

Buckinghamshire County Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

Inspection date: 3 June – 25 June 2014

Report published: 8 August 2014

The overall judgement is that children’s services are <u>inadequate</u>	
It is Ofsted’s expectation that, as a minimum, all children and young people receive good help, care and protection.	
The judgements on areas of the service that contribute to overall effectiveness are:	
1. Children who need help and protection	Inadequate
2. Children looked after and achieving permanence	Inadequate
2.1 Adoption performance	Requires Improvement
2.2 Experiences and progress of care leavers	Requires Improvement
3. Leadership, management and governance	Inadequate

The effectiveness of the Local Safeguarding Children Board (LSCB) is **inadequate**.

The LSCB is not demonstrating that it has effective arrangements or the required skills to discharge its statutory duties.

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Section 1: The local authority - Summary of findings

Children's services in Buckinghamshire are inadequate because:

1. Political leaders and chief officers state that children's social care is not in the top two priorities for the Council. This limits the effectiveness of those with lead responsibility for Children's Social Care to drive up standards and sustain longer-term change.
2. Failures by Buckinghamshire's safeguarding services are widespread and serious. The result is that children are not being effectively protected. Children and young people do always not receive help when they need it.
3. For some months, leaders in Buckinghamshire, including elected members, have had concerns about the quality of services delivered by some social work teams. However, there has been too little analysis of where problems lie and, as a result; remedial action and investment have not led to improvements.
4. Failures in some parts of the service are serious, particularly in assessing and responding to children and young people in need of help and protection. At the time of this inspection, a high number of children in need of statutory intervention and protection were without an allocated social worker. As a result, too many of them are at risk of harm. The level of unallocated work is a long-standing problem.
5. Arrangements to prioritise unallocated work are unsafe. Some children who require continuing help and protection are not allocated to a social worker. Responses to them are piecemeal, with tasks allocated to different social workers. Decisions to close cases without social workers seeing and speaking to children exacerbate risks.
6. Case loads are too high in some areas of the service and this means that social workers are unable to do their jobs effectively. Agencies do not agree about the threshold for intervention by children's social care.
7. Many case records are poor. They do not accurately reflect the child's experiences and important documents are left blank.
8. Care for some looked after children is not good enough. Managers do not know if all statutory visits are completed because performance information is missing. Over 50% of looked after children are placed outside Buckinghamshire and this affects the availability and timeliness of services to meet their needs.
9. Not all young people leaving care have an up-to-date plan. For some, preparation for leaving care starts too late. In addition, the proportion of care leavers who are not in education, employment or training (NEET) is significantly higher than that for Buckinghamshire's young people as a whole.

10. Supervision of social workers is of poor quality and managers' oversight of practice in many teams is inconsistent. At all levels, too many managers are temporary.
11. The system for quality assurance and performance management is ineffective. A number of internal and external audits of social work practice have identified concerns but managers have not taken effective action to address these.

What does the local authority need to improve?

Priority and immediate action

12. Review all unallocated cases that have been closed without the child's needs being assessed and ensure that any necessary action is taken to meet them.
13. Ensure that the local authority as a whole takes responsibility for and prioritises the improvements needed in children's social care.
14. Ensure that all partners understand and agree on the multi-agency thresholds document, that it is implemented and monitored effectively, and that it is supported by clear guidance.
15. Ensure that there are enough suitably qualified and skilled social workers and first-line managers to provide services that are safe, responsive and effective.
16. Ensure that, when children and young people are referred to children's social care, there is sufficient capacity in this part of the service to undertake the work effectively, and that children are assessed swiftly so that their safety is secured.
17. Ensure that suitably qualified staff undertake assessments, that these focus on the needs and wishes of the child, provide a thorough assessment of parental attributes, consider historical factors, and analyse risk and resilience factors in detail.
18. Ensure that information about children and families is shared and recorded in line with legislation and case law, with consent obtained except in circumstances where it would heighten risk of significant harm to a child or young person. Ensure that historical information is included so that risks can be better analysed and understood.
19. Ensure that children and young people are visited regularly, seen alone by their social workers, and have enough time with them to build and maintain positive relationships.
20. Ensure that case records contain an accurate account of the child's experiences, an analysis of their cultural, religious and diversity needs, and detailed reasons for key decisions.
21. Ensure that child protection strategy meetings, discussions and conferences consider the views of all relevant agencies and professionals when determining how to proceed.
22. Ensure that all plans for children and young people focus on their assessed needs, with clear timescales and outcomes by which progress can be measured.

23. Ensure that core groups consistently review progress in achieving the aims of the child protection plan and that escalation processes follow if parents fail to engage.
24. Undertake timely statutory visits to all looked after children and record on the children's case files whether they are spoken to alone.
25. Ensure that managers' decisions for children to return to their families are clearly recorded and supported by a risk assessment and support plan to enable them to be reunited successfully.
26. Ensure that allegations of abuse, mistreatment or poor practice by professionals are dealt with promptly and recorded accurately.

Areas for improvement

27. Ensure that the local authority and partners coordinate and target early help effectively, so that families receive support when their need is first identified.
28. Ensure that social work reports presented at reviews for children looked after include an updated assessment and analysis of the child's progress since the previous review to inform future planning.
29. Review and improve the electronic recording system to ensure that information about children is contained in one place and can be easily accessed by staff.
30. Ensure that children's records are accurate and up to date including ensuring that records of looked after reviews meetings, reports and minutes are on the child's case file.
31. Ensure sufficient Independent Reviewing Officer capacity exists for them to undertake their statutory responsibilities, including monitoring children's care plans and visiting children between statutory reviews.
32. Improve the quality of information about individual children in their permanence reports (CPRs) and about prospective adopters in adoption assessments and ensure that a senior manager agrees the reports before they go to the panel.
33. Ensure that all care leavers have a pathway plan to guide their transition to independence. These should include contingency arrangements, take account of their education and health history, and be updated promptly as circumstances change.
34. Improve the timeliness of initial health assessments for looked after children who live outside Buckinghamshire.
35. Ensure that sufficient foster carers and children's home placements are available in Buckinghamshire to meet needs, and that children are placed out of area only when it is part of their care plan.
36. Review all foster carers annually to determine their continued suitability as carers and to identify their support needs.
37. Strengthen work to close the gap in educational attainment at secondary school between looked after children and other pupils in Buckinghamshire and make sure that looked after children have access to 'good' and 'outstanding' schools.
38. Strengthen the representation of care leavers in the Children in Care Council (We Do Care) and ensure that they are influential in revising the Care Leavers' Pledge.

