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Luton Borough Council

Inspection of children's social care services

Inspection dates: 13 January 2020 to 24 January 2020

Lead inspector: Tracey Scott
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Inadequate

Some services for children have declined since the last inspection. Widespread and serious weaknesses mean that too many children in need and in need of protection do not receive the help they need at the right time. Limited management capacity, exacerbated by changes in senior leadership and increased demand, has contributed to the decline.

A clear focus on transformational change at a strategic partnership level and recent activity to strengthen practice have put in place building blocks for improvement. In some service areas, such as those for children in care and early help, greater stability is helping the authority achieve a more positive impact on the quality of frontline practice.

However, the pace of change has not been enough to address critical weaknesses in practice for children in need of help and protection. Leaders are not fully aware of the impact of these weaknesses on children. In particular, poor decision-making, delay and a failure to take decisive and authoritative action when needs or risks increase mean that some children are left in unassessed or in harmful

situations for too long. Following the focused visit in 2019, the local authority made, and continues to make, strenuous efforts to improve the experiences and progress of children in care.

Although improvements and financial investment have strengthened services by increasing workforce capacity and improving the ratio of permanent staff, caseloads are still too high in some teams to support effective social work practice. Too many children experience frequent changes of social worker.

What needs to improve

- The identification and response to risk and need in the multi-agency safeguarding hub.
- The clarity of purpose and quality of practice during pre-proceedings.
- The quality of child in need and child protection plans.
- The response to 16- and 17-year-old homeless young people.
- The timeliness of initial health assessments for children in care.
- The provision of life-story work for all children in care.
- The completion and impact of return home interviews for children missing from care.
- The sufficiency of local placements to meet the needs of children in care.
- The environment in which care leavers meet their personal advisers.
- Care leavers' access to their health histories and an awareness of their rights and entitlements.
- The rigour and impact of manager oversight in ensuring that children's plans are progressed, and that they are protected from harm.
- The stability of the workforce and the number of changes in social workers that children experience.
- Social workers' caseloads, which are too high in some teams.

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The experiences and progress of children who need help and protection: inadequate

1. Services for children in need of help and protection in Luton are inadequate. Serious and widespread failures mean some children are exposed to potential or actual harm for too long and are not appropriately protected. The risks and needs of children are not sufficiently identified in the MASH or, subsequently, when children's situations decline or do not improve. This includes strategy discussions not taking place, some children waiting too long to be seen for the first time, children being referred to early help when the level of concern indicates statutory social work support is required, ineffective responses to the needs of 16- and 17-year-old homeless young people, and insufficient oversight for children involved in pre-proceedings. Too many children are not getting the help they need at the right time.

2. More children and their families now benefit from early intervention as a result of work with partners to strengthen the early help offer. The Early Help (EH) service supports children and their families well, leading to improvements for children. Practitioners tenaciously support children in order to prevent needs escalating. They continue to do so when children's needs require a higher level of intervention.

3. Thresholds are not applied consistently in the MASH. As a result, some safeguarding referrals are redirected inappropriately to early help services. In some other children's cases, intervention that should step up from early help to children's social care is prevented from doing so by the MASH. For a small number of children, concerns that would normally justify a strategy meeting are downgraded. Inspectors also saw examples where the need to consider a child protection investigation had not been identified in the MASH or on allocation in the assessment team. These children do not have the benefit of multi-agency information-sharing in order to inform risk analysis and subsequent timely planning and intervention for child protection investigations.

4. Staff take decisive protective action when they recognise that children's needs have increased and there are concerns for their safety. Multi-agency strategy discussions are used effectively to share information, analyse risk and appropriately plan child protection investigations. Child protection investigations are comprehensive, and most lead to the right outcome. Interim safety planning is not consistently considered or well evidenced on children's records.

5. Caseloads in the assessment team are too high. As a result, there have been delays in some children's needs being assessed and met. This is exacerbated by poor initial decision-making in the MASH; the seriousness of concerns for children is not always recognised, and subsequent visits to children are not always timely. The local authority recognises this, and leaders have taken steps to increase capacity to meet the demand. Most assessments are reasonably comprehensive, consider the child's history, use multi-agency information to gain a more holistic view and have a clear focus on the child. However, some do not explore the

impact of diversity and the child's experience in enough depth. Most assessments conclude with the right plan for children. Social workers use observation and a range of tools to build relationships with children and gain an understanding of their experiences, wishes and feelings.

