Inspection of Buckinghamshire Council children's services

Inspection dates: 6 December 2021 to 17 December 2021

Lead inspector: Nick Stacey, Her Majesty's Inspector

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Children's services in Buckinghamshire are no longer inadequate, but still require further improvements to be good. No children were identified at immediate, unassessed risk of serious harm and no widespread or serious failures for children were seen across the range of services. Leaders worked highly effectively to ensure that children were safeguarded during the COVID-19 pandemic. The scale and speed of improvement work have been impeded by acute and persistent recruitment and retention difficulties of both social workers and frontline managers and the depth and extent of poor social work practice dating back to the last inspection in 2017. These challenging conditions have been compounded by the pandemic, particularly a large and persistent increase in demand for children's services following children's return to school.

Work with some children, who are the subjects of child in need and child protection plans, reduces risks of further harm and helps parents to better understand and address their children's unmet needs. Many children, particularly those receiving services from the assessment and help and protection teams, have too many changes of social worker. This means that the help they receive is fragmented and episodic rather than carefully planned and underpinned by continuous strong professional relationships. Some children who are in care also commented unfavourably about their frequent change of social workers.

Senior managers have established a comprehensive and rigorous set of performance measures, which gives them a sound understanding of the services provided for children. However, this data is not always used to full effect to provoke enquiries into some significant practice areas that inspectors highlighted, including a persistently high rate of re-referrals and unsuitable accommodation for a small number of care leavers. Regular and forensic levels of scrutiny have promoted improvements in the circumstances and experiences of many children. This approach embraces managers at every level and has enabled leaders and managers to have a more collective, shared culture in understanding and addressing difficulties. The positive impact of quality assurance work has accelerated during the last six months but has been too slow in generating widespread higher standards of practice that improve children's circumstances and experiences.

What needs to improve?

- The understanding, and reduction of, a high rate of re-referrals and assessments that result in no services being provided for children and their families.
- The consideration and cumulative impact of earlier interventions and family histories in children and family assessments.
- The quality of social workers' direct work with children.
- The support provided to children aged 16 and 17 years who present as homeless.
- The impact of independent reviewing officers (IROs) in decisively escalating children's cases when there is drift and delay in the progress of their care plans.
- The quality of case supervision for social workers in order that it promotes consistently effective work with children.
- The engagement and participation of children in care in the corporate parenting work of the council.

The experiences and progress of children who need help and protection: requires improvement to be good

1. Children are identified when they are at immediate risk of serious harm and prompt action is taken to protect them. No widespread or serious failures were identified that left children exposed to serious continuing harm. This is a tangible improvement on the position at the last inspection in 2017. It has been achieved while addressing the considerable additional challenges entailed in safeguarding children during the pandemic.
2. The work carried out in targeted and universal early help services results in discernible improvements in many children's circumstances. Several family centres and three 'family centres plus' offer a valuable range of community-based programmes to support parents. These services prevent many children's difficulties worsening and escalating to requiring intervention from children's

social care. Children at risk of harm are promptly identified in the multi-agency safeguarding hub (MASH), and thresholds between early help and social care are mostly well understood. There is delay in the targeted early help family support team for a small number of children with more complex needs who require referral for statutory help.

3. Staff in the MASH are proficient and balanced in responding to contacts and referrals and this is also a distinct improvement since the last inspection. Information-gathering between partner agencies in the MASH is fluid and provides a history of earlier involvements and thorough intelligence about presenting concerns. This work informs appropriate and prompt recommendations by social workers for managers, who make well-founded decisions.

4. Children referred to the MASH needing urgent safeguarding responses are immediately identified and decisive actions are taken to protect them. Strategy meetings are held quickly, with relevant partner agencies attending or providing information. Discussions produce rounded evaluations of initial risks. Valuable work led by senior managers has resulted in many partner agencies, particularly schools, having a clearer understanding of thresholds and greater confidence in referring children to the MASH. Most schools spoken to during the inspection reflected positively about their communication with social workers and frontline support staff regarding children in need of help and protection.

5. Too many children and families are re-referred who are not at significant risk of harm but require skilled help to improve their circumstances. A significant number of these children are referred on for social workers to complete assessments which culminate in no further action. Some assessments are too superficial. They often list histories of previous referrals and interventions, but do not evaluate these in conjunction with current concerns to provide a coherent picture of children's circumstances over significant periods of time. These omissions lead to episodic assessments where each new concern is typically conceived of as a distinct event. Evaluative and authoritative pre-birth assessments are completed by experienced senior social workers in a court team. Highly vulnerable newborn babies are protected from future harm, either through care proceedings that are initiated when they are born, or through rigorous child protection plans if it is deemed to be safe enough for their parents and carers to look after them.