39. Increase awareness and take-up of the 'staying-put' arrangements for young people to remain with foster carers beyond the age of 18 and develop more choice for care leavers' accommodation, including when they need or wish to settle outside the county.
40. Develop further opportunities for care leavers to take up work experience, apprenticeships and work-based learning.
41. Raise the proportion of children in care and care leavers who are in education, employment or training and close the gap between them and other children and young people in Buckinghamshire.
42. Raise awareness of private fostering and assess and support all privately fostered children in accordance with regulations and guidance.
43. Embed the new performance management framework so that managers at all levels have timely, relevant and accurate performance and quality assurance information to enable them to do their jobs effectively and deliver improvements.
44. Review governance arrangements between the Children & Young People's Partnership Board, the Buckinghamshire Safeguarding Children Board (BSCB) and the Health and Well-being Board so that improved outcomes for children and young people are prioritised, tracked and evaluated across the partnership.

The local authority has the following strengths:

45. Many social workers and their managers are committed to the children of Buckinghamshire. Very recent caseload reductions in some teams are making a positive difference. In some cases, feedback from parents and children showed that social workers had made a real difference to their lives.
46. The out of hours Emergency Duty Team (EDT) is well managed. Children's work is supported by ten sessional workers and a duty rota for senior managers.
47. Identification, tracking and risk assessment processes for young people who go missing or are at risk of sexual exploitation are effective.
48. The local authority has sound working relationships with the Children and Family Court Advisory and Support Service (Cafcass) and the district judges. The work of the Family Court team is well regarded by the judiciary. It is helping to reduce court time and leading to timely decisions for children.
49. The local authority is investing in developing the country's third Family Drug and Alcohol Court (FDAC). This is an example of good, innovative practice.
50. The local authority has jointly commissioned a range of services to support vulnerable children and their families. Children and young people are consulted on these and influence their design.
51. Youth services target their work successfully and commission a good range of services, including drug and alcohol outreach. Young carers have access to an array of support services and take-up is high. Support services for disabled children are also good in terms of choice and quality.
52. Eleven per cent of care leavers go on to higher education and are encouraged to do so throughout their school careers. The After Care team supports them well.
53. For most children, adoption is considered at the earliest stage, in case a return to their family would be unsafe or would not meet the child's needs satisfactorily.
54. Disruptions to adoption placements are low (two in the last year) and excellent analysis of these incidents has been used to improve the service.
55. A training programme for 25 newly qualified social workers is comprehensive and well-established, and there is investment in on-the-job-training for 17 staff.

Information about this inspection

The inspectors have looked closely at the experiences of children and young people who have needed or still need help, protection or both of these. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of social work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff worked with families and each other and discussed the effectiveness of the help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand to what extent the local authority knows how well it is performing and what difference it makes for the people it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. The report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

The inspection team consisted of six of Her Majesty's Inspectors (HMI) and one additional inspector.

The inspection team

Lead inspector: Brenda McLaughlin

Team inspectors: Sean Tarpey, Carolyn Spray, Fiona Parker, Neil Penswick, Chris Davies and Dominic Porter-Moore.

Information about this local authority area²

Children living in this area

- Approximately 117,900 children and young people under the age of 18 live in Buckinghamshire. This is 23% of the total population in the area.
- Approximately 11% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 7.2% (the national average is 18.1%)
 - in secondary schools is 5.7% (the national average is 15.1%).
- Children and young people from minority ethnic groups account for 20.9% of all children living in the area, compared with 21.5% in England as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British at 12%.
- The proportion of children and young people who speak English as an additional language:
 - in primary schools is 16.1% (the national average is 18.1%)
 - in secondary schools is 13.6% (the national average is 13.6%).

Child protection in this area

- At 31 March 2014, assessment had identified 2,428 children as being formally in need of a specialist children's service. This is an increase from 1,973 at 31 March 2013.
- At 31 March 2014, 263 children and young people were the subject of a child protection plan. This is an increase from 190 at 31 March 2013.
- At 31 March 2014, three children lived in a privately arranged fostering placement. This is the same as at 31 March 2013.

Children looked after in this area

- At 9 June 2014, 444 children were being looked after by the local authority (a rate of 38 per 10,000 children). This is an increase from 400 (34 per 10,000 children) at 31 March 2013. Of this number:³
 - 231 (or 52%) live outside the local authority area

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where these were available.

³ The categories below may overlap.

- 68 live in residential children’s homes, of whom 69% live out of the authority area
 - 12 live in residential special schools,⁴ of whom 75% live out of the authority area
 - 330 live with foster families, of whom 52% live out of the authority area
 - six live with parents, of whom 17% live out of the authority area
 - 13 children are unaccompanied asylum seekers.
- In the last 12 months
- there have been 30 adoptions
 - 14 children became subjects of special guardianship orders
 - 130 children have ceased to be looked after, of whom 6% subsequently returned to be looked after
 - nine children and young people have ceased to be looked after and moved on to independent living
 - one young person has ceased to be looked after and is now living in a house of multiple occupation.

Other Ofsted inspections

- The local authority operates one children’s home. It was not judged to be good or outstanding in its most recent Ofsted inspection.
- The previous inspection of Buckinghamshire’s safeguarding arrangements / arrangements for the protection of children was in January 2011. The local authority was judged to be good.
- The previous inspection of Buckinghamshire’s services for looked after children was in January 2011. The local authority was judged to be good.

