

Buckinghamshire County Council

Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection date: 6 November 2017 to 30 November 2017

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Children's services in Buckinghamshire are inadequate	
1. Children who need help and protection	inadequate
2. Children looked after and achieving permanence	inadequate
2.1 Adoption performance	good
2.2 Experiences and progress of care leavers	requires improvement to be good
3. Leadership, management and governance	inadequate

Executive summary

Overall progress in improving services for children in Buckinghamshire since the last inspection in 2014 has been inconsistent and too slow. The strategic response to change has been piecemeal and has not successfully achieved the required wholesale improvements to services for vulnerable children. Consequently, at this inspection inspectors found serious shortfalls in some parts of the service, which led to services for children in need of help and protection and for children looked after being judged inadequate.

The high turnover of social workers, high caseloads in some teams and poor recording have all been significant contributory factors to the slow progress of children's plans, and have led to some children being left at risk and in unsuitable circumstances for too long. Frequent changes in social workers or visits conducted by rotating duty workers make it hard for children to develop trusting relationships or for social workers to properly understand children's experiences and circumstances.

A failure to recognise or respond promptly to increasing risk and an over-reliance on parents' own reports of their progress, alongside weak oversight by managers, have led to some children's cases being closed prematurely. These children are frequently referred again when their circumstances deteriorate.

Most children have assessments and plans in place, but the quality of these is inconsistent. Some plans are ineffective. They do not demonstrate a full understanding of risks to children or their unique individual needs, and are not responsive to changes in circumstances.

Over-optimism about the effectiveness of contracts of expectation and written agreements has led to an over-reliance on their use. For some children, particularly those living with parents on child protection plans or under the placement with parents' regulations, such agreements have been ineffective in ensuring that parents or other family members comply with expectations to keep them safe.

Managers have increased their oversight of social workers' practice. There is evidence of regular supervision, case discussions and intervention by child protection chairs, independent reviewing officers (IROs) and meetings chaired by heads of services. However, they do not consistently lead to the right actions being taken quickly enough. Some processes to improve challenge and oversight have only recently been put in place, and it is too soon to see their impact. Established auditing arrangements detect some of these practice issues, but do not yet focus enough attention on ensuring that children benefit from social work intervention.

Arrangements to meet the needs of unaccompanied asylum seekers when they first arrive are insufficient to ensure that their needs are met.

In response to the findings of the last inspection, elected members made children's services a key council priority. They have maintained this commitment and continue

to financially invest in and promote children's services. There has been an appropriate focus on and investment in stabilising the workforce. This is beginning to have a positive impact. Social work turnover has been reduced and agency staff are used positively to provide additional social work capacity. There is still more work required to ensure that social workers are fully supported to attend relevant training.

Inspectors identified that improvements have been successfully achieved in some service areas, mostly in reaction to the shortfalls identified during monitoring visits. Children benefit from a range of early help services and receive a well-coordinated service when more than one agency is involved with them. The establishment of the multi-agency safeguarding hub (MASH) has been effective, and children who need an urgent response receive a prompt and appropriate service. Children who are vulnerable as a result of going missing now receive timely and thorough interviews on their return to home or care. However, the information from such interviews is not being well used to inform planning to reduce the risk of children going missing again in future. The work of the designated officer is now effective and the response to complaints has been improved.

Thresholds for those children recently coming into care are appropriate. Pre-proceedings and court work have been strengthened and the judiciary has increasing confidence in the applications that the local authority puts before the court. The focus on achieving permanence for children at the earliest stage has enabled the authority to successfully match and place children with a wide range of ages and needs in adoptive families and special guardianship order (SGO) placements. The support for these carers is of an exceptionally high standard.

Recent improvements in the children in care/after care teams and the revised format of pathway plans now ensure that care leavers' views are central to their plans. Further work is required to provide care leavers with all their essential information. Young people enjoy attending the 'We do care' Children in Care Council. The recent development of young people's representatives attending the corporate parenting panel enriches managers' and elected members' understanding of children's and young people's experiences of being looked after.

Senior leaders have worked effectively with their partner agencies at a strategic level to increase the awareness of risks to children who are vulnerable as a result of sexual exploitation. Further work, building on this, is underway to understand and respond to the complex risks that young people face, such as from gangs, 'county lines' (children forced to traffic drugs) and radicalisation.

The recent appointment of an experienced director of children's services (DCS), chief executive and new cabinet portfolio holder for children's services, and continued support from the leader of the council, now provide the local authority with a strong senior leadership team that is committed to accelerating the pace of improvements for children. Leaders accepted all the shortfalls found by inspectors during the inspection and the DCS developed an immediate action plan in response to them.

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The local authority

Information about this local authority area¹

Previous Ofsted inspections

- The local authority operates one children's home, which was judged to be good in its most recent Ofsted inspection.
- The last inspection report for the local authority's children's services was published in August 2014. The judgements for the local authority were:
 - overall effectiveness: inadequate
 - children who need help and protection: inadequate
 - children looked after and achieving permanence: inadequate
 - adoption performance: requires improvement to be good
 - experiences and progress of care leavers: requires improvement to be good
 - leadership, management and governance: inadequate.

Local leadership

- The director of children's services has been in post since October 2017.
- The chief executive has been in post since September 2016.
- The chair of the Local Safeguarding Children Board has been in post since December 2014.
- The local authority uses the 'Strengthening Families' approach to social work.

Children living in this area

- Approximately 122,200 children and young people under the age of 18 years live in Buckinghamshire. This is 23% of the total population of the area.
- Approximately 11% of the local authority's children aged under 16 years old are living in low-income families.
- The proportion of children entitled to free school meals:
 - in primary schools is 7% (the national average is 15%)
 - in secondary schools is 5% (the national average is 13%).
- Children and young people from minority ethnic groups account for 21% of all children living in the area, identical to the level in the country as a whole.

¹ The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Mixed Ethnicity.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 17% (the national average is 20%)
 - in secondary schools is 16% (the national average is 16%).

