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Dear Mr Munday

Monitoring visit of Barnet local authority children's services

This letter summarises the findings of the monitoring visit to Barnet local authority children's services on 27 and 28 November 2018. The visit was the fifth monitoring visit since the local authority was judged inadequate in July 2017. The inspectors were Louise Warren, Her Majesty's Inspector, and Andrew Waugh, Her Majesty's Inspector.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in the areas of help and protection, including:

- the effectiveness of the multi-agency safeguarding hub (MASH) in responding to concerns for children, including the application and understanding of thresholds for statutory intervention and early help
- the quality of practice pertaining to strategy discussions, section 47 enquiries, and assessments that lead to child protection and child in need work and planning
- the quality of case recording, management oversight and supervision. This is to include the use and effectiveness of performance management and quality assurance information.

A range of evidence was considered during the visit, including electronic case records, observation of social workers and senior practitioners undertaking referral and assessment duties and other information provided by staff and managers. In addition, inspectors spoke to a range of staff, including managers, social workers, other practitioners and administrative staff.

Overview

In the areas of practice considered during this visit, the local authority, in conjunction with its improvement partner, is continuing to consolidate progress. Senior managers are fully aware and have clearly identified within their recent self-evaluation (November 2018) areas where social work practice has improved and which areas need further development. The pace of change is purposeful and steady in order to further develop services and consolidate previous improvements to practice. Senior leaders and managers have appropriately focused on ensuring that a consistent and robust quality of social work practice is in place. For this reason, children and their families are now receiving more timely and effective help and support.

Inspectors found strong practice in the MASH. An established team of professionals work together well to respond to the risks and needs of children. Thresholds are well understood, and decisions are timely and well informed so that children are appropriately safeguarded. The duty and assessment teams have a more stable workforce, and this is helping to further embed practice improvements, including a stronger child-centred approach. In the cases considered during this visit, children were kept safe from immediate risks, with timely action in place to protect them. However, children's assessments and plans are not of a consistently good quality, and some are not focused enough to achieve sustainable change or improved outcomes for children and their families.

Findings and evaluation of progress

Inspectors met with staff, who are positive about working in Barnet, and morale is good. All staff reported that their caseloads are manageable. They welcome their regular supervision, peer supervision and informal support from managers and practice development workers to assist them in improving their practice. Some staff reported that they have been helped to professionally grow and develop in Barnet, either as qualified social workers or to be promoted to managerial positions. This is a positive development.

Quality assurance processes are effective and remain a strength. Auditing of case work is firmly established and is linked to clear practice standards and used well by managers to provide staff with a clear understanding of their practice. Performance information is being used to understand trends and to improve and manage services. For example, in the MASH, staff have taken actions to manage seasonal demand, to follow up with partners regarding the quality of referrals, and to raise awareness to ensure better understanding of thresholds and interventions. More detailed analysis of performance information is being progressed by the MASH steering group to improve this further.

Improvements in the MASH have been sustained and further developed since inspectors last visited in February 2018, during the second monitoring visit. Systems and processes, including the blue, red, amber and green (BRAG) system to manage contacts and referrals and assess risks to children are firmly established

and managed effectively. The electronic system functions well and allows managers to appropriately oversee the capacity of staff throughout the day and monitor workloads to ensure that work is progressed to agreed practice standards. Management oversight is strong and consistent, providing clear rationale and direction to progress work and ensure that it is child focused. The increased staffing levels invested in the MASH a year ago have been helpful in contributing to the timeliness and quality of the work and have created a well-ordered and calm environment.

Thresholds in the MASH are consistently applied and staff use the guidance and threshold document regularly to assist in their practice. Contacts and referrals seen by inspectors covered the key areas of concern for children. When children are at risk of significant harm, the duty and assessment team are informed immediately in order to convene a strategy discussion and undertake further enquiries. Inspectors observed good practice; for instance, once a child's case is transferred to the duty and assessment teams, MASH social workers continue to gather historical information and complete checks simultaneously. This helps to inform and improve subsequent decision-making.

Partners in the MASH, including police and health professionals, report improved partnership working. Consultation between agencies is clear and responses for information requests are dealt with within agreed timescales, with a collective sense of responsibility and an appropriate focus on the child. Staff are making effective use of co-location to share and check historical information. This has led to improved decision-making and a greater understanding of potential risks to children.

Daily threshold meetings have improved communication and provide an established forum for professionals to make complex decisions and agree on actions to safeguard children. Partners reported to inspectors that their views and expertise are better used to improve outcomes for children. Fortnightly MASH meetings are valued by staff as they allow for the reviewing and sharing of current and emerging practice. This is improving professionals' understanding of the risks that children may face.

Early help services were re-configured in October 2018 to co-locate and base staff in a new hub system. While staff reported that this is a positive development, it is still too early to measure the impact of these changes for children and their families.

Practice considered by inspectors in the duty and assessment teams and in the cases audited was mostly consistent, appropriately focused and demonstrates that social workers know and engage well with children and their families. Inspectors noted that some children were not visited within timescales in line with practice guidance. Direct work with children is now more evident on case files. While some direct work is purposeful and results in a better understanding of a child's lived experience, not all work with children leads to their views and feelings being clearly expressed in assessments and plans. Case recording is thorough and up to date

and includes helpful case summaries. This ensures that professionals reading the case file can quickly see the main issues of concern.

Where practice is less effective, there have been changes of social workers and actions and issues have been missed, or assessments require updating to ensure that they accurately reflect the current needs of the child.

Following the evaluation of risks, social workers and their managers make effective and timely decisions to help and support children and their families. Strategy meetings are nearly all well attended by relevant agencies and the minutes are detailed with clear action plans and associated timescales to safeguard children. Where risks escalate for children, strategy meetings involving relevant partner agencies are appropriately convened. However, inspectors did note minor purposeful delays in some cases in order to ensure that all relevant professionals could attend, or where the risks for the child require further exploration. Decisions and rationale to 'step down' children either to a child in need plan or to an early help intervention are not always recorded on the case file by managers, so it is not clear for all children how they will be appropriately supported.

Assessments are generally of reasonable quality, providing sufficient detail to understand the child and family's circumstances. However, they do not always fully explore the child's lived experience or the impact of parental history. Inspectors noted that diversity issues are now routinely considered during children's assessments. However, the impact of culture, religion, or ethnicity are not necessarily followed through into the work with parents or children to improve outcomes for them.

The quality of children's plans is still too variable. Although some plans are of good quality, with clear action and timescales, others are not fully in place, such as for those children whose parents have no recourse to public funds. In this area of practice, managers now plan to ensure compliance with practice standards. For other children where the plans are not specific enough or are subject to professional jargon, it is not always clear for children or their families what they need to do to address risks and make sustainable changes.

Partners are appropriately involved in supporting and working with children and families and attend core groups, reviews and meetings. Inspectors found good use of specialist expertise for some children and families, for example a step-parenting worker providing consultation to a family whose children are subject to a child protection plan. This helps to improve relationships and understanding of their family dynamics.

In summary, social work practice considered during this visit has further consolidated and improved since the previous visit to the 'front door'. This has led to stronger work with children and their families. Inspectors saw more work of a reasonable standard of practice; risks for children are reduced, they are making progress and there is stronger and better engagement with them and their families. This concurs with the local authority's own understanding of their

performance. Senior leaders are fully aware of the areas of practice they still need to improve to ensure that all practice is of a good standard.

I am copying this letter to the Department for Education.

Yours sincerely

Louise Warren
Her Majesty's Inspector