Other information about this area

- The Director of Children’s Services has been in post since January 2006.
- The Chair of the LSCB has been in post since 2006.

⁴ These are residential special schools that look after children for fewer than 295 days.

Inspection judgements about the local authority

The experiences and progress of children who need help and protection

Key Judgement	Judgement Grade
The experiences and progress of children who need help and protection	Inadequate

56. Failures by Buckinghamshire’s safeguarding services are widespread and serious. The result is that children are not being effectively protected. Children and young people do always not receive help when they need it.
57. At the start of this inspection, 261 children of those who met the authority’s threshold for statutory intervention by the First Response Team (FRT) did not have an allocated social worker. In March 2014, the number of unallocated cases was high. The local authority commissioned an external agency to work with these children. Many were living in neglectful and unsafe circumstances and had waited months to receive a service.
58. Key areas of social work practice have fundamental weaknesses, including assessment, child protection, management oversight and supervision. This leaves children and young people at risk of harm.
59. Thresholds for services are not understood. Professionals from other agencies report high levels of concern about intervention by children’s social care. Referrers are not responded to routinely, communication is poor and professionals are worried that children are at risk.
60. The absence of coordinated, early, multi-agency arrangements to support universal services, such as health and schools, is leading to increased referrals to social work services. Recent serious case reviews identified these concerns but they have not been addressed.
61. Referrals made by the police about domestic violence when children are present do not contain enough information for an appropriate assessment of risk to be made, resulting in additional work for frontline children’s social care teams.
62. Although there are some examples of good work with children and their families, a significant proportion of work is seriously inadequate and it takes too long for social workers to see vulnerable children.
63. Children’s services have been completely reorganised in the past year. They have focused on implementing new systems and, in doing so, have failed to recognise that the requirements of basic social work practice were not being met. Caseloads in many teams are too high, meaning social workers cannot do their job effectively. As a result, some children at risk and in care are not visited regularly by their social workers. The quality of assessments is poor.

64. Over one third of referrals are re-referrals. Most of the children whose cases inspectors tracked and sampled showed a history of repeat referrals, with the unresolved concerns being re-presented. The child's history is not taken into account routinely when determining whether a child needs help. The result is that decisions are based on incomplete risk assessments.
65. There have been some recent improvements in the First Response Team. A revised duty system is improving the response to referrals. The timeliness of child protection strategy discussions has improved, although these are normally telephone conversations only between the social care manager and the police. This therefore excludes other professionals known to be involved with the child and limits the effectiveness of the discussions.
66. Buckinghamshire commissions and manages a wide range of early help services. Families first (troubled families initiative) is a cross agency collaborative approach that has identified 417 families at the end of June 2013. They worked with 261 families and successfully helped 35 families to meet their goals. It's Family Resilience Service and children's centres use evidence-based tools, such as the Family Star and Graded Care Profile. This assessment and planning tool replaces the Common Assessment Framework, but it is applied only by local authority services and those commissioned by them. There is little evidence that the wider partnership understands and applies it. This seriously diminishes the critical role that agencies such as health, schools and adult services play in helping children. It also leads to inadequate co-ordination of early help services. This means that children do not always receive help early enough to ensure that their needs are met and do not escalate.
67. Youth services target their work successfully and commission a good range of services, including drug and alcohol outreach. Young carers have access to an array of support services and take-up of these is high. Support services for disabled children are also good in terms of choice and quality. Feedback from parents and young people provides some evidence of their positive impact and improved outcomes.
68. Too many managers at all levels are temporary and this leads to inconsistent management oversight. There is an over-reliance on locum social workers. This workforce instability means frequent changes of social worker for children and makes it harder for them to build meaningful and trusting relationships with them.
69. Managers do not routinely audit case file records and so do not secure an accurate view of the quality of practice. Individual performance management is poor, levels of supervision are inconsistent and management oversight is lacking. All this means that social workers lack the support they need to safeguard children effectively.
70. The number of children subject to child protection plans has increased since March 2013 from 190 to 263. Of these, 23% had a repeat child protection plan

compared with 11% during the preceding year. This indicates that children are being taken off child protection plans too early and before risks have been reduced effectively. There is no 'step down' protocol with universal services to ensure that children coming off child protection plans continue to receive structured help.

71. Police and health staff do not attend case conferences regularly.
72. All child protection plans sent to parents' state what needs to happen to enable the plan to end. However, most of the plans simply list tasks: they are not specific, do not have clear timescales and do not specify what the intended outcomes are. Most core group meetings review a family's circumstances rather than measure progress, leading to drift and delay. The core groups do not act or escalate matters where parents are not cooperating.
73. Social workers understand the wishes and feelings of children, but this is not always reflected in case records. There is little evidence of social workers working directly with children. This is largely delegated to other services such as Senior and Junior Catch or Women's Aid refuge support.
74. Too many case files lack chronologies and, even when they do include them, the chronologies are incomplete or not up to date. Records of management decisions and weekly unit meetings are not comprehensive. Some records, such as core group minutes are duplicated to sibling case files, which mean that they are not always personal to the child. This prevents new workers and managers from swiftly understanding when they take over a case or when the allocated social worker is absent. It also reduces the value of the records to children when they read them.
75. Weekly meetings provide a forum for all team members to become familiar with the cases allocated to the team and for group reflection. Such meetings are less effective in the children in need teams because of the complexity of the work and poor staff retention.
76. The diverse needs of children arising from culture, religion, ethnicity, gender, gender identity or sexuality are not detailed enough in assessments or addressed in plans. This information is critical in helping children understand their experiences.
77. Assessments in most tracked and sampled cases identify when poor parental mental health, domestic violence or substance misuse are adversely affecting children. The county commissions a wide range of preventive and support services to work with families.
78. Multi-Agency Risk Assessment Conferences (MARAC) are attended by the relevant agencies, enabling information about vulnerable children to be shared effectively and for action planning to take place for high-risk cases. The appointment of two domestic abuse advisors in children's services ensures that

all decision-making and planning about children at risk of harm from domestic abuse is informed by good-quality information and multi-agency working.