Child protection in this area

- At 31 October 2017, 2,447 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,363 at 31 March 2017.
- At 31 October 2017, 598 children and young people were the subject of a child protection plan (a rate of 49 per 10,000 children). This is an increase from 553 children (45 per 10,000 children) at 31 March 2017.
- At 31 October 2017, four children lived in a privately arranged fostering placement. This is an increase from one at 31 March 2017.
- In the last two years prior to inspection, 11 serious incident notifications were submitted to Ofsted and four serious case reviews have been completed.
- There is one serious case review ongoing at the time of the inspection.

Children looked after in this area

- At 31 October 2017, 471 children are being looked after by the local authority (a rate of 39 per 10,000 children). This is an increase from 455 (37 per 10,000 children) at 31 March 2017. Of this number:
 - 227 (or 48%) live outside the local authority area
 - 54 live in residential children's homes, of whom 65% live out of the authority area
 - seven live in residential special schools,² four live out of the authority area
 - 337 live with foster families, of whom 51% live out of the authority area
 - 27 live with parents, of whom three live out of the authority area
 - 26 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 29 adoptions
 - 32 children became the subject of special guardianship orders

² These are residential special schools that look after children for 295 days or less per year.

- 187 children ceased to be looked after, of whom 1% subsequently returned to be looked after
- 24 children and young people ceased to be looked after and moved on to independent living
- one child ceased to be looked after and is now living in a house in multiple occupation.

Recommendations

1. Take immediate action to improve the quality of management oversight and decision-making at all levels to make sure that children's plans are properly progressed. Ensure that management interventions, including escalations and alerts by child protection chairs and independent reviewing officers, are clearly recorded on children's files and that these actions are followed through.
2. Ensure that appropriate support is in place to meet the needs of children when child protection plans end and also when children return home from care.
3. Improve the quality of assessment and planning to ensure that risk is identified and responded to promptly, especially when risks escalate. Ensure that assessments and plans identify the unique needs and experience of each individual child, particularly when they are part of a large family of brothers and sisters.
4. Ensure that care plans for children reflect their diverse needs and individual identities, and are realistic about achieving change.
5. Ensure that all written records are clear and up to date, and accurately identify the circumstances of children and their families.
6. Take immediate action to ensure that monitoring and visiting arrangements to all children looked after in placements with parents are sufficiently robust to ensure their safety and progress until these arrangements are formally resolved.
7. Review the procedures for accommodating and supporting unaccompanied asylum-seeking children, including those who arrive outside office opening hours, to ensure that their immediate needs and vulnerabilities are appropriately assessed.
8. Ensure that all care leavers have full information about their health histories and what they can expect during their time in care and on leaving care, including information about advocacy and complaints.
9. Apply an appropriate audit tool to ensure that qualitative analysis, alongside quantitative compliance auditing, measures effectively the improvements, impact and outcomes for children.
10. Ensure that all staff receive appropriate training, including mandatory training, in order to improve their key skills and to keep them up to date in their knowledge and practice.

Summary for children and young people

- Services for children in Buckinghamshire are still not all good enough. While there have been improvements since the last inspection in 2014, some children are still not having the right help and support that they need at the time when they need it most. This means that sometimes children's problems have become worse before they have the right help.
- Most social workers work hard to support children, but some social workers have many children to support and do not always have enough time to do all that they need to do. Some children have too many different social workers and, because they do not know them well, they sometimes find it hard to trust them or to tell them what may be worrying them. This makes it difficult for some social workers to know how best to help them.
- Not all managers check to make sure that social workers do the work that they need to do quickly enough to help children.
- Sometimes the help that social workers provide to children and their families ends too soon. This means that some families or professionals have had to again ask for help from social workers.
- Young people who go missing always have a chance to speak to someone about why they went missing and to think about what might help them to keep safe.
- Most children who are in care have plenty of support and live with people who look after them well. They also have a great deal of support to go to school and do well in their lessons.
- A small number of children who are in care and living with their parents do not always have regular social work visits. Some of these children have not received the help that they need quickly enough. Managers know this now and are working hard to make sure that these children are supported.
- Some children who have been in care don't get the right support to help them settle in and become used to being back home again.
- Once the decision is made that adoption is the best plan for a child in care, much work is done to make sure that their adoption takes place quickly.
- Young people leaving care have help from workers who know them well. More work needs to be done to make sure that care leavers know their health histories (what illnesses or injections they have had in the past), and also for them to know about all their rights.
- Children who take part in the 'We do care' council enjoy going to these meetings. Some also take part in interviewing social workers and managers for their jobs. They now attend the corporate parenting panel, a meeting with managers and councillors, to let them know what it is like to be in their care.

<p>The experiences and progress of children who need help and protection</p>	<p>Inadequate</p>
<p>Summary</p> <p>There are widespread and serious weaknesses in some services to safeguard children in Buckinghamshire. These critical weaknesses span the child protection and court social work teams. Risks are not always recognised, and weak managerial oversight at all levels is a common feature in too many children’s cases. As a result, some children remain without the protection that they need.</p> <p>Social work intervention is not always sufficiently responsive to changing and increasing risk, particularly when children experience neglect or are exposed to domestic abuse. Social workers do not always recognise when parents’ engagement is not genuine or meaningful. Heavy caseloads in some teams and a high level of staff turnover make it difficult for children to build relationships with their social workers.</p> <p>A wide range of early help services provide much-needed support for children. These services are well coordinated when children require support from more than one agency. However, children who receive help from a single agency do not always have the help that they need at the right time, consequently they are referred to children’s services many times.</p> <p>Threshold decision-making in the multi-agency safeguarding hub (MASH) is mostly appropriate. Children in need of an urgent response receive a timely and effective service. Relevant partner agencies attend strategy meetings held in the MASH and share information appropriately. These key meetings are generally effective and, where appropriate, lead to child protection enquiries and child protection conferences for those children most at risk.</p> <p>Overall, assessments, including those of unborn children, are too descriptive of families’ circumstances and some lack insight into the child’s experience. They give little consideration to children’s needs arising from their culture, ethnicity or race.</p> <p>The quality of children’s plans is too variable. Core groups share information, but they are not effective in progressing children’s plans. Child protection plans are ended too quickly, without evidence of sustained change.</p> <p>The response to children who go missing or who are at risk of sexual exploitation is improving, but is not yet sufficiently robust for all children. Return home interviews are timely and of good quality, but are not used to inform plans to reduce risks to children. Assessments of children at risk of sexual exploitation are not sufficiently comprehensive to inform effective safety planning.</p>	