6. Once they are transferred to the family safeguarding teams, most children are seen regularly and at appropriate intervals. However, too many children experience repeated changes of social worker. This affects their capacity to form meaningful relationships with social workers and contributes to a loss of momentum in progressing some children's plans.

7. The quality of plans for children in need of help and protection is too variable. Some have too many actions and lack clarity. This is confusing for families and dilutes the focus of the professionals involved. Better plans identify key needs and actions and are clear about outcomes and timescales. Adult workers within the family safeguarding teams bring added value, intervening effectively with families where issues of parental substance misuse, domestic abuse and mental health are causing significant harm for children. While child protection conferences are well attended, child protection planning is not always effective in addressing continuing or increasing concerns for children. Consequently, some children are left in harmful situations.

8. The local authority is sometimes too slow to take decisive and effective action when concerns for children do not reduce or risks increase. Pre-proceedings are not well understood or used effectively by practitioners and managers. Too few children are subject to pre-proceedings, and when they are, this does not consistently lead to authoritative action to safeguard them. Consequently, some children come into care too late and in an unplanned way. Senior manager oversight and tracking of these arrangements are not rigorous enough in mitigating these shortfalls.

9. The local authority's response to vulnerable 16- and 17-year-olds who present as homeless is not good enough. There is too much emphasis on diverting these children away from statutory intervention, without an assessment of their needs or of whether they would benefit from being looked after by the local authority. This leaves some children living in unsuitable and unsafe situations and their needs not being met. Leaders accepted the deficits in practice that were identified by inspectors.

10. Disabled children benefit from child-focused intervention and clear assessments of their needs. They are safeguarded effectively through timely recognition and response to risk. Children who are privately fostered are well supported. They live in suitable accommodation and their needs are assessed and reviewed effectively. Experienced and suitably qualified designated officers, who are well regarded across the partnership, provide highly effective oversight and management of allegations against professionals in Luton. Staff are responsive and work proactively to identify and support children who are electively home educated and children missing from education.

11. Good-quality return home interviews completed by the missing persons coordinator with children who have been or who go missing from home provide a rich picture of push-and-pull factors and associated risks. Information and intelligence are shared promptly and effectively with the police and other partners. While a sensitive and child-centred approach supports children at risk of exploitation, some plans are not specific enough to provide an effective means of understanding vulnerability, reducing risk or increasing safety. Careful consideration is given to arrangements for children who need alternative education provision, taking account of their safety as well as their educational needs. Leaders recognise that there is more to do to fully embed practice in response to risk outside of the family, and they are taking steps to establish a specialist team for this area of work.

12. The local authority's response to children at risk of radicalisation is a real strength. A knowledgeable, specialist worker brings added value and depth to social work understanding and intervention. Tenacious, proactive social work is helping to reduce risks for children.

13. When female genital mutilation or forced marriage is identified as a potential concern, swift and authoritative action is taken to reduce the risk. However, subsequent action is less meaningful, and children do not always have the benefit of an appropriate level of visits or direct work to understand their situations and reduce risk.

14. Social workers receive regular supervision. However, management oversight and critical challenge are not sufficiently rigorous to address serious shortfalls in practice and ensure that children's assessments and plans progress without delay. Senior managers' oversight and support has not been sufficient to address these shortfalls.

The experiences and progress of children in care and care leavers: requires improvement to be good

15. When it is no longer possible for children to continue to live safely at home with their birth families, social workers make every effort to find suitable alternatives with family or friends, including with families overseas. Most children who need to come into care do so in an unplanned way, and some should come into care sooner. This means that, for some, the right foster home is not available, and they experience an unnecessary subsequent move. This issue has been a real focus for leaders, and the number of moves children experience is reducing. The continuing shortage of foster carers in Luton means that too many children are living at a distance from family and friends.

16. In the last six months, the local authority has strengthened its approach to permanence. Persistent efforts are made to secure adoption for children where this is appropriate. Managers have good oversight of children for whom permanence is the plan; they provide rigour and challenge to ensure that plans are progressed. However, some children are still waiting too long for permanence to be achieved.

Social workers carefully consider whether it is possible and appropriate to keep brothers and sisters together. Assessments and plans for children to return home are not always well recorded. This will make it difficult for children to make sense in later life of significant decisions made for them. It also contributes to a lack of clarity about the level of support in place when children do return home.

