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Dear Mr Munday,

Monitoring Visit to Barnet children's services

This letter summarises the findings of the monitoring visit to Barnet children's service on 25 and 26 April 2018. The visit was the third monitoring visit since the local authority was judged inadequate in July 2017. The inspectors were Louise Warren, HMI, and Tara Geere, HMI.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in the area of vulnerable adolescents across a range of teams, including children in need, children subject to child protection plans and children looked after. All the children's cases reviewed had been considered at the multi-agency sexual exploitation (MASE) panel or the children were deemed to be at high risk of being missing, gang affiliation or criminal exploitation.

Inspectors focused on:

- the effectiveness of partnership working for vulnerable adolescents
- the effectiveness of management oversight and supervision
- the quality of assessments and planning.

A range of evidence was considered during the visit, including electronic case records, supervision files and notes, case management records, performance data, audits and progress reports. Inspectors spoke to a range of staff, including managers, social workers and practitioners.

Overview

In the areas of practice considered during this visit, the local authority is consolidating the recent improvements to services for children and young people identified during the previous monitoring visits. Senior leaders and managers are maintaining their focus and there is an appropriate pace of change in continuing to develop and embed improved quality social work practice across the service. Senior leaders and managers understand that services for children continue to require improvement.

Some developments, such as improved quality assurance processes and an increase in permanent staffing, are becoming better established. The improvement board and the local authority improvement partner continue to provide expertise and support to senior leaders, and to appropriately monitor the pace and implementation of improvements to services. Managers and auditors are now more effectively auditing social work practice, with appropriately decreasing oversight from the improvement partner.

Current practice for those children at risk of child sexual exploitation and of going missing is well embedded operationally and strategically. Since October 2017, senior leaders have appropriately developed the scope of the strategic focus to include children who are at risk of gang affiliation, radicalisation and criminal exploitation. This has led to improvements in practice and more effective oversight of these co-related issues.

Inspectors found some improving progress in the quality of social work practice. Immediate risks for almost all children are adequately addressed. Less case work was of an inadequate standard than on previous monitoring visits, and most children were being appropriately safeguarded. Practice remains inconsistent and some case work remains inadequate.

Findings and evaluation of progress

Staff spoken to by inspectors reported consistently that they enjoy working in Barnet, and that senior managers and managers are approachable and available to offer support and guidance. Caseloads are manageable, although a very small number of staff reported case work pressures. New staff are being recruited to vacancies and permanent staffing is continuing to stabilise. Social workers and other staff report that an effective range of training and support is available to them.

Quality assurance processes, aligned with senior managerial oversight, is identifying and addressing issues effectively, leading to improvements in social work practice. The cases tracked and audited by the local authority for this monitoring visit accurately reflected deficiencies in practice and identified the more positive areas of case work. Reflective sessions by auditors following a finding of inadequate practice

are providing opportunities for further monitoring. This oversight of poor practice is enabling social workers to learn and better recognise the components of good practice. Inspectors found some very thorough senior management oversight on some cases. However, the identified actions required are not always being followed through by social workers and team managers quickly enough. This means that, the plans for some children are not being progressed effectively to achieve positive outcomes or improve their circumstances.

For vulnerable adolescents at high risk of exploitation, regular and effective strategic multi-agency sexual exploitation (MASE) meetings and operational 'Pre-MASE' meetings provide effective scrutiny, advice and guidance to multi-agency partners and social workers. This is leading to improved safeguarding practice. Recent plans to broaden the scope of these meetings to become a vulnerable adolescent risk panel is positive. The Safeguarding Adolescents at Risk Group (SARG) was formed in 2017 to broaden the scope of strategic planning and operational practice. The new vulnerable adolescent strategy, launched in April 2018, provides the foundation for a new vulnerable adolescents' at-risk panel (VARP), which is a positive development. However, these developments are still relatively new and are not yet embedded to influence frontline practice.