Inspection findings

11. The local authority has not made sufficient progress since the last inspection of children's services in 2014. Although there are now strong arrangements in place to support effective decision-making in the multi-agency safeguarding hub (MASH), inspectors found serious weaknesses in respect of the assessment, planning and management oversight of children in need of help and protection. During the inspection, a number of cases regarding serious concerns were referred back to the local authority in respect of poor risk management. This was particularly evident for those children where the risks were intensifying. These weaknesses in practice correspond to the local authority's own findings in a review of the quality of child protection plans which it completed in August 2017. Senior leaders accepted inspectors' concerns and took immediate action to strengthen intervention for these children.
12. Management oversight, in the majority of children's cases, is inadequate. Managers at all levels, including child protection chairs, lack the necessary rigour to ensure that children's plans are progressed. They are not consistently effective in ensuring that critical actions, such as decisions to convene strategy discussions and legal planning meetings, are undertaken. As a result, some children experience delay in becoming looked after and others remain in unacceptable situations for too long. Heavy caseloads and a high level of staff turnover in some teams further compound these weaknesses. Frequent changes of social worker prevent children from developing meaningful relationships and contribute to delays in progressing children's plans.
(Recommendation)
13. Some children's cases are allocated to managers rather than to social workers, due to increasing workloads and insufficient social work capacity. In these circumstances, a series of duty workers who do not know or fully understand children's history or experiences undertake child protection visits. This leads to delays in meeting the assessed needs of children and in progressing their plans. One child described the impact of such change when she spoke about being 'fed up with social workers cancelling visits and then ringing up and demanding to see me that day'.
14. A strong interface between the family resilience service and the core social work teams ensures that transfer arrangements are in place to step children's cases up or down, according to the level of need. However, inspectors identified examples where social workers had been over-optimistic about parents' capacity to change, resulting in premature case closure after child protection plans had ended. This was particularly evident where social workers had not been curious enough or had accepted parental self-reporting without supporting evidence.
15. The prevalence of domestic abuse is one of the local authority's biggest challenges. It is a risk factor for 62% of children who are subject to a child

protection plan. Services available to support children and their parents are insufficient, with many having waiting times of several months. The multi-agency risk assessment conference (MARAC) considers children living in households where domestic abuse is a risk. Agency attendance at these important meetings is good, but there are delays by social care in recording actions, which consequently dilutes safety planning for children.

16. At 33%, the re-referral rate remains high compared to the England average (22%) and that of statistical neighbours (21%). The local authority has analysed the data and concluded that there is a range of causes for this high rate, including changes in processes in the MASH, delays in children accessing services and a lack of understanding of the long-term impact of domestic abuse. However, a common finding from this inspection is that inconsistent practice, poor management oversight and the closing of children's cases prematurely are key contributors to high re-referral rates. (Recommendation)
17. A wide range of early help services are in place for children and families, but they are not yet consistently effective in meeting the needs of children who require low-level support. When children need support from more than one agency, this is coordinated effectively. A panel of professionals, including representatives from schools, health and police services, meets fortnightly and considers requests for early help and to identify suitable multi-agency support. The local authority acknowledges that there is more to do to improve the early help offer and has well-advanced plans in place to do so.
18. The family resilience service works across the county and delivers effective intensive early help. During 2016–17, it supported a significant number of children (1,870) who have a wide range of needs, including those connected to domestic abuse, behavioural issues and parental mental ill health. Early help assessments and plans are mostly comprehensive. The local authority uses a range of approaches, including feedback from children and families, to evaluate the impact of the service. This is making a positive difference to some children's lives, but is not yet reaching all the children whom it needs to or having a demonstrable impact on reducing the number of referrals to children's social care.
19. When children are in need of help and protection, the MASH is the central point of contact for members of the public and professionals. The vast majority of referrals from partners are of good quality, enabling prompt decision-making about next steps. Professionals seek parental consent before sharing information. The recent introduction of a daily MASH meeting to consider children's cases that are more complex is improving information sharing and supporting timely decisions about the level of intervention required. However, information gathering where children's needs are at a low level is not always sufficiently prompt, meaning that a small minority of children's needs are unmet for too long.

20. Strategy meetings held in the MASH benefit from attendance from relevant partner agencies that share information appropriately. These meetings are generally effective and, where appropriate, lead to child protection enquiries and conferences for those children most at risk. However, once children's cases are transferred from the MASH, strategy discussions are not consistently effective. Health and education representatives do not routinely attend or contribute to strategy discussions. Consequently, in some situations, valuable and important information is not available to inform decision-making.
21. Overall, assessments are too descriptive and fail to draw on the family history or consider the child's needs arising from their culture or religion. Social workers routinely gather children's views, but the work undertaken with children does not demonstrate enough professional curiosity to find out what is happening to them to ensure a sound understanding of what life is like for them. Some assessments are of better quality, notably those carried out by the family assessment support team (FAST), and clearly identify risk and have a good level of analysis. (Recommendation)
22. The quality of children in need and child protection plans is too variable. Inspectors saw some good examples of both, but many lack clarity about the actions required or the timescales in which these actions are to be completed. Some plans include too many actions, making it difficult for families and professionals to understand where to focus their attention. Some plans do not explain the consequences or contingencies if the changes are not made. (Recommendation)
23. Relevant agencies attend core groups and share information, but do not drive forward the plan for the child effectively. Children do not routinely attend child protection conferences. Independent advocates are available for children involved in child protection processes, but the take-up of advocacy support is too low. Social workers visit children regularly and see them alone. However, the purpose of the visit is not always clear. Weaknesses in case recording, including delays in uploading documents, are evident. This could potentially lead to significant information not being available to the out-of-hours service and to a lack of clarity on the actions required to ensure that children are protected. (Recommendation)
24. Effective arrangements are in place to monitor both those children who are electively home educated and those who go missing from education. The local authority regularly updates thorough records. A home visitor carefully assesses educational and safeguarding arrangements for these children.
25. There are effective systems in place to support the assessment of 16- and 17-year-olds who present as homeless. However, the quality of assessment of young people's needs and the corresponding plan is too variable, and young people are not routinely informed about their rights to be accommodated under section 20 of the Children Act 1989.

