol and substance misuse. Inspectors saw plans with unrealistic expectations of parents, requiring them to overcome their addictions in unlikely timescales. Plans and services are not always focused sharply enough on what needs to change within the family to secure timely improvements in children's circumstances.

- For a few children, there has been delay in addressing neglect. This stems from an over-optimistic view of parenting capacity within the multi-agency and social care teams. The local authority recognises that practice could be strengthened by greater professional curiosity and increased use of risk assessment tools, including the graded care profile. The authority has plans to ensure that there is greater use of its social work model, systemic practice, to address inconsistencies in practice.

- Social workers are able to articulate children's experiences to inspectors, but this is not well reflected in the written records. Assessments do not adequately describe children's lived experiences, and a lack of depth and analysis in many assessments means risks for children are unclear. Insufficient accounts of family history mean that children's continuing needs are not fully understood. Children's individual needs are not always well captured, particularly when they are part of a large sibling group.

- The quality of social work planning for children is inconsistent. Too often in written plans, it is unclear to parents and carers what needs to change by when. Plans do not always address the needs identified in assessments or set clear measurable actions to track progress. Repeated descriptions of family crises, without succinct analysis of the impact on children, blur the picture for all parties and make it harder to steer planning to improve children's circumstances. A lack of clear contingency planning spelling out the consequences for families of disguised- or non-compliance contributes to drift for children. For a few children, this results in weak social work practice.

- Core groups and review meetings are not sufficiently child-focused. This means that social workers focus on the activity of the adults, and the emphasis on impact for children is lost. Without clear, measurable targets,

progress is uncertain. This contributes to a higher proportion of repeat plans for some children or delay in escalating cases to the public law outline.

- Senior leaders understand the challenges in child protection work, and have established plans to ensure a clearer emphasis on the risk of harm to children by reducing drift in plans and introducing more authoritative social work practice. The local authority was responsive to feedback during this visit. They have already introduced new checkpoints to independently review child protection plans, of between 12 and 18 months duration, to check whether there are timely improvements to children's circumstances.

- Strategic oversight of children at risk of exploitation is well developed. However, very few children are assessed to be at high risk of exploitation and are able to benefit from the monthly multi-agency review of their plans through the 'tasking meeting' to disrupt perpetrators and reduce risk. The local authority is reviewing the practice and application of risk assessment tools for children at risk of exploitation as part of their development work. They do not yet understand why so few children are considered to be at high risk of exploitation. A recent decision to review high risks more regularly through strategy discussions is aimed at improving information sharing and risk management.

- Children's views are captured in assessments and there are examples of direct work that is focused on helping them understand their experiences. Social workers need more capacity to develop trusting relationships with children and better convey what life is really like for them. The low level of participation by older children in conferences and core groups does not help them to understand the plans to keep them safe. In the cases in which children did attend conferences, their voices positively influenced their plans.

- The supervision of staff, although regular, is not always directed at ensuring that sufficient progress is being made to improve children's circumstances. There is little evidence of challenge, and actions are not well monitored from one session to the next. Management oversight varies between social work teams and child protection managers, and this results in inconsistent practice across the local authority. For example, interim safety plans following a strategy discussion are a standard expectation in one team but are not evident in others.

- The range of multi-layered audit activity by the local authority has identified some practice development themes. However, it does not consistently identify all practice issues for managers. The local authority has plans to review the audit tool to focus more clearly on impacts on children. There is more to do to ensure that the learning from audits routinely improves practice.

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

Yours sincerely,

Caroline Walsh
Her Majesty's Inspector