79. The out-of-hours Emergency Duty Team (EDT) is well managed and children's work is supported by ten sessional workers and a senior manager duty rota. The relationship with the police is good. Day-time managers in children's social care confirm that the interface with the EDT works well.
80. A well-regarded family court assessment team is staffed by experienced social workers. They undertake assessment work under instruction from managers and the family court. They also assist with viability assessments of family and friends as potential carers, and welfare reports ordered by the courts. The judiciary and legal services praise the quality of the team's court reports and confirm that it has contributed significantly to ensuring that the average length of court proceedings is 26 weeks. This reduces delay for children in achieving permanence.
81. Identification, tracking and risk assessment processes are currently protecting 91 children who go missing or are at risk of child sexual exploitation. The Multi-Agency Risk Management (MARM) meeting and Sexual Exploitation Risk Assessment Conference (SERAC) have good multi-agency attendance and share information about young people. RUSafe, a Barnardo's service jointly commissioned by health, the local authority and police, visits all children on their return after they have been missing and provides a range of support services. The launch in schools of *Chelsea's Choice* (a theatre production that is raising awareness of child sexual exploitation among young people in the UK) has led to increased referrals, including self-referrals, to RUSafe.
82. The Child and Adolescent Mental Health Service (CAMHS), provides an outreach service for 'hard to reach' young people.
83. The system for managing allegations against professionals and the lack of resources has resulted in the Local Authority Designated Officer (LADO) not being able to respond promptly to allegations of harm or potential harm caused by professionals. Records are not always accurate. In one case seen, unsafe recruitment practice was evident but the recording of the LADO's actions was unclear. The LADO remains without an adequate database and this affects how managers' record and quality assure the work.
84. The local authority has a lack of focus on children who are privately fostered. The capacity of the team has been reduced and it is not always meeting regulatory requirements. The number of privately fostered children is low at only three. There is a lack of awareness across the county about the importance of notifying the authority of such arrangements.
85. Children missing from education are identified, tracked and responded to effectively. However, case files of the small number who cannot be traced are closed without ensuring that they are safe from harm.

The experiences and progress of children looked after and achieving permanence

Key Judgement	Judgement Grade
The experiences and progress of children looked after and achieving permanence	Inadequate

86. Some children now in care remained in harmful situations for too long and came into care too late. This was the result of poor practice and poor assessments, resulting in delayed decision-making by managers. However, when children’s needs and risks are assessed appropriately, decisions to look after them are timely. Inspectors did not find any children who were in care unnecessarily.
87. The local authority is currently assessing all young people who are looked after on a voluntary basis to determine whether their circumstances have changed sufficiently for them to return to their birth families. Inspectors saw a number of cases where children had recently returned home, but none of these young people had had a risk assessment to consider whether previous concerns had been ameliorated. For a small number of children this led to continued instability and further periods in care. Managers’ decision-making was not clear.
88. The local authority is not effectively monitoring the well-being of all children in their placements. A number of sampled cases showed that social workers do not visit their looked after children often enough. In some cases, statutory guidance setting out the minimum frequency of visits is not followed. Managers’ ineffective oversight of this work and poor-quality recording mean that they do not know how prevalent this is or the impact it may be having on children and young people.
89. The Public Law Outline (PLO) is used effectively to make timely decisions to initiate care proceedings. The Court Social Work Team provides a specialist service to assess children’s needs, avoid delays and prepare court care plans in care proceedings. In the last quarter, the local authority has met the 26-week national target for completing care proceedings. Family group conferences are used to identify how extended families can support parents to provide care for their children and to consider suitable alternatives where this is not possible. If family and friends are potential carers, they are assessed without delay to determine their viability to provide care and permanence for children via increased use of Special Guardianship orders.
90. In the majority of cases, a plan for permanence is considered at the second review. Parallel planning addresses contingencies and helps to avoid delays.
91. The local authority is taking action to ensure that arrangements for children living long-term with their foster carers are formalised. This is being achieved through formal matching agreements. These include the wishes of the

child/young person and are ratified at a permanence panel. This is important to help children and young people feel secure about where they will be living if they cannot return to their families. For the majority of children, placement stability is good.

92. Some social workers are able to talk about the children they work with in a way that shows they know the children better than the case records reflect. Children's views, wishes and feelings are not always evident in case records, so it is not clear how well they are able to contribute to their plans. Care plans prepared for the courts, however, represent children's views well and their wishes are clearly influential in shaping their futures.
93. Social workers carry out life story work at different stages of children's lives. This helps children to understand and deal with their difficult experiences, make sense of their complex feelings and explore their identity. The availability of this resource has recently increased, with specialist workers undertaking it, but not all looked after children are yet benefiting.
94. Looked after children have ready access to independent advocacy. This helps them to express their views and so inform decisions about them. However, those placed out of area do not always have timely access to independent visitors. Currently, 30 children are waiting for this support.
95. The Independent Reviewing Officers (IROs) do not have enough time to meet all their statutory responsibilities, including monitoring children's progress and visiting them between reviews. They prioritise the children who are most in need of visits, routinely see all children alone before their reviews and challenge poor practice on behalf of individuals. However, a lack of capacity in the Children in Need teams means the challenge from IROs is not having a significant impact on overall practice for looked after children.
96. The quality of care planning and reviews is inconsistent. Of particular concern is the number of reviews which take place without a social work report. This means that children's progress and changing needs are not always considered. Although IROs provide a safety net in these cases, there is a risk that important information will be missed and plans not tailored to meet changing needs.
97. The majority of case records are poor. The electronic social care record shows blank plans and review reports entered on the system and key documents stored in other systems. Case records do not accurately reflect the child's journey and the reasons for key decisions. This limits social workers' ability to talk to children in the future about their lives and new social workers' understanding of the case. This also limits the capacity of IROs and managers to track young people's progress effectively.
98. Looked after children do well at primary school. The large majority make better than expected progress from their starting points and, overall, they are doing almost as well as other children in the same age group by the end of Key Stage

