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Dear Tolis

Third monitoring visit of Buckinghamshire children's services

This letter summarises the findings of the monitoring visit to Buckinghamshire children's services on 22 and 23 May 2019. This was the third visit since the local authority was judged inadequate for overall effectiveness in January 2018. The visit was conducted by Donna Marriott, Nicola Bennett and Pauline Higham, Her Majesty's Inspectors.

Since the last inspection, the local authority has made steady progress in improving the quality of intervention when children are first referred to the multi-agency safeguarding hub. Most children are receiving helpful support when they are first referred to children's social care, but variable practice remains evident within both the multi-agency safeguarding hub and assessment teams.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made, with a particular focus on:

- the quality of management decision-making in the multi-agency safeguarding hub (MASH) and the application of thresholds for intervention
- the quality, effectiveness and impact of assessment and planning in managing risk and improving children's outcomes when they are first referred to the local authority
- the arrangements in place to respond to children missing and at risk of exploitation
- the quality and timeliness of supervision, management oversight and decision-making, social work capacity and caseloads.

A range of evidence was considered for the visit, including electronic case records, discussions with social workers and their managers and reviewing other supporting documentation.

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Overview

Leaders are making steady progress in improving the service to children when they are referred to children's social care. The multi-agency safeguarding hub (MASH) provides a mostly effective response to children's needs for early help and statutory intervention. Systems in the MASH are efficient, leading to timely and decisive action for most children.

Considerable work has taken place to strengthen social workers' and managers' understanding of thresholds. This has led to more confident, timely responses for most children. However, for a small minority of children, strategy discussions are not always convened when they are needed. This leaves children in situations of unassessed risk of potential harm.

Management oversight has been strengthened since the last monitoring visit, and social work caseloads have reduced. This is beginning to provide social workers with the conditions they need to better support children and families.

Findings and evaluation of progress

Action taken by leaders during 2018 to tackle poor performance in the First Response service, initially led to a period of instability and high staff turnover. This resulted in difficulties in allocating children's cases for assessment during the latter part of 2018. Some children were nominally allocated to managers and waited too long to have their needs assessed. Leaders have worked purposefully to respond to these shortfalls, leading to substantial improvements. At the time of this monitoring visit, all children who need a statutory assessment have an allocated social worker, and the majority referred for statutory support now receive a timely response.

The MASH provides a mostly effective response when children are first referred. Work to strengthen systems and increase efficiency has led to improvements in the timeliness of referrals being progressed. Initial screening decisions are timely and appropriate. Contact and referral officers rigorously gather background information to inform next steps. Information-sharing with partners is effective and parental consent is routinely sought when appropriate.

Considerable work has taken place to ensure thresholds are applied more consistently. This has included multi-agency training and reviews of 'live' cases with MASH staff. This has strengthened the quality of referrals from agencies, led to more consistent decision-making in the MASH and reduced the number of referrals that do not meet the threshold for children's social care.

Children and families benefit from a range of early help services, but the early help service is under-developed. Performance information is too limited to inform an accurate understanding of the effectiveness of the service. Leaders have worked proactively with partners at a strategic level to redesign the early help offer, with a plan to launch the new service in September 2019. More work is needed to engage

all professionals, such as school staff, in providing early help interventions for children to prevent need escalating.

Thresholds for early help are appropriately applied by managers in the MASH. The development of the early help hub in the MASH has been positive in strengthening communication between MASH and early help services. Management oversight of the work allocated to early help within the MASH is regular but is not always sufficiently clear or timebound. When children's cases do get transferred to this part of the service, they are not allocated to specific officers to progress actions, which results in unnecessary delays in progressing some referrals, preventing timely assessment of children's needs. Workers in the early help Family Resilience Service provide a range of interventions to support children and parents. Not all intervention is effective in helping to improve family circumstances, as delays are evident in stepping a small minority of children's cases up to social care when their needs escalate or their circumstances do not improve.

