Dear Gladys Rhodes White

Monitoring visit of Buckinghamshire children’s services

This letter summarises the findings of the monitoring visit to Buckinghamshire children’s services on 11 and 12 April 2017. The visit was the third since the local authority was judged inadequate in August 2014. The inspectors were Donna Marriott HMI, Linda Steele HMI and Pauline Higham HMI.

Based on the evidence and cases seen by inspectors during this visit, the local authority is making steady progress with improving services for children looked after. However, there are some areas where the pace in achieving the change required has been too slow.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the areas of:

- The quality of assessment and planning for children looked after, in particular achieving timely permanence.
- Placement support, commissioning and sufficiency.
- Management oversight of and case recording on children’s files.
- The effectiveness of the local authority as a corporate parent.

The inspectors considered a range of evidence, including electronic case records, supervision files and notes, and other strategic documents provided by the council. In addition, the views of children looked after, social work staff and managers informed inspectors’ findings.

Overview

The local authority is making steady progress in improving the quality of services to children looked after. Social workers remain positive and morale is good. Outcomes for some children are improving. Inspectors saw examples of sensitive, child-focused
work and timely permanence planning. Permanence is considered early for the majority of children, but permanence planning is not yet sufficiently robust.

Services for children in Buckinghamshire were found to be inadequate in June 2014. Despite some improvements seen by inspectors in the quality of support to children looked after, inconsistencies in practice remain and managers are still not effective in tackling shortfalls or driving all children’s plans.

Senior managers have taken some effective action to respond to weaknesses identified by inspectors during previous monitoring visits, including work to reduce the number of children waiting for life-story work, ensuring that assessments of children’s circumstances take place prior to reviews and developing more robust systems to respond to children missing from home or care. There has been some progress in all of these areas, although some children continue to wait for life-story work and the response to children looked after who go missing is not yet consistently effective, particularly for those children who live outside the area.

The corporate parenting panel takes a clear interest in the progress of children looked after and care leavers and celebrates their achievements, but the panel is yet to evidence that it is improving outcomes. Currently, there is no regular representative of foster carers or children from the Children in Care Council at the corporate parenting panel, which means that the panel does not have the opportunity to hear at first-hand of foster carers’ and children’s experiences.

FINDINGS AND EVALUATION OF PROGRESS

Improved practice is evident in respect of services and support provided to children looked after. However, in some areas, the improvements identified as necessary at the last inspection have not been achieved quickly enough.

The development of an increasingly stable workforce, with manageable caseloads, has been critical to the progress achieved to date. Social workers spoken to by inspectors are positive about working in Buckinghamshire and morale is good. Staff appear to be embracing the consultation on the proposed restructure for the children in care service. Despite these positive improvements, children from the children in care council spoken to by inspectors said that they have experienced too many changes in social worker. This was further evidenced in case sampling.

There has been sustained improvement in the quality of case file audits. Audits completed for case tracking are comprehensive, and most identified critical issues.

Although improved outcomes were evident for the majority of children whose case files were audited, practice fell well below the required standard for one of the six children. For this child, safeguarding action had not been effective and the response to ‘missing’ incidents was not timely.
Children looked after receive regular visits from their social workers, with visits tailored to children’s individual needs, including for those children living some distance outside the authority. Children’s views are consistently sought through direct work, attendance at reviews or through the use of the recently implemented web-based tool, ‘Mind of my own’ (MOMO). Inspectors saw some good examples of sensitive direct work, including work to help children to understand their histories. Social workers clearly articulate the work that they undertake with children, but this is not always evident in children’s case files. The number of children waiting for life-story work has been significantly reduced since the last monitoring visit in November 2016 due to the focused action taken by the local authority. However, too many children continue to wait for this important work to help them to make sense of their histories.

In response to concerns identified by inspectors at the last monitoring visit, senior managers have introduced an assessment and progress report. Consequently, in the majority of children’s cases sampled by inspectors, assessments were up to date and were used to inform planning. Assessments carefully consider the issues of culture, religion and identity for children, and examples of sensitive, child-focused practice were seen by inspectors. Children’s health and education needs, as well as contact with those people who are important to them, are given thoughtful attention in assessments and plans.