26. The response to children at risk of child sexual exploitation and those who go missing has recently improved, but it is not yet consistently effective. Return home interviews are timely and of good quality, yet are not used consistently to inform plans to reduce risks to children. The multi-agency Swan unit provides intensive work with children at risk of exploitation and coordinates the successful disruption of the adults seeking to exploit them. However, assessments of children at risk of sexual exploitation are not sufficiently comprehensive to inform safety planning.
27. Following a recent restructure, two specialist teams work with disabled children. These teams competently assess need and risks, taking authoritative action in the majority of children's cases. There is a good range of resources and multi-agency support for disabled children. Strengthened transitions arrangements have improved the pathway for children moving into adulthood.
28. Significant awareness raising and the development of clear policies have enabled the local authority and its partners to respond effectively to concerns regarding both female genital mutilation and radicalisation.
29. Awareness raising about private fostering has been undertaken, and arrangements to monitor children have been strengthened. A nominated social worker now leads on private fostering assessments. Nevertheless, delays are still evident in conducting assessments.
30. The designated officer provides a timely and effective response to concerns about adults who work with children. Work to raise awareness of the designated officer role to ensure a full understanding of professionals' responsibilities has taken place with a wide range of professionals. Close working arrangements are evident in the majority of cases sampled.
31. The service for children and their families who need support and intervention out of hours is sound. In the children's cases seen by inspectors, comprehensive support was effective in resolving difficulties for children and information was appropriately passed to daytime teams for further action.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Inadequate</p>
<p>Summary</p> <p>There continues to be some serious inadequacies in the service to children looked after in Buckinghamshire. A small number of children have experienced further significant harm and neglect while being looked after, and growing risks do not always receive a timely or effective response. When children return home from care, assessments about whether these arrangements are suitable and safe are not sufficiently rigorous. Children in care who are placed with parents are not all visited regularly, and there is insufficient oversight of their safety and progress.</p> <p>The local authority has made some improvements for children looked after, but not enough to improve the circumstances for all of these children. Oversight by independent reviewing officers (IROs) has increased, but they are not yet reliably making a positive difference for all children looked after. Increased oversight of the Public Law Outline (PLO) during pre-proceedings leads to the appropriate and timely initiation of court proceedings, when necessary. Improvements in the quality of return home interviews for children who go missing now provide much richer information, obtained by persistent, specially commissioned workers.</p> <p>The timeliness of health assessments and reviews has improved. Children looked after have access to a wide range of appropriate provision to meet their mental health and emotional needs.</p> <p>The virtual school's careful monitoring of personal education plans gives children good support with their education, allowing them to make suitable progress in line with their level of development. Their attendance at school is good.</p> <p>The authority has been successful in maintaining a service-wide focus on achieving permanence at an early stage. The majority of children live in accommodation that meets their needs. An effective adoption service enables adoption for comparatively large numbers of children from a wide spectrum of ages and needs. Adopters receive excellent support, when required.</p> <p>Recent developments in the corporate parenting panel provide the Children in Care Council with the opportunity to give its views directly to senior managers and elected members.</p> <p>Care leavers' pathway plans now incorporate their views. However, care leavers do not yet receive summaries of their health history and not all young people know about their entitlements.</p>	

Inspection findings

32. There continue to be critical weaknesses in the service to children looked after in Buckinghamshire. This has resulted in a small number of children experiencing further significant harm while in care. A few children in care and placed with parents have continued to live in neglectful circumstances and some have not had all their basic needs met. For these children, the local authority did not recognise escalating risks and did not take firm action to protect them. When children looked after go missing and are vulnerable to criminal or sexual exploitation, risks are not analysed and the response is delayed and weak. Important information obtained from children in the comprehensive return home interviews does not quickly inform analysis and plans to reduce risks.
33. Thresholds for entry to care and recent decisions to look after children are appropriate to safeguard them. Effective mediation and interventions with families in crisis by the children and teenager community help team, CATCH, has helped families to restore fragile relationships and appropriately supported many children to avoid re-entering care unnecessarily.
34. When children return home from care, assessments about whether it is safe to do so are not sufficiently dependable and plans to support children are not always strong enough. For a small minority of children it was uncertain if it was safe for them to return home. Senior management approval and oversight were absent before some children left care. There is an overly optimistic view about parents' and other family members' willingness and capacity to comply with contracts of expectations, leaving some children at home without adequate support. (Recommendation)
35. Social work practice is not always sufficiently child focused. Some assessments are thoughtful and lead to logical and well-formulated conclusions and recommendations. However, in too many cases a lack of professional curiosity has adversely affected decisions about the safety and well-being of children. Basic questions about historical events or children's current circumstances are not explored and evaluated. Significant information is not always included in assessments and, for these children, the resulting plans and interventions are often vague and generalised.
36. The quality of management oversight is inconsistent, unclear and contradictory, sometimes leading to further delay. Supervision is not always regular and is predominantly focused on tasks and actions. There is very little recorded evidence of insightful, reflective case discussion.
37. In more recent children's case files, independent reviewing officer (IRO) monitoring is visible and comprehensive. IROs compile careful minutes of reviews with specific and timely actions, demonstrating an overriding focus on the child. IROs meet with and listen to children, encouraging them to take part in or contribute to their reviews. However, IROs' escalations of their concerns

to managers have not prevented some children from experiencing delay in achieving permanent homes or ensured that they are safe. (Recommendation)

