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Dear Tolis

Fourth monitoring visit of Buckinghamshire children's services

This letter summarises the findings of the monitoring visit to Buckinghamshire children's services on 16 and 17 October 2019. This was the fourth visit since the local authority was judged inadequate in January 2018. The visit was conducted by Donna Marriott and Nicola Bennett, Her Majesty's Inspectors.

There is evidence of limited improvements having been made to services for children in care since the last inspection. Work to improve the availability of local placements for children is beginning to deliver results. Independent reviewing officers (IROs) now maintain greater oversight of children's plans. However, poor practice remains, which continues to have a negative impact on the timely progression of children's plans and prevents some children from achieving timely permanence.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in respect of the support provided to children and young people in care. A range of evidence was considered for the visit, including electronic case records, discussions with social workers and their managers and reviewing supporting documentation. Inspectors also met with senior and political leaders and young people in care.

Overview

Progress is less evident in respect of services for children in care than it is in other parts of children's services seen during previous monitoring visits. Leaders have focused on improving compliance across the service, particularly where there have been concerns about children's safety. Progress has been hampered by difficulties in recruiting to a critical management post. Consequently, some poor practice continues to have a negative impact on the quality of services to children in care, leading to drift and delay for some children. Some areas of practice are beginning to improve, for example the availability of local placements for children and the effectiveness of independent reviewing officers (IROs).

The leadership team has an accurate understanding of the quality of services, and improvement activity is appropriately targeted.

Challenges in recruiting social workers and managers, and continued high staff turnover, mean that it is difficult to consistently ensure basic practice standards. Children confirmed this, telling inspectors that they continue to experience too many changes of social workers. This, combined with weaknesses in supervision and management oversight, has a negative impact on children's experiences and on the timely progression of their plans.

Findings and evaluation of progress

When children come into care, social workers and managers are thoughtful about trying to identify the right home for them. Most children live with families or in homes where they are well supported and cared for. Carers are committed to the children they look after and demonstrate care and ambition for them. Focused work is beginning to deliver results, leading to an increase in the number of foster families and children's homes. However, further work is required to increase the number of local foster families because too many children continue to live too far from home. Despite this, children who live at a distance from their family and friends are well supported.

Since the last inspection, work has been done to strengthen the response to unaccompanied minors when they first arrive in the area. Care is taken to identify the right accommodation, and young people are provided with the support they need to make a successful transition to life in Buckinghamshire. However, some challenges remain. There is further work to do to ensure that the transferring of children's cases from the emergency duty team to the day team is consistently effective. Visits to these young people do not always take place in a timely way to ensure early assessment of risk and need.

Social workers visit most children with frequency that is appropriate to their needs. Although, for a minority of children, visits are not frequent enough. Some purposeful direct work takes place to understand children's views. However, this is not evident for all children who need it, and some wait too long to get help to understand their life stories and experiences. Not all children who would benefit from advocacy and independent visitors have access to these services.

The quality of practice remains too variable, with delays in recording evident. Case summaries provide a good overview of the child to enable workers to quickly understand their experiences. At the time of the last inspection, chronologies and assessments were not consistently being updated in response to children's changing circumstances. This makes it difficult to understand children's lived experiences. Assessment and progress reports provide an updated assessment of children's experiences. However, most lack sufficient detail to support professionals in understanding children's current needs.

Children's health needs are assessed, but not always in a timely manner. Concerted effort by the partnership and the corporate parenting board has led to some improvements in the timely completion of health assessments, but this has not been sustained over time. Considerable work has taken place to strengthen access to emotional well-being services, including enabling foster carers to access the child and adolescent mental health service (CAMHS) directly.

Social workers focus appropriately on children's educational needs. Personal education plans are completed in a timely manner, and the virtual school is proactive in providing comprehensive and rigorous oversight of children's progress. Staff from the virtual school visit children when they come into care, and they are strong advocates of promoting children's access to education and learning opportunities.