The timeliness of initial health assessments has declined since the last monitoring visit due to a shortfall in capacity in the health service. The local authority has taken action to develop a more robust and sustainable approach to managing this process, and timeliness is again improving.

An improved focus on care planning has resulted in the majority of children’s plans having clear actions and timescales. Pathway plans are in place prior to children reaching the age of 16 and provide an overview of children’s needs. Senior managers recognise that the documents are not an effective tool for encouraging children to participate in their plans and have begun work to develop a new format, in consultation with young people.

Permanence is considered at an early stage in the child’s journey, but planning for permanence is not yet sufficiently robust for all children. The quality and effectiveness of permanence planning meetings are variable and the process for matching and approval of children with their long-term carers is not always clear. The impact of this is that some children wait too long to experience security and belonging. Prior to the monitoring visit, senior managers had already drawn up a plan to address weaknesses in matching and approval by an agency decision maker and panel.

There is careful consideration of decisions to place children with friends and family, with thorough and timely assessments of connected persons and special guardians. Once a decision is made for children to live with adoptive families, proactive work by the adoption team takes place to find the right match. Despite some action to
improve child permanence reports, concerns continue about the quality, which has the potential to impact on achieving timely decision making. Once the decision is made for adoption, family finding is proactive and families are well supported through the adoption process. Helpful support is provided for children when they move to live with their adoptive families, and the support packages seen by inspectors were comprehensive.

Independent reviewing officers (IROs) maintain regular oversight of planning for children. They visit children before their reviews to ensure that they are supported to participate. IROs are proactive and provide challenge, but are not always effective in rectifying deficits or driving children’s plans. Not all children’s reviews are brought forward when they experience changes of placement. Senior managers acknowledged that this shortfall resulted from a misunderstanding regarding required practice, and they plan to issue guidance to rectify this.

The support provided to foster carers has improved. In children’s cases seen, foster carers’ supervising social workers visit them regularly and annual reviews are taking place, although there has been a recent slight decline in timeliness. Carers receive effective support, including access to training.

Sustained work has taken place since the last inspection to reduce the number of children placed out of county at a distance from family and friends. This includes a campaign to recruit foster carers, cross-regional market stimulation events, engagement with independent fostering providers and a review of in-house fostering services through an externally commissioned improvement partner. It has had some success, with a small reduction in the current number of children placed out of county. However, too many children continue to be placed at a distance, which results in disruption to important relationships, changes in education and challenges in accessing services. Inspectors saw the adverse impact of this in some children’s case files.

When commissioning out-of-area placements for children, there is no routine consideration of what support will be available should a child go missing from care. The impact of this was evident in several children’s cases sampled, where processes to respond to missing episodes were not sufficiently robust and it was not clear whether return home interviews had taken place. Since the last monitoring visit, processes for children who go missing from care or home within Buckinghamshire’s boundaries have been strengthened, including tighter monitoring of the return home interviews that are undertaken by an externally commissioned provider. Although recent performance information suggests some improvements in the number of return home interviews carried out in response to ‘missing’ episodes, the quality of the interviews remains variable. Some examples fall below the required standard due to insufficient or weak analysis.

Management oversight and supervision are evident in children’s case files. However, managers do not always record their rationale for decisions and are not consistently effective in following through actions and driving children’s plans. The recently
introduced supervision template, although not yet embedded, provides a more robust structure for tracking actions and progress.

Leaders have taken action since the last inspection to strengthen corporate parenting arrangements. Members have received training to support them in their work and to ensure that they understand their responsibilities. The corporate parenting panel takes a clear interest in the progress of children looked after and care leavers, and celebrates their achievements. The panel has been instrumental in driving some projects, such as the development of the local authority’s pledge to children looked after and care leavers, and the introduction of a web-based tool to enable children’s participation. However, there is a lack of evaluation of the impact of this work in respect of improving outcomes for children. Currently, there are no regular representatives of foster carers or children from the Children in Care Council at the corporate parenting panel. This is a missed opportunity to hear at first-hand about foster carers’ and children’s experience.

Children told inspectors that they find their involvement in the Children in Care Council helpful and that it has been crucial in helping them to develop confidence.

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

Yours sincerely

Donna Marriott

Her Majesty’s Inspector