6. A sustained rise in referrals has featured a sharp increase in the number of strategy meetings and initial child protection conferences (ICPCs). This surge in volumes led to a high number of delayed ICPCs. This trend has reduced substantially since the summer but remains significantly higher than the rate prior to the onset of the pandemic. Inspectors did not find any avoidable harm arising for children because of delays, and most of the children had tight initial safety plans in place.

7. Children who are the subjects of child in need and child protection (CP) plans are seen regularly by their social workers and many receive help that improves their circumstances and helps to keep them safe. However, the quality of direct

work with many children often has little purpose beyond seeing them and recording observations and conversations. Frequent changes of social workers, and their very demanding workloads, have a detrimental impact on building constructive relationships with children and their families. Emerging indications of improving practice were seen with some children on CP plans over the last six months which redressed previously entrenched patterns of drift and delay. A specialist disabled children team undertakes effective safeguarding work with a small number of children on CP plans.

8. CP plans are thorough and comprehensive, but they often use too much professional language. Some plans could be shortened and simplified to make them more accessible and helpful tools for children, parents and professionals. Most child protection advisers regularly seek updates on children's progress between their scheduled review meetings, but their scrutiny is not always incisive enough when plans are floundering.

9. Child protection core groups and child in need review meetings are convened regularly. These forums helpfully update parents and professionals on key developments and events, but they rarely assess the continuing effectiveness of children's plans in addressing unmet needs and reducing risks to them.

10. When concerns about children's safety and well-being increase, work in the pre-proceedings stage of the Public Law Outline (PLO) is effective. Panels and monitoring systems provide managers with a sound understanding of the progress families make during the process. The PLO phase is not misused as an automatic gateway to subsequent care proceedings, and some families safely exit the PLO due to effective work that improves parenting and reduces risks to children. Some children experience delays because of overdue external assessments. Changes in social workers result in some internal assessments being submitted late.

11. Decisions to remove children from parental care are careful and in the best long-term interests of the child. These critical decisions are accurate and made by managers of appropriate seniority; however, the supporting rationale is not always explicit enough on children's files. The quality of most social work statements for care proceedings is detailed and analytical, providing a sound basis for recommendations for the court. The designated family judge echoed these findings but was also concerned at some delays in care proceedings caused by social workers who suddenly leave.

12. The referral pathway to a specialist missing and exploited hub (MEH) is well understood, and workers know most of the children well. Effective work by the team maps children's connections with risky locations. Active police investigations are instigated concerning local employers when there is evidence about potential child exploitation. A Missing and Child Exploitation (MACE) multi-agency forum meets regularly to review the progress of work with children at the greatest risk. Well-targeted disruption activities are initiated, and appropriate actions are pursued when concerns about children escalate. The work of the MEH has been weakened, however, by the temporary

redeployment of some staff into other social work teams due to high demand levels.

13. Management oversight and case supervision with social workers are regularly recorded. Records are functional and task-centred, and social workers are helped to prioritise what work needs to be completed. Records rarely demonstrate inquisitiveness about children's experiences, or any beneficial outcomes of the work being done with them.

14. Some children aged 16 and 17 years old who present as homeless are not well supported when they present to children's social care. A small number were identified by inspectors that should have been promptly offered support as children in care due to their considerable vulnerabilities. The local authority urgently reviewed the circumstances of these children.

15. Allegations about professionals or volunteers who work with children are swiftly and appropriately responded to when they are first received by the local authority designated officer (LADO). Partly due to a large backlog of work, subsequent enquiries are not all closely tracked, and many take too long to complete.

16. Work to support and safeguard a small number of children living in private fostering arrangements earlier this year was not careful enough. These children previously attended local language schools and were unable to return to their home countries due to travel restrictions. No children experienced harm, but basic checks on their carers were not completed.

17. The local authority has suitable oversight of most children not currently placed full-time in education. Children identified as missing education are kept under review until they are back in school or local authority officers are confident that they are safely in the care of another local authority. The number of pupils identified as electively home educated is increasing steadily over time, as has been the case nationally. Officers are alert to the reasons why parents electively home educate their children, and prioritise their contact with, and oversight of, families suitably.