Managers in the MASH ensure a timely and effective response to concerns regarding domestic abuse. The recently introduced daily triage meetings provide a forum for reviewing lower risk domestic abuse notifications from the police. These result in timely and appropriate decision-making about next steps, but no record is kept of these important decisions. This has the potential for the assessment of risk or need to not be informed by important historic information.

When children need protecting, the response is mostly effective, but the threshold for child protection intervention is not consistently applied. Although managers in the MASH recognise when children are at risk of, or have suffered from, significant harm, strategy discussions are not consistently held in a timely manner, which causes unnecessary delay. This is to some degree mitigated by the timely and decisive action taken by the assessment teams, though this is not always the case. In addition, in a small minority of children's cases, not all relevant agencies are consistently engaged in strategy discussions, particularly health partners.

Contact and referral officers in the MASH ensure that there is effective oversight of children who go missing. Not all children who go missing are offered return home interviews and, when they are offered, they are not always completed. Those that take place are not always completed in a timely way. Leaders recognise that this is an area for improvement and are working to improve practice in this area. The recording of return home interviews is of good quality, is suitably probing and demonstrates sensitive exploration of the incident with children to better understand their circumstances.

Considerable work has taken place to strengthen the strategic response to children missing and at risk of exploitation. The child exploitation team has recently been restructured to improve the oversight of children at risk of exploitation and to provide them with a more coordinated response. However, it is too early for this change to evidence any positive impact. When new concerns come to light about children at risk of exploitation, appropriate action is taken. Strategy meetings are

held quickly and result in a plan to reduce the risk of harm, or further harm, to children. Leaders and managers across the partnership recognise the importance of disruption activity, and they are proactive in taking action to ensure that children are safeguarded.

Most children are visited regularly, but sometimes initial visits to children take too long and there can be gaps in visiting after initial intervention. This is an improving picture, with most managers closely monitoring performance to see if visiting is proportionate to children's needs.

Most child protection enquiries are thorough and lead to appropriate decisions. The quality of recording of the child protection enquiry remains too variable, with insufficient analysis. When children are identified as being at risk of significant harm, this leads to decisive and timely action to safeguard them, including convening child protection conferences to develop initial protection plans when these are required. Progress has been made in the timeliness with which initial child protection conferences are convened, but there are still some delays evident.

Leaders have acted to improve the timeliness with which children's needs are assessed, with an increasing proportion assessed in a timely manner. Most assessments effectively identify risks and needs, but not enough are individualised for each child in the family and include an analysis of need and risk for the child, or of the parent's capacity to care for the child.

Leaders' persistence in seeking to strengthen management oversight is beginning to deliver results. Supervision is taking place and the quality of management oversight has been strengthened. Managers are now more consistent in driving children's plans and supporting social workers, although leaders recognise that this work is not yet of the consistency, quality or regularity needed. The leadership team rigorously overview service performance, making good use of data and performance information, holding managers to account for performance through the introduction of team scorecard reporting. This is further triangulated by regular dip sampling of children's cases by senior managers to ensure have a good understanding frontline practice.

The senior leadership team has a sound understanding of the improvements that are needed in children's services and is steadfastly determined to improve the quality of services for children. Leaders are acutely aware of the importance of creating strong foundations to ensure that social workers and managers have the right conditions in which to carry out their work. Although social worker and manager turnover remains high, leaders are beginning to see greater stability in the service. Where needed, capacity has been increased. Caseloads, although still too high for some social workers, are beginning to reduce, with a considerable reduction in caseloads across the service since the last monitoring visit. Managers now have the capacity to allocate children's cases when they are first referred, though some pressures remain.

Staff spoken to during the visit told inspectors that they enjoy working in Buckinghamshire. They report being well supported by managers, and that leaders are visible and approachable. Newly appointed staff receive a thorough induction, which helps their transition into the service.

Thank you and your staff for your positive engagement with this monitoring visit. I am copying this letter to the Department for Education. It will be published on the Ofsted website.

Yours sincerely

Donna Marriott
Her Majesty's Inspector