17. Children have up-to-date, comprehensive health assessments, dental and optician checks, although initial health checks when they first come into care do not happen quickly enough. Professionals routinely use strengths and difficulties questionnaires to understand children's emotional well-being, but it often takes too long for them to access relevant support if they need it. The virtual school works well with other providers to support the educational progress of children in care. Leaders understand how well pupils are learning and developing in school. The virtual school staff regularly attend meetings to oversee pupils' personal education plans (PEPs) and make good use of information to ensure that pupils get the support they need. The virtual school takes a robust approach to challenging permanent exclusions where appropriate. Overall, school attendance for children in care is increasing and exclusions are falling.

18. Most care plans for children in care are clear, specific and measurable. Children are encouraged to participate in or contribute to their reviews, most of which are timely. Review minutes are comprehensive and detailed and are focused on the child's experiences and progress. They lead to clear, straightforward recommendations. Decisions taken, and actions agreed at previous reviews, are systematically and rigorously reviewed in a way that helps to avoid or reduce drift or delay. Independent reviewing officers (IROs) are effective advocates for children in care. They provide sensitive but suitably rigorous critical challenge when things are not going well.

19. Increased capacity and stability within the looked after children team have improved the frequency of social work visits to children in care and mean they have fewer changes of social worker. Some children, however, have experienced multiple changes of social worker, making it very difficult to have meaningful relationships with them. IROs provide stability and continuity for children. Most children benefit from longstanding relationships with their IRO.

20. Systems and processes for supporting young people missing from care are reliant on social workers referring to an independent agency rather than a dedicated person within the service, which is the case for children in need of help or protection. In marked contrast to children missing from home, when children go missing from care, they are not routinely offered an opportunity to talk to an independent person about why they went missing and the risks they may have been exposed to.

21. Most foster carer, connected carer, adopter and special guardianship assessments are comprehensive and insightful, but some are taking too long. Fostering and adoption panels scrutinise assessments rigorously and provide constructive

challenge and feedback. Adopters and foster carers speak positively of the support they receive.

22. A greater focus on early permanence is having a positive impact on some children. Permanency planning meetings are comprehensive, and child focused. Action is taken to progress plans for children. Careful consideration is given to arrangements for children to spend time with family and friends. When this needs to be supervised, a well-run contact centre helps to create an environment in which children and their families can enjoy their time together.

23. Workers are persistent in achieving adoption when this is the plan for the child. Children whose plan for permanence is not through adoption are not supported to gain an understanding of their life histories through life-story work. This gap means that children do not have the opportunity to fully understand and explore with a trusted adult why they cannot live with their parents. Leaders recognise this omission and have plans to address this soon.

24. For a period since the last inspection, a lack of marketing and recruitment activity reduced the pool of Luton adopters significantly and there is now a shortfall of adopters. Luton is now part of the Adopt East Alliance regional adoption agency. Recent activity has been successful, and the number of adopters has started to increase. Timeliness to achieve adoption is improving, but some children are waiting too long. Adopters are well prepared to care for their children and post-adoption support is effective. Life-story books are completed and used to help children understand their identity and history.

25. An active and committed young people's panel, the children in care council, has influenced service delivery, recruitment and training within the council. A young commissioner role has strengthened quality assurance processes and provides a greater depth of understanding about young people's lived experiences. The children in care council's relationship with the corporate parenting board has improved, but some of the young people feel frustrated by the lack of tangible progress on a number of key issues, including improving support for children's mental health and emotional well-being and addressing the lack of direct work with children to help them understand why they are in care. While progress has been made in some of these areas, this has not always been effectively fed back to the young people's panel.

26. Pathway and transition planning start too late for children in care. Once they are in the care leavers 18+ team, most care leavers have purposeful pathway plans that take good account of risks and needs.

27. An increased focus on compliance means that the local authority is now in touch with the vast majority of its care leavers. Personal advisers work hard to engage and get alongside young people, often going the extra mile to support them at times of crisis. However, some young people experience too many changes of worker. The office accommodation of the leaving care team does not provide space

for sensitive information to be shared by young people confidentially or provide a welcoming physical environment for them.

28. Most care leavers are living in suitable accommodation, including staying put arrangements with their former carers. However, the practice of returning to a panel to ratify the plan post-18 means that some young people are left too long with uncertainty about the support they will receive into adulthood. A very small number of particularly vulnerable 16- and 17-year-olds are living semi-independently in placements that do not meet their needs.