38. The quality of case recording is variable. Too many children's files are not up to date, or have incomplete documents, care plans and case notes which lack information about significant events or changes in a child's circumstances. However, in a small number of children's case files, succinct, clear chronologies and case summaries help the reader to understand the child's current circumstances quickly. Social workers do not record when return home interviews take place or the significant information gained from these interviews. Incomplete records make it difficult for other professionals, such as the out-of-hours service, to make effective decisions about the safety of children, particularly where children regularly go missing or are at high risk of sexual or gang-related activity. (Recommendation)
39. Arrangements for the support and oversight of children looked after who are living at home under placement with parents' regulations are not sufficiently diligent. Visits to children living under these arrangements are not frequent enough, and when visits are undertaken there is a lack of professional curiosity about children's living circumstances or progress. Management oversight has not identified these practice shortcomings. Consequently, a small number of children have remained in unacceptable or harmful circumstances for too long. (Recommendation)
40. The local authority's own process of undertaking initial age assessments has led to inappropriate placement decisions for a few unaccompanied asylum-seeking children. Their vulnerability in the early days of coming into care is not sufficiently recognised or responded to appropriately, delaying their progress and failing to ensure their safety. Procedures for supporting these children when they come into care over the weekend are not sufficiently rigorous in assessing risks and meeting their immediate needs. (Recommendation)
41. The majority of care plans are not up to date or specific enough to understand the child's lived experiences or the risks and difficulties that they face. These plans do not effectively or promptly address delays or deterioration in children's conditions. Weaker plans lack concrete actions to progress children's circumstances, and managers and IROs do not consistently follow up to ensure that actions are undertaken. (Recommendation)
42. Children have benefited from increased oversight and tracking of the pre-proceedings phase of the Public Law Outline (PLO) following the recommendations made in earlier monitoring visits. A dedicated electronic workspace for PLO and court work is a positive development. However, it is new, and not all staff are fully trained and confident in using the workspace. Letters before proceedings are mostly clear, and parents understand what changes they need to make and the timescales for doing so. A few examples seen were weaker, and included information that had been 'cut and pasted' from the case file, making these letters impersonal and reducing their impact.

43. The quality of practice in care proceedings has improved. Relationships with the judiciary are constructive and there is an informed debate about areas of shared concern, such as domestic and substance misuse. IROs are working more closely with the Children and Family Court Advisory and Support Service (Cafcass). Social workers' court expertise has increased and they now have a better understanding of when to ask the court to make a decision about children. This helps to reduce unnecessary delay for children in court proceedings.
44. Social workers visit children and demonstrate a genuine desire to improve their circumstances, yet the visits are not always effective, because they are not sufficiently inquisitive about what is going on in children's lives. Some social workers know children well, but this is not always evident from children's case records. Most social workers do not routinely record or consider in depth children's wishes and feelings. Assessments and plans do not clearly differentiate between the views and needs of individual children when brothers and sisters are included in the same assessment report. In most cases seen by inspectors, children's diverse needs and different ethnic and cultural backgrounds are not fully recognised and understood. (Recommendation)
45. Some children spoke warmly about their social workers, but others have had too many changes of social worker. One described the impact of having to make new relationships as making her feel 'like a doll with a string that's been snapped'. Another child had waited anxiously for an additional week to find out if he could stay long term in his foster placement, because his social worker was away and nobody had remembered or thought about the importance of telling him the outcome of the final hearing. Frequent changes of social worker also disrupt the success of direct work, where trusting relationships need to be established before sensitive purposeful work can take place.
46. The majority of children benefit from early consideration of permanence and there is service-wide priority given to achieving permanence for children looked after. This is particularly noticeable for babies and very young children, and is increasingly evident for older children and those moving towards independence. Improving tracking and monitoring arrangements are helping social workers to identify permanent homes for children earlier. Children are carefully assessed for the most suitable permanent placement with special guardians, adopters, connected persons or long-term fostering.
47. The majority of children live in placements or accommodation that meet their needs, and are well cared for. However, a small minority of children experience multiple placement moves or live a long way from their home area, which disrupts their education during the initial weeks of care. Comprehensive plans to develop more local placements for all children looked after are in place, and these efforts are gradually increasing the number of suitable placements nearer to home.

48. Foster carers are assessed, trained, approved and supported well. Conscientious, dedicated supervising social workers support carers carefully and record their work correctly. An experienced fostering panel chair capably oversees an inquisitive panel that probes approvals and matches carefully. However, in one case seen by inspectors, the reasons for recommending and approving a carer with past behaviours that could present a potential risk to children were not sufficiently clear or authoritative. The quality of prospective foster carer assessments would be improved by a more nuanced consideration of applicants' potential vulnerabilities, as well as documenting their considerable strengths.
49. The timeliness of health assessments is improving. Children placed out of county generally receive a timely service, because of a pool of general practitioners who promptly undertake initial health assessments. Children with mental health and emotional well-being needs benefit from timely access to a range of therapeutic services and pathways. A dedicated multidisciplinary child and adolescent mental health looked after children team provides access to the right level of service. Children and families appreciate the support of mental health 'buddies' to navigate the complex interface between different services.
50. There are clear improvements in the quality of the return home interviews conducted by the commissioned service, which is persistent and tenacious in this work. Informative and comprehensive information about children's reasons for going missing and their wishes and hopes for the future are sensitively elicited and plainly recorded. However, social workers and managers do not always use this helpful information effectively to inform safety planning for high-risk young people who go missing.
51. Children's participation and influence on decisions and plans are improving. The 'We do care' Children in Care Council interviews applicants for jobs in children's services and, more recently, young people have attended the corporate parenting board. Children have access to advocacy and receive support when they want to make a complaint. A large number of children benefit from having independent visitors, including those children placed out of county.
52. The school attendance of all children looked after up to the age of 16 is good, and the virtual school team makes sure that their children attend schools that are judged as good or outstanding. Children looked after receive very few fixed-term exclusions, and they return to school as a result of successful steps, taken in partnership with the virtual school team, to reintegrate them. Effective arrangements enable the small number of children looked after who are missing education to receive suitable alternative education and improve their attendance and achievement. The virtual school also works well with other local authorities to provide suitable education for children living out of county.
53. All children looked after in schools have personal education plans (PEPs), which the virtual school monitors carefully and regularly for quality and impact. Children have benefited from the introduction of an e-PEP. Using the new

format, pupils express their views about their experiences clearly and well. This has made the process of allocating pupil premium funding more efficient and effective, providing children with opportunities to develop self-confidence through attending extra courses and personal tuition for improving their English, mathematics and other skills. This funding also allows children to benefit from being mentored, attending nurturing courses and receiving counselling. Children looked after are making appropriate progress in their level of development at the different key stages. The difference in achievement between children looked after in Buckinghamshire and their peers is decreasing.

54. The virtual school staff keep a log of all incidents of bullying. The staff, through the PEP review process, check how schools deal with issues and the measures put in place to support pupils and prevent further bullying.