2. However, the gap between their attainment and that of all children in Buckinghamshire has widened by the age of 16. As is the case nationally the worst performing group comprises those who become looked after in their teens.
99. In 2013, only 4% of looked after pupils who are eligible to sit exams achieve five GCSEs at A* to C including English and mathematics. This is in stark contrast to the 71% rate for all children in Buckinghamshire and to the 15.3% for all looked after children in England.
100. 70% of looked after children are currently in good or outstanding schools, many of which are selective. School placements and moves for looked after children are managed well and, although choice is problematic in rural areas, the county provides good additional support and seeks to minimise disruption to the children's education. Many children who move live with carers outside of the county's boundaries are able to maintain their school placement.
101. The virtual school, Education of Children in Public Care (ECPC) team, tracks the progress and attendance of all children looked after and reviews their Personal Educational Plans (PEPs). The virtual school also provides pastoral and behavioural support. Monitoring by the ECPC underpins decisions about how best to support each child, including through direct teaching, commissioned tuition, mentoring and enrichment activities. For some children with high aspirations, trips to universities and 'taster' days are very effective in helping them to progress to higher education. Teachers, carers and pupils regard the ECPC's tailored support and challenge very positively. The ECPC is also monitoring closely the use of the Pupil Premium, although it is too soon to measure impact.
102. At the time of the inspection, all looked after children either had full-time school places or were on the roll of a school part time and also with an alternative education provider. Five pupils were on a school's roll but not attending for 25 hours; they had tuition and youth provision brokered and monitored by the virtual school ECPC, both in the county and in other local authority areas.
103. Whether the bullying of looked after children is monitored. In the past two years, 18 incidents have been logged. Looked after children's absence from school overall is low at less than 5%.
104. Children and young people do not have enough choice about their placements. The local authority provides six residential beds in the county and 111 local authority foster carers. This means that over 50% of looked after children are placed out of the county. For particular reasons, some children need to live away from their home area, but most do not. The majority of placements out of the county are the result of insufficient resources within it and not because of assessed needs. For children placed out of area, distance adversely affects their relationships with family, the frequency of their visits home, the ability to maintain continuity of school place and access to health assessments.

105. As part of a consortium of local authorities, Buckinghamshire has undertaken some good work to increase access to placements that support children and young people's cultural needs. Through the consortium, work has been done with a mosque to provide placements for seven children. Placements are also arranged for young asylum seekers in communities that meet their needs. Young people with specific cultural needs receive well-coordinated, tailored support.
106. Initial health assessments take too long, an average of 62 days from when the child becomes looked after, so any health needs are not tackled early enough. This is particularly worrying in cases of long-term neglect where information about health is needed to inform assessments and long-term plans.
107. Insufficient capacity in the fostering team means that approximately 25% of foster carers did not have annual reviews last year. The result is that oversight to confirm their continuing suitability and identify any support, training and development needs is insufficient, although foster carers say they are well supported. Supervising social workers do not always visit them often enough and do not provide sufficient support and supervision.
108. A range of training is available for foster carers, who report favourably on its quality and usefulness in helping them to support children and young people, as well as manage and understand their behaviour.
109. Agencies monitor young people who are at risk of child sexual exploitation and children are taken into the care of the local authority if risks cannot be safely managed at home. The majority of young people at risk of child sexual exploitation are placed out of the area for their own protection. When necessary, in a very few cases, secure accommodation has been used to ensure their safety. Senior managers monitor children who go missing effectively and they are subject to ongoing risk assessments.
110. The Children in Care Council, 'We Do Care', does not represent looked after children as a whole, including those placed out of area. It is underdeveloped and the pledge has not been updated since 2012. Senior managers are insufficiently involved and fail to drive support for this work. The few members who attend have pursued areas of particular interest and have contributed to small but significant improvements in services, including the website for 'We do care' which is about to be launched. However, the impact and reach of the Council overall are minimal.
111. Young people in care are supported by the council to access a wide range of leisure activities.

The graded judgement for adoption performance is that it is requires improvement

- 112. Adoption is considered at the earliest stage in case planning for most children, where a return to their family would be unsafe or would not meet their needs satisfactorily.
- 113. Buckinghamshire now tracks looked after children whose plan is likely to become one of adoption. The average time between children entering care and moving in with their adoptive family is 474 days, a significant improvement on the average of 649 days over the last three years. The time between Buckinghamshire receiving court authority to place a child and the authority deciding on a match to an adoptive family averages 200 days. This is better than performance nationally but not as good as that for similar authorities (at 162 days).
- 114. Forty nine per cent of children wait more than 20 months following court proceedings before their adoptions are completed. This is just above the national figure (45%) and that for similar authorities (41%).
- 115. The numbers of adopters awaiting assessment (40) and children awaiting adoption (43) are in line with national figures and those for similar authorities.
- 116. The timeliness of work to prepare and support individual children for adoption has improved recently, but overall performance is not as good as that of similar authorities. Some children experience unnecessary delays in finding a permanent home. The delays investigated by inspectors were because some social workers had not completed work in a timely manner and because 'family finding' was not sufficiently robust. Although, rightly, temporary staff have been taken on to add capacity, the quality of their work is inconsistent.
- 117. The majority of potential adopters to whom inspectors spoke described good support from social workers. However, they were critical of the timeliness of adoption work, with many describing delays. Almost 80% of approved families, experienced delays, performance which is worse than for similar authorities (71%) and the national average (58%). However, performance in placing babies for adoption is better.
- 118. The local authority has identified and is tackling problems of capacity in the Permanency and Children in Care Teams. This is improving management oversight and ensuring that cases are allocated appropriately: some managers had been carrying out direct work, limiting their own capacity to manage.
- 119. In the majority of cases inspectors saw, children awaiting adoption have experienced changes of social worker, meaning they lack important, continuing support from one individual. This is a particular problem for children who have

already experienced significant and traumatic changes. Adoption assessments are not always of good quality and this has led to unnecessary delays for a small number of children and adopters. Ofsted's last inspection of adoption services in October 2011 identified the quality of assessments as a weakness. This has not been rectified. Inspectors came across a small number of examples of distressed children and their adoptive families who had to cope with further delays because the adoption panel had rejected poor-quality reports.