29. Care leavers who are struggling with their mental health and emotional well-being do not always get the help they need when they need it. Not all young people have easy access to their health histories or know about the care leaver offer. Leaders recognise that the completion rate for post-16 PEPs is low, and they are already working to address this. The proportion of 17- and 18-year-old care leavers entering sustained employment, education or training has, over time, been slightly lower than the national average. While there are some clear strategies to support older care leavers, these are less evident for this age group. A council-wide mentoring scheme is helping young people to explore opportunities that might not otherwise be open to them. Care leavers are benefiting from the guaranteed interview scheme.

The impact of leaders on social work practice with children and families: requires improvement to be good

30. The local authority is outward-facing and has sought external scrutiny and support via partners in practice to support improvements. This activity has highlighted poor understanding of thresholds across the partnership. In response, the local authority is implementing an action plan, beginning work to revise the threshold document and strengthening the interface with early help and the MASH. Overall, the focus has been on systems and processes, with not enough attention given to addressing the impact of poor decision-making and delay on children.

31. Quality assurance activity and impact has been strengthened following the introduction of a new service director for quality assurance, practice and innovation post and subsequent investment in increased capacity. A focus on improving the reach and effectiveness of quality assurance arrangements over the past six months has brought a shift from compliance towards a consideration of quality and impact. This renewed focus has led to improvement in the effectiveness of practice audits, which are more accurately highlighting shortfalls in the quality of practice. Social workers are better supported to reflect on findings, and actions from audit are followed through. Performance and accountability meetings with service directors and service managers are strengthening the director of children’s services line of sight to practice and have helped to make progress in some areas.

32. Good-quality performance information is available to support managers, but this is not always used effectively to drive better practice in teams. For example, progress

in improving the delivery of return home interviews when children in care are missing is stubbornly slow. Senior manager oversight of pre-proceedings work has not been effective enough to consistently ensure that timely, decisive action is taken to reduce harm to children and keep them safe. An improvement plan co-developed with frontline workers has seen some success in improving performance and timeliness in some areas, for example the timeliness of completing assessments and visits to children in care.

33. Financial investment has supported a reduction in caseloads across most of the service, but these remain too high in some teams. Staff turnover in the assessment team has led to incoming locum social workers being allocated sizeable caseloads almost immediately on arrival. This means that it is hard for some children to develop meaningful relationships with their social workers. The resulting lack of continuity contributes to delay and a lack of decisive action where risks for children are not reducing. While most frontline managers are now permanent members of staff, too many social workers have had too many changes of manager. This has limited the pace of improvement and has undermined continuity in decision-making.

34. The recruitment and retention of social workers is a real challenge and is an area of key service and corporate focus. Turnover of staff is still high, but is beginning to reduce, and the local authority has been successful in working with some locum staff to accept permanent contracts. Luton has a strong ethos of 'growing their own', and social workers and personal advisers are supported to gain professional qualifications to further their careers. A comprehensive training programme is available, and all staff, including locum practitioners, are encouraged and supported to attend.

35. Currently, the local authority does not have enough foster carers. In January 2019, remuneration allowances were brought in line with independent fostering agency rates. Since that time, the local authority has noted that carers are positively engaging and actively involved in marketing events. A recent radio campaign saw an increase in the number of enquiries. Strengthened commissioning arrangements mean that senior leaders have better oversight of placement sufficiency. Despite continued challenges in the sufficiency of local placements, placement stability is improving, and children are experiencing fewer moves than previously. Recent work involving young commissioners in quality assuring semi-supported accommodation for young people has ensured that most are better supported, although a very small number have been living in accommodation that did not sufficiently meet their needs.

36. Leaders demonstrate commitment to their role as corporate parents. The lead member and young people speak warmly of each other and there is evidence of genuinely good relationships and care between corporate parents and young people. Investment in a mentoring scheme is opening opportunities for a small, but growing, group of young people. Young people are supported to remain with their carers to better support them in making the transition to adult life. Young people have a strong voice in Luton and have influenced service delivery and practice in a

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wide range of forums. However, they are frustrated by the time that some actions take to progress.

37. Leaders have acted to increase frontline management capacity in order to improve oversight of practice. However, managers and child protection chairs are not consistently providing the right level of critical challenge and are not ensuring a more decisive response for some children, such as those in pre-proceedings. IROs are better at this and provide much stronger challenge and oversight in supporting the progress of children’s plans.

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