When children go missing, or there are concerns regarding potential exploitation, the response is not sufficiently robust. Return home interviews (RHIs) sometimes do not happen or they are delayed. When they do take place, they are comprehensive, and risk is assessed. However, information from RHIs is not used consistently to inform the assessment, or the child's plan. Although some effective work takes place to respond to children at risk of exploitation, there is variability in the quality of practice. Risk assessments are not always completed or updated, and planning is not consistently robust. Strategy discussions, in response to increasing concerns, are not always timely, nor do they consistently lead to effective safety plans for children.

The quality and effectiveness of care planning is poor. The quality of children's care plans varies significantly and too many lack important details. Changes in social workers mean that it takes time for new workers to get to grips with children's plans. Managers do not consistently oversee children's plans to ensure that actions are progressed at the pace needed.

Most children live with carers who meet their needs well. Care plans are reviewed regularly, and children participate as appropriate. IROs demonstrate far greater rigour in identifying and responding to shortfalls in practice than they did at the time of the last inspection. IROs' scrutiny of children's plans is now more evident in children's files. They challenge poor practice, and the systems for overseeing this have improved. However, this challenge is not always responded to, or acted on, by team managers. Consequently, this is not yet having a demonstrable impact on ensuring that actions are completed, or that children's plans are progressed at the pace needed. Although IROs ensure a focus on early permanence, they are not consistently driving plans to formalise matching for children with their long-term carers.

When children first come into care, there is a better awareness of the need to promote early permanence. Examples of effective and child-centred work are evident. Careful consideration is given to whether children can return to their birth families. Since the last inspection, senior managers have ensured better oversight of the day-to-day arrangements for children who return to live with their parents. However, there has been a lack of urgency in ensuring that these children's plans for

permanence are progressed and that care orders are discharged in a timely way. New arrangements are not always identified or assessed promptly.

When children cannot return to the care of their birth families, many benefit from living with connected carers, special guardians and adoptive families. Some children's plans for permanence are progressed with the pace and attention needed. Assessments of connected carers are thorough, providing the detail needed to inform good decisions. Children are supported to remain with carers, promoting their sense of belonging. Those children for whom adoption is their plan increasingly move to live with their adoptive families more quickly.

Not all children living in long-term arrangements have been formally matched with their carers. This means that there is uncertainty for children, which can impact negatively on their sense of belonging. At the time of the monitoring visit, leaders had already developed a plan to respond to these shortfalls. This included work to progress permanence plans, refresh procedures and introduce permanence tracking, but this has been impeded by the challenges recruiting to the ongoing recruitment challenges.

Political leaders are committed corporate parents. They have ensured that there is the financial and political focus needed to support service improvement. The corporate parenting board has matured in its approach since the last inspection. The board is appropriately constituted and informed by the work of the 'We do care' Children in Care Council, which regularly shares its views and reports to the board. The board is appropriately reviewing areas of practice, having moved from a strong focus on performance data in 2018. However, there is insufficient structure to focus the board's activity, and no work plan, targets or delivery dates. It also lacks a focus on demonstrating what difference it makes in delivering improvements for children in care.

A tenacious and appropriately targeted recruitment campaign has had limited success in recruiting sufficient staff. Social worker turnover continues to contribute to some high caseloads and delays in implementing children's plans. The quality and effectiveness of management oversight continues to be inconsistent and is sometimes poor. A lack of management direction on children's cases, particularly when they are first allocated to social workers, contributes to drift and delay for some children. Supervision, although now more evident on children's case files, does not take place consistently, and where it does, it is not of the quality needed to ensure that plans progress.

The implementation of the quality assurance programme has had a positive impact on some parts of the service. However, there has been insufficient focus on auditing cases from the children in care service. This is because resource has been focused on improving practice in those parts of the service where the greatest risks were evident. Team managers are not sufficiently engaged in audit activity, which hampers leaders' work to embed the practice changes that are needed.

Thank you and your staff for your positive engagement with this monitoring visit. Please also thank the young people who gave up their time to meet with inspectors. I am copying this letter to the Department for Education. It will be published on the Ofsted website.

Yours sincerely

Donna Marriott
Her Majesty's Inspector