120. The quality of case recording by social workers is variable. Child Permanence Reports are not consistently satisfactory, yet these are essential to ensure that children are matched with the right adoptive parents and to give prospective adopters the information they need.
121. An experienced adoption panel and agency decision maker are effective in scrutinising proposals to match children with adoptive parents, with evidence of good challenge by the chair and the agency decision maker. The part-time panel advisor, legal services and the panel's medical experts provide good support.
122. Disruptions to adoption placements are low (two in the last year) and excellent analysis of these has been used to improve the service. For instance, children are now not placed at the beginning of the summer holidays.
123. Adopters are positive about the quality of preparation, training and support they receive. The range of pre- and post-adoption support, including advice lines, surgeries, and family and friends groups, is good. The local authority employs two clinical psychologists to support families and help prevent adoption placements breaking down. This work is of a high standard. The authority also provides a post-adoption letter box service to enable children to receive agreed correspondence from their birth families.

The graded judgement about the experiences and progress of care leavers is that it requires improvement

124. Care leavers are helped to keep themselves safe, and to feel safe where they live, through effective direct work from the After Care Team.
125. The vast majority of care leavers (135 of the 142) keep in contact with their personal advisers in the After Care team. Staff assess young people's changing needs effectively and, as a result, are able to provide the necessary help and support. The team's successful outreach support to raise care leavers' expectations is attracting increasing numbers to come back to ask for support up to the age of 26, when they are either still in education or need assistance.
126. Personal advisers are allocated to all care leavers and, despite staff shortages, they make direct contact with and support for care leavers a priority, allowing

them to build good, purposeful relationships with them, and to understand and respond to young people's aspirations and feelings.

127. A high proportion of care leavers (70 of 142) do not have a current, complete pathway plan or equivalent. This means that managers do not have an explicit record of the young person's views and assessed needs for review and quality assurance. However, plans that are in place reflect and are shaped by young people. The absence of personal advisers as a result of sickness and long-term training in the After Care team means that many young people have too short a time to prepare for leaving care. Young people who spoke to inspectors confirmed this; they said that such work starts too late.
128. Senior managers are aware of, and are tackling, problems of a lack of capacity. They are collaborating with other agencies (health and education) to ensure that young people's needs are prioritised. Supervision and a team approach help practitioners to manage their work, and some are now updating plans. However, workloads in the team remain high and more work is required to sustain improved practice.
129. Services are tailored to meet care leavers' needs. Partnerships with health, youth offending teams, and drug and alcohol services to support young people who need these services are good. Young people receive accurate information and guidance about their rights and responsibilities. Support for young parents is particularly well established. Services for the few asylum seekers and refugees known to the After Care team support them well across a broad range of legal, financial and health matters.
130. The proportion of care leavers who are not in education, employment or training (NEET) is too high at 25%. Although this is lower than the national average for care leavers, the rate is much higher than that for their peers in Buckinghamshire (6%). The figure of 25% represents 38 care leavers between 18 and 24 years of age. It is a continuation of the gap in achievement seen for older looked after children, with too few gaining useful qualifications, skills and experience for work. Provision for care leavers to take up vocational training and work-based learning is insufficient. Very few care leavers are currently in apprenticeships and only one of these is within the authority's services.
131. Personal advisers are successful in encouraging a small number of care leavers who are without qualifications, including some young parents, to return to flexible learning in colleges. These young people make good progress from a low starting point. The challenge remains for the service to expand its impact to encompass the majority of young people who are not currently engaged in education and training.
132. A growing number of care leavers achieve highly and are supported financially, practically and through the option of remaining with their foster carers to go on to higher education. Currently 17 are at university and 10 more are on track to

go in the near future. While this is positive, it represents only 11% of care leavers.

133. The lack of a published 'staying put' policy means that not enough care leavers are aware of the possibility of remaining with their foster carers beyond their 18th birthday.
134. Young people have access to a good range of accommodation in supported lodgings and, for most, in their own tenancies. Some housing options offer young people bespoke guidance on practical and financial skills to maintain their tenancy. Personal advisers play a big part in helping care leavers to manage independently.
135. The majority of care leavers move into suitable, permanent housing of their choice. Seven are currently in houses in multiple occupation and one young person is in bed and breakfast accommodation. In all such cases, the accommodation is assessed for suitability and risk assessments developed in relation to the young person's needs. The range of accommodation is being expanded further. This benefits those who are able to live in Buckinghamshire. However, staff reported that the choices for those who wish to remain living outside of the county are more challenging. Care leavers know about advocacy, access to interpreters, bursaries for further and higher education, and how to complain. Their feedback to the After Care team shows that they are happy with the range of services and the level of contact offered by most personal advisers. Managers have responded appropriately to complaints by young people.
136. Practitioners and managers routinely listen to care leavers about the services that are provided for them, but representation of care leavers on 'We Do Care' is low and continuity is fragile. At a time when the authority is considering revising the Care Leavers' Pledge, care leavers have too little opportunity to exchange their views and have a say.

