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Mr David Johnston
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Dear David

Monitoring visit of Buckinghamshire children's services

This letter summarises the findings of the monitoring visit to Buckinghamshire children's services on 30 November and 1 December 2016. The visit was the second since the local authority was judged inadequate in August 2014. The inspectors were Linda Steele HMI and Donna Marriott HMI.

Based on the evidence and cases seen by inspectors during this visit, the local authority is making steady progress to improve services for children in some areas. The local authority has taken action to strengthen practice in respect of children at risk of sexual exploitation and children who go missing, but the pace of improvement in these areas is not meeting expectations and the use of the public law outline is not yet effective.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the areas of children looked after with a focus on:

- thresholds for care, the quality of support provided, management oversight and recording on children's case files
- the effectiveness of the public law outline and legal planning meetings
- the capacity and effectiveness of the independent reviewing service
- timeliness and quality of health assessments
- the response to children looked after who go missing and/or are at risk of child sexual exploitation.

The visit considered a range of evidence, including electronic case records, and other information provided by the judiciary, Children and Family Court Advisory Support Service (CAFCAS) and the local authority's commissioned legal service. In addition, we spoke to a range of staff including managers, social workers and independent reviewing officers (IROs).

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Summary of findings

- Social work practice has improved for children entering care in the last six months. However, drift and delay are still evident for some children who have been subject to statutory intervention for some time.
- Decisions for children to become looked after in the vast majority of cases seen by inspectors were timely and appropriate.
- Management oversight is evident in case files, through unit meetings and supervision but is not always effective in driving children's plans, or ensuring that actions are completed.
- Social workers do not regularly update assessments in response to children's changing circumstances.
- Risk assessments of children looked after vulnerable to, or at risk of, sexual exploitation are inconsistent and in some cases absent.
- There is evidence of proactive work to disrupt and respond to concerns of sexual exploitation, including the use of sexual harm orders and abduction notices.
- Social workers see the vast majority of children looked after on their own and visit them regularly, according to their plan, which is often more frequently than prescribed by statutory guidance.
- The quality of the recording of interviews, carried out by commissioned services, when children return after going missing is poor. Return home interviews are not timely and the take-up by children is not good enough.
- The system in place to monitor the progress of work, which meets the threshold for public law outline, is not effective. The pre-proceedings tracker is not regularly updated, monitored, or used by managers and therefore does not give a coherent overview of public law outline work.
- Too many children are waiting for important life story work to enable them to understand their life histories.
- There has been investment in the IRO service, which has resulted in increased capacity and real improvement in the service. Consequently, IROs are now rigorously monitoring children's progress; they advocate for children and hold social workers and managers to account.
- There has been significant improvement in the timeliness and quality of health assessments for children looked after.
- The judiciary and the Children and Family Court Advisory Support Service report positive improvements in the quality of practice in court proceedings.

Evaluation of progress

The current leadership team has been effective in achieving improvements in some parts of the service, most notably in the work carried out to strengthen the independent reviewing service, stabilise the workforce, and improve the timeliness and quality of children's health assessments. Senior managers have strengthened their auditing tool, which now places an increased emphasis on the quality of social work practice. As a result, there is greater focus on outcomes and the child's lived experience

Despite evidence of stronger managerial grip in some areas since the last inspection, there remains too much variability for children in care. Some managerial decision-making does not effectively drive children's plans to ensure that they receive appropriate intervention. Social workers do not always complete actions from supervision and managers do not rigorously track or challenge the lack of progress. Consequently, there has been drift and delay for some children. Inspectors saw children in a very small minority of cases where they had been in unsatisfactory circumstances for too long. A more robust approach to performance management and auditing had been effective in enabling managers to identify these shortfalls and take appropriate action.

Assessments and care plans do not consistently demonstrate a comprehensive analysis of children's needs. When children looked after return to the care of their parents under legal orders, assessments to ensure suitability are not sufficiently robust and not always completed. Social workers do not always update assessments with significant events in children's lives, and this contributes to drift and delay. In a small minority of children's cases, care plans were not available for the first review.

Recording in children's case files is improving. Helpful summaries of the child's journey identify key issues. Children's wishes and feelings are evident in case recording. However, there continue to be delays in uploading key documents to children's files. For example, legal planning meeting minutes, public law outline letters, and return home interviews.

The judiciary report positive improvements in the timeliness of court proceedings and the quality of evidence presented. In most cases the quality of evidence is now good. CAFCAS report the local authority is responsive and communicates well with them.

When the plan for children is not to return home, life story work is not always available when needed by the child. This means some children have gaps in their knowledge and understanding about their histories. Senior managers are aware that there are 61 children currently waiting for life story work. A reconfiguration of the service will increase capacity but has not yet reduced the number of children waiting for this work.

When children looked after go missing, they do not routinely receive timely return home interviews to gather intelligence and develop a more comprehensive

understanding of the risks. Prior to this monitoring visit, managers had already identified that the arrangements to protect children missing from care and home needed strengthening. They have taken action to review and recommission the return interview service, strengthen missing procedures and appointed a 'missing children' coordinator. This work is in development and the impact is too early to consider.

The response to children looked after who are vulnerable to or at risk from sexual exploitation is inconsistent and not as effective as it is for new referrals to the multi-agency safeguarding hub and SWAN unit (child sexual exploitation unit). Not all children looked after have an up to-date-assessment that identifies risks or effectively drives planning. There is further work needed to provide a more coherent and joined up approach to the management of risk for these children. Nevertheless, there is evidence of proactive work to disrupt and respond to concerns of sexual exploitation, including the use of abduction notices and sexual harm orders. Senior managers have recognised the weakness in practice in this area and have undertaken work, including developing the case management system to ensure a more coherent holistic overview is available.

When children are on the edge of care, the use of the public law outline is not always effectively used. Public law outline letters are not always clear or written in a language that is accessible to parents and carers. Management oversight of pre-proceedings is not consistent and the tracking of this work lacks rigour, which means that there is not a clear overview of public law outline work. Consequently, public law outline processes do not always ensure a robust or timely response to escalating risks.

Social workers see the vast majority of children looked after on their own with visiting tailored to children's individual needs. They talk knowledgeably about the children they support and reflect their views in case records. There is evidence of direct work to build relationships and help children understand their experiences, but this would benefit from being more structured to ensure that it is responsive to children's needs. While ethnicity is on record, the wider impact of equality and diversity is not always fully explored. Social workers report caseloads in the children looked after units, of 16 to 20 children, as manageable. The vast majority of social workers in the children in care units are now permanent staff.

Since the inspection in August 2014, the local authority has invested in the IRO service, which has resulted in the appointment of permanent IROs and manageable caseloads. The majority of reviews of children looked after take place on time. Children are encouraged to attend, and IROs routinely see children before their reviews. IROs are robust in challenging drift and delay on cases and escalating concerns about the support provided to children.

Senior managers and health partners have responded positively to the findings of the last inspection and have significantly improved the quality and timeliness of health assessments.

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

Yours sincerely

Linda Steele

Her Majesty's Inspector

The letter is copied to the Department for Education [at SocialCare.INSPECTION-IMPROVEMENT@education.gsi.gov.uk]