<p>The graded judgement for adoption performance is that it is good</p>
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55. More children have been placed with adoptive families by Buckinghamshire in recent years than in most other local authorities. These include older children, brothers and sisters, disabled children with special needs and children from minority ethnic communities. Securing adoptive families for a significant number of children needing permanent families is a notable achievement.
56. The time that it takes for children to move into their adoptive families from the point when they come into care has been longer than that in the majority of other local authorities. However, this measurement has to be balanced by the breadth and complex needs of many of the children who are adopted in Buckinghamshire. The process of family finding and matching justifiably takes longer for some children. In the past 12 months, unpublished local authority data indicates that timeliness is improving significantly, and there is well-founded expectation that this will become a sustained trend.
57. Determined efforts have identified more children who may require permanent families at an earlier stage. Family finding starts for many children before decisions for adoption have been formalised, indicating stronger and earlier parallel planning. Fostering for adoption placements are well established, enabling children to move quickly and seamlessly into their adoptive families if court directions allow. Early permanence planning for children also includes special guardianship and connected persons' assessments. This is demonstrated by a sizeable increase over the past year in the number of special guardianship order arrangements for children. All forms of suitable permanence arrangements for children are carefully weighed and balanced during care proceedings.
58. Family finding is thorough and careful. Close attention and thought are given to skilled and sensitive profiling of children needing a permanent family. Proactive, determined efforts to find a suitably matched adoptive arrangement are made

for all children needing adoptive families. Particularly vigorous attempts are made for brothers and sisters to be adopted together, and for children with developmental delays and special needs to be adopted even where there are uncertainties about the future impact of their needs. Potential adopters are well informed and prepared to understand these complexities and the associated uncertainties. They are given comprehensive medical information and advice, providing them with important information about children to help them to consider whether they can meet their needs throughout their childhood.

59. Social workers and managers in the adoption service are experienced, committed and knowledgeable about the children, potential adopters and adoptive parents whom they work with. Managers provide specialist, clear direction and oversight for social workers. Adopters spoken to report a high standard of service throughout the adoption process.
60. Assessments of potential adopters are well written, with carefully considered analysis and reflection interwoven into accounts of applicants' personal histories and underlying motivations in considering adoption. Potential vulnerabilities are sensitively explored. Assessments still take too long to complete, but the timeliness has improved substantially over recent months. There are strong grounds to consider that this positive trend will continue, following effective changes to the service structure, and this will promote greater practice specialism and more dedicated management oversight. Applicants from a diverse range of ages, sexual orientations, cultural backgrounds and family structures seek to become approved as adopters. This is likely to be an important factor in the local authority's success in matching a wide spectrum of children to adopters.
61. Most assessments of potential special guardians and connected persons are undertaken in the adoption service also, resulting in effective, balanced and detailed evaluations of the suitability of these long-term caring arrangements for children. A strong commitment to placing brothers and sisters together when it is their joint best interests is exemplified in authoritative 'together or apart' assessments, which are informed by a clear awareness of child development and attachment theory.
62. The adoption panel is led by an experienced and knowledgeable chair and benefits from a balanced membership, including adopters and an adoptee. Professional, legal and medical advice to the panel is skilled and assured. Panel meetings are well recorded, demonstrating diligent preparation and careful, probing questions of proposed adopter approvals and matches to children. The quality of the approved decision maker's decision-making has improved over the last six months, illustrated by extensive background reading and informed comments that explain the reasons for decisions.
63. Child permanence reports seen by inspectors were of a good standard, but the panel chair considers that not all of them are of a consistently high quality, noting that there is a discernible recent improvement. Adoption team social

workers are advising social workers who prepare the reports in other teams on how to compile and improve them.

64. Children are diligently prepared for moving to their adoptive families. Imaginative and sensitive approaches help them to begin to understand what their new home looks like and who is in their family. Foster carers and their family members are closely involved in this preparatory work and remain in contact with children following their moves to permanent families. This eases children's integration into their adoptive families and avoids abrupt endings to important relationships and attachments. There have been no pre-adoption order breakdowns in the year preceding the inspection. Social workers prepare colourful and illustrative life-story books and later-life letters with evident care, affection and curiosity about children. This helps children to understand and further develop their positive self-identities as they grow up, with the help of their adoptive parents.
65. The availability, quality and breadth of adoption support are a considerable strength in Buckinghamshire. This offer is also available to special guardians and other permanent carers looking after children through connected persons arrangements. Adopters report that it is responsive and effective, and has a positive impact by ameliorating serious difficulties in managing children's difficult behaviours, particularly during their adolescent years. The adoption support fund is extensively used to provide evidence-informed therapeutic interventions, and adoption workers are trained in therapeutic techniques. The virtual school pays close attention to supporting the educational progress of adopted children and those in other permanent family settings.
66. Children who are adopted benefit from appropriately assessed contact with those important to them through both direct and letterbox contact. This enables children to maintain relationships, where appropriate, and receive letters that will help them to make sense of their identities as they grow up. Support for birth parents is readily available, helping them to make difficult decisions and to remain involved with their birth children, where appropriate, through indirect contact and by providing information for ongoing life-story work.

The graded judgement about the experience and progress of care leavers is that it requires improvement to be good

67. The Aftercare team supports 194 care leavers, including 32 young people who were previously unaccompanied asylum-seeking children. Children looked after have the benefit of support from their social worker and personal adviser from the age of 16 to help their transition to becoming independent. They are pleased with the help that they receive and the availability of their personal advisers.