Leadership, management and governance

Key Judgement	Judgement Grade
Leadership, management and governance	Inadequate

137. Leaders, including elected members, have known about the concerns in children’s social care over the past 12 months. They have consistently agreed to additional funding to increase capacity. However, there is insufficient analysis and understanding of the issues, underlying complexities and continuing risks to children’s services, leading to reactive or retrospective council responses rather than those based on effective strategic planning. Responses include injections of cash to cover overspends. As a result, any sustainable impact in tackling the longstanding weaknesses is limited and too many vulnerable children in Buckinghamshire remain at risk of harm.
138. Political leaders and Chief Officers state that children’s social care is not the highest priority for the County Council. This limits the opportunity for those with lead responsibility for children’s social care to tackle deficiencies effectively, drive up standards and achieve sustainable improvements.
139. Arrangements across the Children & Young People’s Partnership Board, the Buckinghamshire Safeguarding Children Board (BSCB) and the Health and Well-being Board to make outcomes for children a shared priority are not aligned. This means that the collective accountability of these boards in helping and protecting vulnerable children is inhibited.
140. The Corporate Parenting Panel is constituted appropriately, chaired by the Lead Member for Children’s Services, with cross-party member engagement, district councillors, officers of the County Council and a representative from the independent advocacy service. However, the panel’s work is underdeveloped. Members of the panel do not have sufficient knowledge and understanding of their roles and responsibilities to make critical enquiries about the quality of services for looked after children. This is essential if outcomes for all children in care and care leavers are to improve.
141. Buckinghamshire council has constructive relationships with Cafcass and the district judges, and attendance at the Family Justice Board is good. The work of the Family Court team is well regarded by the judiciary and by solicitors acting for parents. This is helping to reduce court time and leading to timely decisions for children. In addition, there is financial commitment from and investment by children’s services for creating the Family Drug and Alcohol Court (FDAC). This will be the third in the country and is an example of innovative practice.
142. There is a comprehensive and well-established training programme for 25 newly qualified social workers. This is linked to local universities and moderated in partnership with other local authorities. Positive investment in a ‘grow your own’ approach through the Frontline initiative has recruited eight staff to begin

work and on-the-job training in September 2014. Nine staff members are undertaking social work training with the Open University. While these developments are welcome, their potential impact is some way from realisation.

143. The local authority has had difficulties in recruiting experienced social workers. All levels in the organisation rely too much on locum staff. Managers and social workers come and go, leading to significant instability in the workforce. Children and their families experience frequent changes in social workers, often at short notice. This has a negative impact on children developing meaningful relationships with their social workers and leads to drift and delay.
144. At all levels, managers and partners lack a sense of critical enquiry about the impact of poor performance on vulnerable children. Performance management information and effective quality assurance are not established. As a result, senior leaders have not analysed, in detail, the deep-seated problems, the findings from which could drive improvement. Internal or external audits that have taken place have identified concerns, but subsequent action has been limited and ineffective.
145. Management oversight of cases, including scrutiny by senior managers, is ineffective and not systematic. Supervision does not occur in accordance with the local authority's own policy. As a result, managers do not routinely monitor and assess progress and risk to children.
146. At the time of the inspection, management arrangements to monitor the risks to children with no allocated social worker were unsafe. Some children, including those who had alleged physical abuse, were not seen, and some remained in neglectful and unsafe circumstances after they were referred to children's social care.

What the inspection judgements mean: the local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after, and the welfare of care leavers is safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place. However, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services in which widespread or serious failures create or leave children being harmed or at risk of harm or result in looked after children or care leavers not having their welfare safeguarded and promoted.

Section 2: The effectiveness of the Local Safeguarding Children Board

<p>The effectiveness of the Local Safeguarding Children Board (LSCB)</p>

<p>The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate.</p>
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Priority and immediate action:

147. Ensure that all partners are fully engaged in the delivery of the Prevention and Early Intervention Strategy so that children and their families have timely access to early help and support.
148. Ensure that the multi-agency thresholds document is agreed and understood fully by all partners, supported by clear guidance, including on partners' roles and responsibilities, and implemented and monitored effectively.
149. Ensure that the leadership role of the BSCB in safeguarding is clearly established across Buckinghamshire, and that governance arrangements within the Board and with other key strategic bodies are effective in identifying and prioritising work to meet the needs of children, young people and their families.
150. Ensure that a funding formula is developed, agreed and implemented to provide sufficient resources for the Board to undertake its core business.
151. Ensure that staff in all agencies are aware of the escalation policy within and between partner agencies and how to use it.
152. Ensure that the Board evaluates its effectiveness and provides challenge when necessary.

Areas for improvement

153. Ensure that operational staff are included in a programme of routine multi-agency audits of front-line practice to provide rigorous scrutiny of work in this area. Individual agencies must own the findings of audits and use this information effectively to promote improvement.
154. Ensure that young people's views routinely inform service improvement.
155. Ensure that more privately fostered children and young people are identified and supported by promoting awareness of private fostering.
156. Ensure that the BSCB undertakes effective monitoring and quality assurance of multi-agency safeguarding practice. This should include robust analysis of

safeguarding data, including information from all key partner agencies so that issues and implications for multi-agency safeguarding practice are identified and addressed.

Key strengths and weaknesses of the BSCB

157. Clear protocols describe the relationship of the Board with other key partnerships. However, partnership working is undeveloped and ineffective. Recognition of responsibilities and the sharing of accountabilities for helping and protecting children are limited.
158. Accountabilities between the independent chair of the BSCB, the DCS and the Council's Chief Executive are defined and include formal regular meetings. However, these arrangements have not led to the serious and widespread risks to children in social care being fully understood, addressed or prioritised.
159. The Board engages District Councils and has appointed two lay members as required.
160. The Board has not been effective or robust in assessing whether agencies are fulfilling their statutory duties to help and protect children. This fundamental failing has delayed the recognition of deficits in services. Consequently, some children and young people at risk of harm and requiring statutory services from children's social care have not received them in a timely manner. Assessments of risk and need have been delayed. The BSCB has not been effective in ensuring that partners work together to reduce risk for all children who are identified as needing assessment, support and intervention.
161. The BSCB does not monitor and evaluate the quality and effectiveness of multi-agency safeguarding work systematically or robustly. Although the Board and the Monitoring and Evaluation sub-group undertake some monitoring of performance, this is too restricted to children's social care data. The Board does not have a performance dataset from across the partnership. The focus of the information presented is too narrow and the Board members are not sufficiently enquiring to understand and challenge day-to-day practice. As a result, practice and performance remain poor.
162. In response to concerns following Jimmy Saville enquiries the LSCB led a review of the safeguarding arrangements across the hospitals within the Buckinghamshire Healthcare Trust. This complex review was effective as it worked across both adults' and children's services. More recently the BSCB has considered the findings of a recent audit in relation to the appropriateness of referrals to the sexual abuse referral centre (SARC). This has uncovered poor practice in relation to the recording of S47 strategy meetings. The BSCB has failed to ensure that all key partners contribute fully and actively to improving the delivery of prevention and early help services. Partners have been too slow to take on full responsibility for their roles in promoting children's welfare. The Early Help Strategy and offer is a very recent development. The capacity of the

