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Mr John Readman
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Dear John

Monitoring visit of Lancashire children's services

This letter summarises the findings of the monitoring visit to Lancashire children's services on 27 and 28 February 2018. The visit was the sixth monitoring visit since the local authority was judged inadequate following an inspection in September 2015. The inspectors were Paula Thomson-Jones, HMI, Stella Elliott, HMI, and Tony Theodoulou, Ofsted Inspector.

The local authority continues to make some progress in the improvement of its services for children in need of help and protection.

Areas covered by the visit

Inspectors focused on the initial responses to children in need of help and protection who are referred to children's services via the multi-agency safeguarding hub (MASH). A range of evidence was considered during the visit, including electronic case records, supervision files and notes. In addition, inspectors spoke to a range of staff, including managers, social workers and other practitioners.

Overview

At the time of the inspection in 2015, the 'front door' to children's services consisted of two referral routes. Initial screening was undertaken by unqualified staff and arrangements were complex, with referrals for children often being passed to many different parts of the team prior to decision-making and action being taken. During 2017, the local authority worked with partners to streamline its front door service. The aim was to develop a more efficient referral system to ensure that all children receive a timely and effective response.

All children are now referred via a single point of access to the MASH and are screened in a timely way by social workers. Children's needs, and the level of risk they are experiencing, are then considered by three multi-agency locality teams. This

has improved the timeliness of response to children, enabled more effective management oversight of work, and supported a better quality of information sharing between partner agencies.

For some children living in situations where there is domestic abuse, there is a delay between incidents of abuse taking place and referrals being received by social care staff in the MASH. This leads to delay in some children getting the support they need.

When children are at immediate risk of significant harm, action is taken quickly to keep them safe. However, for some children this is still happening without effective strategy discussions taking place. Participation by partner agencies remains weak, and in many cases seen, there was insufficient sharing of information to inform investigations. Investigations are focused on the most recent incident and do not always lead to a holistic assessment of risk and need. For a small number of children, although they are not at immediate risk, the lack of consideration of all available information leads to them not getting the help that they require to prevent future harm.

The local authority has successfully used its own quality assurance processes to assess the impact of the revised arrangements. Audit activity continues to be effective and provides accurate evaluation of the quality of practice. Many of the findings during this monitoring visit confirm the local authority's own findings from their internal audit activity.

Findings and evaluation of progress

Understanding of thresholds is improving, and the majority of referrals made by partner agencies other than those made by the police are appropriate and meet the threshold for children's social care. Most agencies provide enough information about the concerns to enable a decision to be made about next steps for children. The quality of this information remains variable, with weaker examples seen in referrals from health partners, such as general practitioners and hospital staff. In some cases, this leads to social workers having to make extra inquiries to gather information and can cause delay in responding to children's needs.

Additional resources have been established in the MASH to improve and develop screening, assessment and prioritisation of domestic abuse reports. Despite this, the combination of the large volume and poor quality of incident reports, and unreliable initial risk rating means that police staff at the MASH and social workers spend considerable time trying to review and prioritise this work. High-risk incidents are well prioritised and responded to quickly, but some lower level incidents take longer to respond to, leading to delays for some children and families being offered help.

Referrals from the police form the largest proportion of work in the MASH. The majority of these are reports of incidents of domestic abuse. Significant numbers, approximately 70%, do not meet the threshold for social work intervention, meaning that large numbers of children referred to the MASH do not need or receive any help or support from children's social care.

When children need help out of hours, this happens quickly and effectively. Information is recorded and followed up appropriately to ensure that children are safe.

All contacts about children are passed directly to the MASH to be reviewed by qualified social workers. This is an improvement since the inspection, when unqualified staff undertook initial screening.

The contact records show that social workers review the historical information available on children's files, but not in sufficient detail and usually recorded as a one-line summary. The history is not used to inform a robust analysis of risk and need, and is not focused on the lived experience of children. As a result, analysis and decision-making is often focused on a recent incident rather than the holistic view of the experiences of children.

Referrals are recorded by social workers and reviewed by managers in a timely way. Thresholds are applied effectively for most children. Those at immediate risk are identified and are referred to the locality teams quickly for further action to keep them safe. The locality teams hold timely strategy discussions, but these are often brief meetings which do not demonstrate good information sharing or robust planning of investigations. This is despite a recommendation being made at the last inspection to improve the quality of strategy discussions.

The records of section 47 inquiries evidence the actions taken during the investigation, including children being seen and spoken to, but are focused on the recent incident rather than a wider analysis of risk. For some children, this means that a decision is taken not to proceed to a child protection conference without a holistic assessment of all known information. This results in some children being stepped down to child in need prematurely before all information has been assessed and the level of cooperation of parents established. In a small number of cases, this led to inappropriate case closure when parents did not cooperate with child in need work.

For other children referred to the MASH, managers appropriately guide social workers to gather further information to inform decision-making. This includes review of case files, gathering information from partner agencies and making contact with parents or carers. These activities result in a timely and effective response to presenting concerns for most children, and their cases are allocated swiftly for support from social work teams or from early help services.

In some cases seen, parents were contacted at too early a stage, and the issue of consent was discussed with them before the workers had reviewed the historical information available. In some of these cases, an earlier review of the information would have resulted in a different course of action and reduced delay in a service being provided to the child and their family.

When the needs of children have not clearly met the threshold for social work intervention, but a further assessment would help clarify their needs, they are passed to a team of social workers to undertake short-term social care assessments. In the cases seen during this visit, the work in this team was sufficient to determine appropriate decision-making about next steps.

There is evidence of social workers in the MASH using the local authority practice model more consistently to evaluate risk. This is not yet well developed and is not yet resulting in consistently good-quality practice.

The understanding of, and response to, children who are experiencing domestic abuse in their families is not well developed. The local authority has already identified this as a weakness and is planning to review practice in the MASH. Currently, practice remains focused on the severity of the most recent incident and the actions of the victim, and the experiences of victims of abuse or their children are not sufficiently considered. As a result, some children do not get the help and support they need at the right time.

Management oversight of work in the MASH is organised and ensures a timely response for the majority of work. Managers in each locality team have a good understanding of children currently being considered, and they monitor the progress of work effectively.

Social workers in the MASH have supervision regularly, even when there are frequent changes in line manager arrangements. However, there is little evidence that supervision is being used to develop practice or drive performance. There are few actions arising from discussions and these are not followed through.

The staff resource to develop the revised MASH has been created with temporary funding and is currently comprised of 63% agency social workers and managers. The management structure remains unclear and is currently reliant on additional temporary capacity. The local authority plans to establish the current model as a permanent arrangement, but funding for this has not yet been agreed by the council. Although many agency staff have been in the service for some time, and some want to stay, some risk remains regarding the future stability and sustainability of this service.

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

Yours sincerely

Paula Thomson-Jones

Her Majesty's Inspector