68. Personal advisers are in regular touch with all but three care leavers, and the Aftercare team knows the whereabouts of these young people. The young people feel able to make contact with their personal advisers when they need to, particularly when they need advice or assistance.
69. Care leavers are aware of risks to themselves, and they feel safe where they live. They have good relationships with their personal advisers and therefore know that they can go to them for help or if they have concerns about their well-being or safety. For example, timely action and guidance from their personal adviser helped one young person to remove themselves from an abusive relationship.
70. The revision of pathway plans has improved the way in which personal advisers and young people engage productively in the process. The plans are focused on the young people's immediate situations and they are reviewed by assistant team managers to check that the needs of young people are met. However, there is no process or forum to share either good practice or the learning from reviewing the pathway plans.
71. The quality of pathway plans is too variable. The action plans are not specific in explaining what young people need to do and when. They do not include details of what to do if plans change or do not turn out as expected, therefore do not encourage young people to think ahead. This omission does not help young people to improve their skills to be adaptable and creative in looking ahead.
72. The majority of pathway plans reviewed at inspection do not include assessments of risks related to the circumstances of the young people. Consequently, they are not necessarily aware of the difficulties that they may face. Limited information about the history and personal background of each young person does not provide a full, rich picture that a young person can relate to when they want to look back and reflect on the progress that they have made in their life.
73. Care leavers receive good support from their personal advisers for their health needs, such as accompanying the care leavers to the doctor or arranging for them to see the nurse. The pathway plans record important information such as their national health numbers and details of health professionals such as the dentist and doctor. Those young people who experience mental health difficulties receive help readily from the mental health team.
74. Care leavers do not receive a summary of their health history. However, young people have been involved in the design of a health passport, which is being trialled by some young people in the Children in Care Council. Nevertheless, the production and dissemination of these health passports to all care leavers have not progressed quickly enough. (Recommendation)

75. The financial help that care leavers receive from the Aftercare service enables them to become more independent and learn how to manage their money carefully. They use sensibly the grants for which they are eligible, such as for accommodation and equipment for study. Care leavers studying in higher education, while valuing their independence, appreciate the support of their personal advisers when they need it.
76. Care leavers who are in custody, young parents and those who are pregnant receive appropriate assistance from their personal advisers. They are visited regularly, and are given sound practical guidance and emotional support that help to build their confidence to face challenges. Young people acquire the skills that they need to make their way on their own.
77. Care leavers receive appropriate help in finding suitable accommodation. The numbers of care leavers currently in accommodation that is deemed to be unsuitable are very small. At the time of inspection, seven were in custody and two care leavers were living in bed and breakfast accommodation, having been recently released from custody. The accommodation was assessed for risk, but the use of bed and breakfast in these cases highlights a deficiency in both planning and suitable placement availability.
78. Relationships between the local authority and the providers of accommodation are good. The local authority trains its staff to be alert to safeguarding issues affecting young people. Appropriate checks are carried out to make sure that the accommodation is of a high standard and secure, and that young people feel safe.
79. The Aftercare team works closely with the local authority's commissioning team in the housing bidding system, and care leavers take precedence for local authority accommodation. At the time of inspection, 29 young people remained living with their foster carers after their 18th birthday as part of the 'staying put' programme, an increase from 22 in January 2017.
80. Care leavers receive good support that enables them to continue with their education or find employment or training. The number that stay in education or gain employment or training has increased this year. A high proportion undertake appropriate courses that prepare them well for their next steps. Currently, the Aftercare team is supporting 13 care leavers in higher education.
81. The partnership and transition arrangements through the virtual school and with the local college are very effective. Currently, the local authority does not provide apprenticeships or traineeships specifically for care leavers, but plans to address this are now advanced. However, young care leavers with special educational needs can undertake supported internships.
82. Care leavers take part in the annual celebration of achievements for young people. As members of the Children in Care Council, they take part in interviewing and making decisions on the appointment of social workers. Four

young people are currently being trained as champions to advocate on behalf of other young people.

83. Care leavers have contributed positively to producing a booklet setting out what they can expect during their time in care and on leaving care. However, the majority of young people are unaware of its existence, due to the newness of the booklet. Formal means to learn from young people, for example from complaints or suggestions, are still not promoted effectively to them. Several care leavers were unaware of how to make their views known or make a formal complaint. (Recommendation)

Leadership, management and governance	Inadequate
<p>Summary</p> <p>Since the last inspection in 2014, services for children in need of help and protection, and for children looked after, have not improved sufficiently quickly or consistently. At this inspection, inspectors saw critical weaknesses, and some children, including a small number of children for whom the local authority is a corporate parent, were left in risky or neglectful situations for too long. Senior managers within children’s services have not been effective in adequately identifying all areas of the poor practice or serious deficits seen by inspectors.</p> <p>Managers do not consistently provide social workers with sufficient challenge or support. Decisions made by managers are not always implemented, and managers’ failure to track children’s progress means that plans for some children are not swiftly progressed and their circumstances do not improve quickly enough.</p> <p>Inspectors recognise that there has been a considerable shift in the priority given to children’s services by senior leaders since the last inspection. The chief executive, newly appointed director children’s services (DCS), leader of the council, cabinet portfolio holder and elected members are now clear about their statutory responsibilities and are committed to, and ambitious for, children in Buckinghamshire. Children are now a top priority for the council, and significant and necessary financial investment has been made in services for children and their families.</p> <p>Inspectors found some areas of progress and improvements, including in response to the poor practice identified in previous monitoring visits. However, the majority of these improvements are very recent and it is too early to evidence sustained positive impact for children.</p> <p>The recently updated quality assurance framework now focuses on monitoring practice and has had some positive impact on improving practice in some areas. However, not all areas of practice have been subject to robust monitoring and the audit tools are not yet aligned to measure improvements for children effectively.</p> <p>A suite of regular performance information feeds into a range of forums. However, due to poor recording in children’s case files, information reports are not yet consistently accurate. This prevents managers from having a comprehensive and accurate understanding of the needs of children and the quality of frontline practice.</p> <p>Despite a concerted effort to stabilise the workforce, children still have too many changes of social workers. This, coupled with high caseloads in some teams, makes it difficult for children to build meaningful relationships with their allocated worker.</p>	

