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Dear Jayne Ivory

Focused visit to Blackburn with Darwen children's services

This letter summarises the findings of a focused visit to Blackburn with Darwen children's services on 7 November 2018. The inspectors were Paula Thomson-Jones, Her Majesty's Inspector, and Alison Smale, Her Majesty's Inspector.

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

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

Overview

Children in Blackburn with Darwen who are at immediate risk are protected. The quality of most of the help and protection services they receive has remained the same since the last inspection in October 2017, with some improvements to some aspects of the service. Children have their assessments updated more regularly, and those in pre-proceedings are more closely monitored, which has reduced drift and delay. Outcomes for many children are improved by the work of the family group conference service, which has been established since the last inspection.

Some children benefit from the good-quality work by individual practitioners, but for many children, particularly those suffering neglect, the service remains too variable, and some children live in neglectful situations for too long, where they suffer harm.

The ability of the service to improve the quality of practice considered in this visit has been impacted on by a lack of progress in some key areas. Despite the recommendation from the last inspection, the partnership has been far too slow to develop its response to neglect, with an action plan that has not yet been implemented.

The workforce remains under huge pressure. The caseloads of social workers and their managers have increased and remain too high. This has impeded progress in improving the quality of assessments and care plans.

What needs to improve in this area of social work practice

- The strategic multi-agency approach to ensure that children who are suffering neglect are helped and protected at the earliest opportunity.
- Social workers having workloads that allow them to spend sufficient time with children.
- Quality assurance activity, including audits that offer effective opportunities for learning and practice improvement.
- The quality of assessments and plans, with clear analysis, that lead to improved outcomes.
- Management oversight that focuses on improving quality and outcomes as well as compliance.

Findings

- Since the last inspection, most children now undergo a recent assessment that captures the strengths and needs of their families. Families are involved in assessments, but the information is not always sufficiently triangulated, and, in some cases, there is over-reliance on self-reporting by parents. In addition, brothers and sisters who live together do not have their needs well considered because assessments are too focused on one presenting issue or one specific child. Social workers now gather information about children's history, but do not always use this effectively to understand their lived experience.
- In all cases seen, social workers had undertaken some direct work with children to inform assessments. For some children, the work resulted in greater understanding of their experiences, and their wishes and feelings informed the assessment and subsequent care planning. For others, the work resulted in a brief amount of information about their likes and dislikes, which added little to the

assessment or plan. There has been little improvement in the way in which assessments evaluate children's needs in respect of their identity since the inspection. In most cases, there is superficial acknowledgment of ethnicity, but other than this, little is written about the experience of children growing up in their household and what this means for their sense of self.

- All assessments seen by inspectors contained an analysis, which in most cases had followed the model prescribed by the local authority. Stronger examples were effective in identifying risks and strengths and came to clear conclusions, but in many cases the assessment was too lengthy and included description rather than analysis. This leads to a lack of clarity about the rationale for next steps, and to actions being planned that are not effective in addressing the child's lived experience.

- Since the last inspection, the development of a family group conference service is a strength and has had a positive impact on children and their families. Conferences are taking place for a wide range of children and result in some effective support to enable them to either stay at home, or to live with other family members. Conferences result in detailed and practical family plans, with good-quality work, which relate closely to the lived experiences of families. The use of family group conferences has improved the way that families are engaged in assessment and planning, particularly the inclusion of absent fathers. This has resulted in some positive plans which involve both parents or other family members, even in complex extended family relationships.

- However, this strong work is not used well to strengthen the impact of child in need or child protection plans. Although there were stronger examples of outcome-focused planning, with clear and easily understood targets and timescales, most plans were weaker, with unclear or no outcomes identified. This led to drift and delay for some children who live in neglectful situations for too long without their situation improving.

- Where children's circumstances do not improve, appropriate consideration is given to legal action through the Public Law Outline. Since the last inspection, greater oversight from senior managers has ensured better progress of pre-proceedings work. There is now regular review and tracking of progress, with decisions being made based on up-to-date assessments.

- There has been improvement in ensuring that processes are consistently followed, but the quality of work is not consistently good. Letters before proceedings are not always clear enough for parents to understand what needs to change. Poor planning leads to reviews of progress being ineffective, with professionals often measuring activity for compliance rather than real change for children. For some children, pre-proceedings end too early without workers ensuring that their situations have really improved and without contingency plans in place.

- Evidence of management oversight is present on children's case records, but the quality remains variable, with most being focused on compliance rather than demonstrating reflective discussions about practice. Management oversight is not yet effective enough, and often does not have enough impact to prevent drift and delay for children or ensure that they get the best possible service.

- Social workers feel supported by their managers and have access to them for informal help when needed. All social workers seen receive regular supervision, but records of discussions are often about attendance and compliance with intervention rather than about impact for children. Actions are followed up from previous supervision but tend to be brief and lack clear objectives or timescales.

- Despite a recommendation from the inspection in 2017 that practice in response to neglect was an area for improvement, the partnership has not progressed this work quickly enough. The re-launched neglect strategy does not identify or evaluate what people in the local area need. Neither does it identify priorities or actions for improvement. The action plan is not yet implemented, 12 months after the recommendation was made. The proposed multi-agency audit of the partnership response to neglect has not taken place.

- There has been some training to raise awareness of the strategy and a focus on ensuring that the graded care profile is used as a tool to support assessment. However, this work has not been enough to lead to consistent improvement in the responses of all partner agencies to some children experiencing neglect.

- The local authority has responded to feedback from the last inspection by developing additional good-quality performance reports to include child-level data that enables individual case monitoring. Wider performance data is presented in a clear, understandable way, with targets and comparator information to evaluate progress and performance. Although these reports do not offer commentary to help understand the quality of the work with children behind the data, where there are concerns about areas of performance, additional investigation is undertaken to understand the issues and identify remedial actions.

- Most audits of casework accurately identify strengths and areas for improvement in the practice they are reviewing. However, that learning does not always translate into improvements in practice. There is a lack of consistency in how audits are undertaken. Some workers had taken part in audits and afterwards were given the opportunity to reflect and improve their work with families. Other workers had limited involvement and the feedback given was in writing afterwards rather than face-face, limiting the opportunity for reflection.

- The local authority system to assure the quality of audits is not effective in ensuring that they are consistently accurate or making a difference to children. The focus on audit themes restricts the evaluation of wider practice and the opportunity to look at practice holistically. Cases were seen during this visit that had been subject to an audit but where significant drift and delay for children who

were suffering neglect had not been identified. There was little evidence from reviewing the work on children's files that comments or learning from the audit are systematically used to have a positive impact on practice or on the child's experience.

- At the last inspection, inspectors were reassured by council leaders that resources would continue to be available for children's social care to ensure that children are properly protected. The council reaffirmed this position and stated that it was committed to providing sufficient resources to enable high-quality support.

- The senior management team recognises that to improve the quality of practice and implement the recommendations from the inspection, frontline staff must have workloads that enable them to spend more time with children. During this visit, inspectors were informed that additional resources have been agreed to create more social worker posts, but this has yet to have any impact.

- Caseloads for all staff seen during the visit remain too high. Children do not see their social workers as often as they should. Workers fulfil their statutory duties but are not able to build trusting working relationships with all children that would make a real difference to their outcomes. Newly qualified and inexperienced social workers have too much work. This often includes more complex child protection work which is beyond their level of knowledge and experience.

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

Yours sincerely

Paula Thomson-Jones
Her Majesty's Inspector