Board to progress its ambitious work plan faces significant difficulties. Buckinghamshire County Council's proposed budget cuts and agencies' reluctance to commit resources have contributed to financial pressures. This has led to the postponement of the Annual BSCB Conference. Due to issues of capacity some partner's agencies are unable carry out individual agency safeguarding audits under section 11 of the Children Act 2004.

163. The work of the Board and the Child Death Overview Panel is compromised by funding cuts. The appointment of a BSCB Training Manager is for one year only as funding is not assured beyond this. Frontline auditing activity has not occurred as agencies report that their capacity is not sufficient to release managers or practitioners to undertake such work. Attendance at some sub-groups is variable. Some sub-groups lack vice-chairs and there are too many changes in membership.
164. External audits have been helpful in identifying practice strengths or deficits, such as poor partnership knowledge and compliance with the 'Harder to Reach' protocol, but they have not focused on front-line practice.
165. The Board continues to develop a range of appropriate policies and procedures. However, review of their impact is not undertaken routinely or systematically. The BSCB therefore cannot be assured that these policies and procedures have improved practice to safeguard children. Inspectors found variable knowledge, for example, about compliance with and the use of the child protection, medical and escalation policies.
166. A threshold document has been refreshed very recently, but its launch was piecemeal and the accompanying guidance has not yet been published. Similarly, the information-sharing protocol to govern work within the proposed Multi-Agency Safeguarding Hub (MASH) is yet to be finalised and formally agreed. This results in confusion and poor practice in relation to consent and confidentiality issues.
167. The BSCB has recently worked to raise awareness among children, young people and professionals of issues relating to missing children and those at risk of child sexual exploitation. A variety of approaches has been used to raise young people's awareness of sexual exploitation and to minimise risk for those at risk. *Chelsea's Choice*, a drama piece on this topic, has been shown to young people in secondary schools across the county. Evaluation highlights much evidence of positive feedback from these initiatives. A strong feature is that all RUSafe staff attend performances to give opportunities for young people to discuss concerns and use the service.
168. The number of children known to be privately fostered remains extremely low. Actions to promote agency and public awareness of private fostering arrangements have not led to more children being identified. The BSCB needs to do more to promote such awareness so that children, young people and carers can be assessed and offered support.

169. Throughout the past 12 months, the BSCB has delivered against a number of objectives. A system for sharing electronically with all schools all notifications from the police of domestic violence has now been re-established. The E-Safety group has been effective in engaging positively with children and young people to raise awareness of risks when using the internet. A new initiative deals with gang-related issues, and a further initiative contributes to the Prevent agenda through work with the police and local communities to identify young people who are at risk of being influenced by extremists. However, some statutory requirements in safeguarding practice remain unmet.
170. The BSCB Learning and Improvement Framework outlines processes for challenging partners through Section 11 audits and for contributing to learning. These processes have been broadened to include scrutiny of single-agency training. Arrangements for peer scrutiny and quality control of the Section 11 audits are effective in demonstrating challenge and impact. For example, District Councils' environmental health staff have now received training in recognising neglect.
171. Serious case reviews (SCRs) are initiated in line with statutory guidance. The progress of reviews and the implementation of recommendations that arise are monitored and reported to the Board. In the last 12 months, the BSCB made two new notifications to Ofsted, both of which led to SCRs. Five SCRs have been concluded, of which four have been published. One is not yet published because of current court proceedings.
172. Events to disseminate learning from SCRs are arranged for practitioners. These have been effective in raising their awareness of key issues such as teenage suicide; harder to reach young people; domestic abuse and risk to babies and those unborn.
173. The events have been less effective in tackling a common theme within Buckinghamshire's SCRs, namely the need to promote escalation and challenge within and between partner agencies. Work in this area must be a priority.
174. The BSCB has continued to provide core multi-agency training. This covers a broad range of safeguarding issues. To some extent the training has been developed to tackle local and national issues that emerge, including learning from SCRs. All courses are evaluated on the day and efforts are also made to contact the participants later to consider the longitudinal impact of training. All BSCB courses have been modified to reflect the requirements of Working Together to Safeguard Children 2013. New courses have been developed on child sexual exploitation, escalation, conflict resolution and challenge. However, the Board's capacity to maintain breadth in its training activity is significantly compromised, both by funding restrictions and because some agencies do not release staff to participate.
175. The Board's annual report provides information about its activity over the year 2013–2014, including lessons learnt from SCRs and CDOP. The report includes

performance data, but it lacks analysis of key themes, such as the increasing population of looked after children or the high percentage of re-referrals. The report makes no reference to privately fostered children and young people other than to say that they are a priority. These are significant deficits.

176. The Chair of the Board challenges strategic partners appropriately on key issues. For example, the Health and Well-being Board has been asked to develop a suicide prevention action plan and there has been challenge to the authority on budgetary cuts to children's social care. However, the Board remains concerned about the lack of police representatives at initial and review child protection conferences, attendance by health professionals and input from them to strategy discussions. As a result, the LSCB has not been able to demonstrate effective influence on agencies in terms of addressing deficiencies in practice.

What the inspection judgements mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Its evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and its impact is evaluated regularly. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics above.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made

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