Inspection findings

84. Inspectors found that senior managers within children's services were not aware of all of the weaknesses identified during this inspection. Other shortfalls identified during previous monitoring visits had not all been dealt with effectively. As a result, some children have not received timely help that was proportionate to risk. Poor oversight of a small number of children looked after who are placed with their parents has left them in neglectful situations for too long. These children, for whom Buckinghamshire is the corporate parent, have needs that have not been well met and some have suffered further harm.
85. The chief executive, leader of the council, newly appointed director of children's services (DCS) and cabinet member for children's services, supported by corporate services, elected members and partner agencies, have shown their commitment to improving the quality of social work practice for children in Buckinghamshire. Senior leaders openly acknowledge the serious failings identified in 2014 and now ensure that children's services are a top priority for the council. There has been significant and necessary financial investment since the last inspection in 2014.
86. Although new to the post, the very recently appointed DCS is an experienced leader with considerable experience of working at a strategic level in several local authorities. He accepted all of the shortfalls identified by inspectors during this inspection and promptly developed an action plan to deal with them.
87. Suitable governance arrangements are in place between all relevant strategic boards. A recently established meeting of the chairs of the boards, chaired by the Buckinghamshire County Council chief executive, is ensuring that there is clear alignment of priorities and has improved the quality of joint working arrangements. Recently, joint work across all boards has focused on awareness raising and identification of female genital mutilation and an update of the neglect strategy.
88. Regularly updated multi-agency performance information within the joint strategic needs assessment (JSNA) informs commissioning activity. A review of commissioning structures has recently started, focused on ensuring that evidence-based commissioning meets the needs of local communities and improves outcomes. Operational children services leads have only very recently become involved with contract monitoring to consider the quality of services, and it is too early to see any impact of this to improve services.
89. Collaborative regional and cross-regional work on the children looked after and placement sufficiency strategy has been effective in increasing the range and choice of local residential placements. Significant investment in two in-house residential children's homes, due to open in 2018, will extend the choice of local residential placements further. Recruitment activity has led to a small net gain in in-house fostering households. However, there is still more work to do in ensuring that children have access to a wider range of high-quality placements.

90. Inspectors found that management oversight of children's cases occurs more frequently than at the time of the last inspection. However, the decisions made by managers are not always implemented, sometimes due to changes in the child's social worker. Failures by managers to consistently monitor children's progress mean that, for some children, plans are not implemented swiftly and, as a result, children's circumstances do not improve. This correlates well with the findings of the local authority's own audit of supervision undertaken in June 2017, in which, of 91 files audited, 57% did not yet meet the standard of good. (Recommendation)
91. A suite of regular performance information now feeds into a range of routine forums and management meetings. However, due to poor recording in children's case files by frontline staff, information reports are not yet consistently accurate, including the submission by statutory return to the Department for Education. This prevents managers and leaders from having a comprehensive and accurate understanding of the needs of children or the quality of frontline practice. (Recommendation)
92. Inspectors found clear improvements in arrangements for corporate parenting, with a comprehensive induction, training and ongoing briefing programme in place for elected members. The recently relaunched bi-monthly corporate parenting panel, chaired by the cabinet member for children's services, has a wide membership and appropriately includes foster carers, independent reviewing officers, education representatives, commissioners and operational health service staff. Children in Care champions, supported by the participation officer, have very recently begun to attend these meetings. This is a welcome development and inspectors observed their contribution to the meeting, bringing alive the experience of children and young people.
93. However, despite appropriate challenge raised by the panel, the pace of change to implement some issues has been slow. For example, health summaries for care leavers are still in draft. The chair and the DCS acknowledge that reports and data produced for the corporate parenting panel require further development to ensure that panel members receive the information that they need to understand and challenge performance effectively to improve outcomes for children. Work is underway to achieve this by improving the data included on the corporate parenting dashboard.
94. Quality assurance activity is not yet consistently driving improvement in practice. The quality of audits seen by inspectors on cases tracked during the inspection has improved, accurately identifying all areas of weaker practice. Inspectors saw some areas of improvement. However, not all areas of practice have been subject to robust monitoring, and the audit tools do not give sufficient attention to qualitative as well as quantitative data. (Recommendation)
95. Ongoing work is in place with social workers and frontline managers to understand the impact of non-compliance with practice standards, especially in

relation to case file recording. The principal social worker is picking up the quality of recording through his work with staff since his recent appointment in August 2017. However, it is too early to see the impact on improving practice for children and the accuracy of management information reports.

96. Learning from complaints and compliments has improved. Quarterly reports reflecting on findings are regularly considered at performance forums and at the county managers groups to help to improve the quality of practice. However, there is more work to do to ensure that complaints are responded to in a timelier manner.
97. Strengthened partnerships with education and health services have led to better coordination and wider availability of both statutory and early help services and resources to Buckinghamshire children and their families. Alongside partner agencies, there has been effective prioritisation and development of strategic responses to child sexual exploitation. A wide range of awareness raising in the community is overseen by the Buckinghamshire Safeguarding Children's Board and the Safer and Stronger Buckinghamshire Partnership Board. Appropriate further work is in development to identify and develop crossover between child exploitation, 'missing', county lines, gangs and radicalisation to safeguard children further.
98. The council has made significant financial investment in children's services in recognition of the improvements still required. This includes ongoing work to improve the integrated children's recording system and resources to build and sustain workforce stability. The churn in social work staff has been reduced, and at the end of September 2017 it was 14.2%. Close monitoring of the development and stability of the workforce through regular monthly meetings is in place, assisted by the development of significantly improved staffing data reports. This is resulting in more timely recruitment to vacancies. The reliance on agency staff is being reduced, but the local authority has made a positive decision to invest in agency staff where necessary to cover vacancies, including those arising from sickness or maternity leave, and also to increase the social work establishment to support the cohort of 18 newly qualified social workers. Despite this concerted effort to stabilise the workforce, some children still have too many changes of social workers and this, coupled with heavy caseloads in some teams, makes it difficult for children to build meaningful relationships with their allocated worker.
99. The annual training needs assessment does not currently track attendance at mandatory training. The local authority cannot be sure that all staff have received the correct training or attended updated training to ensure that their knowledge, skills and practice are up to date. Currently, there is no collation of the training needs that are identified in individual staff annual appraisals to underpin the training programme. (Recommendation)
100. In partnership with Buckinghamshire New University, children's services have established a social work academy offering a range of master classes and pop-

up continuing professional development events. All staff and partners spoken to spoke positively about the range of learning and development opportunities available to them. The local authority is actively engaged in 'growing its own' social workers, in partnership with Buckingham New University and the Open University, through the 'Step up to social work' programme. Newly qualified social workers in their first year of practice benefit from a good range of workshop support, reduced workloads and enhanced supervision.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. 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 work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of 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 what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who 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.

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

The inspection team

Lead inspector: Margaret Burke

Deputy lead inspector: Tara Geere

Team inspectors: Linda Steele, Kate Malleson, Nick Stacey and Peter Green

Shadow inspectors: Maria Anastasi

Senior data analyst: Judith Swindell

Quality assurance manager: Janet Fraser

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Piccadilly Gate
Store Street
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk
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