The effective gathering of information from multi-agency partners currently informs disruption activities, including mapping and the linking of children at risk across the borough. This informs and promotes preventative and awareness-raising work. Appropriate oversight by senior leaders ensures that the monitoring and reviewing of children only ceases following their managerial sign off and agreement that risks have been sufficiently addressed. This provides an important and effective safeguard for these children.

Within the cohort of vulnerable adolescents considered by inspectors during this visit, it was evident that social workers are routinely attending multi-agency strategy meetings (SEAM) to analyse and share the risks that children are facing. Social workers report that they find these meetings useful in pulling information together to identify and provide better support to safeguard children. However, inspectors noted gaps in health and police attendance, which limits the effectiveness of these meetings. A recent example of a young person attending a SEAM meeting provides evidence of good practice in assisting professionals to consider risk from a young person's perspective. For children missing, the return home interview (RHI) take-up is low at 47% (March 2018) and is not effectively engaging all children. However, information from those RHIs that have been completed is being appropriately used to inform disruption activity, preventative work and the mapping of locations of concern.

The identification of risk, and the use of risk assessments within case recording, remains variable. Despite SEAM meetings happening regularly, some risks for children, although recognised and closely monitored, are not fully addressed. For example, for some children subject to child protection plans and child in need plans,

thresholds for legal planning are not always being considered when risks escalate. This means that some children become looked after in reactive or emergency circumstances. For other children, professionals were over-optimistic about the challenging nature of the risks they were facing or of their resilience to protect themselves. This means that some cases are 'stepped down' from a child protection plan to a child in need plan too soon. On occasion, this has led to less focus by professionals and an escalation of risk.

More specialist multi-agency working and support for young people is provided by the targeted youth service, the Westminster drug project and the art against knives project. Further helpful support from the virtual school assists children looked after to remain in school, or find a new school, college place or work opportunity to address risks, and has been successful in providing valuable activities and educational opportunities.

While children are seen regularly by their social workers, practice is variable. Some children are being seen at six-weekly intervals, though this is not always sufficient to build positive relationships or respond to the changing, complex situations that children are facing. Inspectors found some better practice where social workers are visiting weekly. This enables them to know their children well and build positive relationships to understand their needs more fully. There is variable evidence of the voice of the child being used to underpin planning. Parental engagement is inconsistent, and fathers are less engaged than mothers in assessments and planning.

The quality of assessments remains variable and not all assessments routinely explore parental capacity or analyse historical issues within families to inform understanding and planning. This means that not enough assessments are comprehensively addressing all the issues that impact on children's lives. Inspectors found some stronger assessments where children were involved and were able to contribute to share their views, aspirations and feelings. Children's diverse needs and those of their families are not consistently addressed sufficiently to inform their sense of identity, family heritage or other protected characteristics.

Plans for children are inconsistent and generally of weak quality. For example, some care plans and pathway plans were out of date and not fully informed by children and their families. Inspectors found evidence of reactive planning, which, while keeping children safe immediately, does not address longer-term issues, or is insufficiently targeted to improve outcomes. Child in need planning is inconsistent, with less oversight by managers and other professionals. In response to this, the local authority has created a child in need panel that will begin to address and improve performance in this area. There is too little evidence of child protection chairs or independent reviewing officers providing consistent challenge to address weaker planning or drift and delay. The local authority is currently reviewing this service to make improvements.

Supervision records seen by inspectors are of variable quality and supervision is not always happening regularly for all social workers. In some cases, supervision was not effective in progressing plans in a timely way or providing space for reflection on complex practice issues. More recent records demonstrate improving management oversight and supervision is evidencing better management grip to improve practice. Other records demonstrate that supervision is very comprehensive and thorough.

In summary, the pace of change has remained consistent and focused. The quality of social work practice is now slowly improving, and inspectors have seen less inadequate practice during this monitoring visit. Senior leaders are fully aware that there are still areas of considerable challenge before practice is of a good standard and the needs of children are well served.

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

Yours sincerely

Louise Warren

Her Majesty's Inspector