The experiences and progress of children in care and care leavers: requires improvement to be good

18. The experiences and progress of some children in care are not strong enough. Some older children wait too long for permanency arrangements to be confirmed and associated drift is not always challenged effectively. Direct work with children often lacks a clear purpose and is fractured by changes in children's social workers. A small number of care leavers live in unsuitable accommodation.

19. Inspectors spoke with several young people who have left care and children in care. Many care leavers valued the support provided to them during the pandemic and most children are living in secure and stable foster families.

Children repeatedly emphasised how their trust in social work support had been undermined by their experience of their social workers frequently changing.

20. Diligent early permanence work is conducted with children who have recently entered care, particularly during care proceedings. Fostering placements are quickly matched and approved. Parallel adoption planning is proactive and demonstrates that adoption is considered for older children and those with special needs. Permanence options are thoroughly considered for some, but not all, children in long-term care. When children have been in long-term care with relatives, proactive discussions encouraging carers to apply for special guardianship orders lack sufficient urgency, resulting in a small number of children remaining in care longer than is necessary.

21. Permanence planning meetings are held regularly, but some records comprise too many descriptive updates. For older children, they do not consistently result in challenging drift in their care plans, and this is further exacerbated by their social workers changing.

22. Work with some children living with their parents under a care order requires strengthening. Some children have well-considered assessments and plans devised before applications to discharge their care orders are made. For others, weaker planning and drift leads to avoidable delays in discharging their care orders. When children return home in an unplanned way, there are some delays in confirming the suitability of these arrangements.

23. Most children in care are settled and feel safe where they live, including a large proportion of children in long-term care who are placed outside Buckinghamshire, and older 16- and 17-year-olds living in semi-independent settings. No children are living in unregistered children's homes.

24. Although most social workers can describe why children are living where they are and explain why it is the right place for them, this is not always well documented. Important documents are not always accessible in children's files. Care experienced adults accessing their records later in life would struggle to understand why critical decisions had been made at specific points in time.

25. Review meetings for children in care take place on time and the appropriate professionals and family members are usually involved. Children's views are presented, either in person or by someone who knows them. The regular footprint of the IROs is present on children's files, but formal escalations are not consistently recorded to address drift in care planning.

26. Care plans are refreshed regularly, and most are informed by updated six-monthly social work assessments. The effectiveness of some care plans is limited as they contain generic rather than individualised actions.

27. Some children told inspectors that they are frustrated at how many social workers they have had to work with and consequently having to tell their stories repeatedly to new workers. Work with some children has been impeded by changes of social worker. Children in care are mostly visited within the timescales stipulated in their plans but conversations about what is happening

to them and what the future holds often lack detail. A specific service completes life-story work with children, rather than their social workers. This arrangement leads to delays in the completion of this important work due to a long waiting list.

28. Professionals in the MEH have a sound knowledge of the more vulnerable children in care. There is effective partnership working and information-sharing through the MACE and consultation with social workers about possible child exploitation. Direct work with children in care has also been adversely affected by the redeployment of some hub workers to support pressured social work teams across the service. Not all children benefit from diligent return home interviews after an episode of going missing, especially if they are living outside Buckinghamshire.

29. School leaders have described the benefits of clear expectations from, and useful communications with, the virtual school in supporting their work with children in care. They value staff expertise and approachability in working together for the benefit of children in care. Personal education plan review discussions illustrate that the virtual school is well informed about children's outcomes, both academically and, in a broader sense, of their wider development.

30. Children in care have their routine health needs met. Some children receive support with their emotional health and well-being, but others experience considerable delays in waiting for child and adolescent mental health assessments or interventions. Following triage, two-year waiting times are not uncommon. Most care leavers are provided with their health histories to ensure that they have an understanding of their childhood health to carry forward into their adult lives.

31. An established Children in Care Council called We Do Care provides opportunities for some children in care and care leavers to have their views heard on the services they receive. Direct engagement by the corporate parenting panel with children in care and care leavers is too limited. No children are represented on the main board. Children in care can access the support of advocates if they wish, and a small number do so.

32. Repeated staffing changes and sickness absence in the fostering service have had an adverse impact on some elements of work. The quality of a small number of foster carer assessments is weak and delays are evident in the completion of some connected person assessments. As a result, some children live for short periods in unlawful family placements. However, foster carers appreciate receiving regular supervision, support and training. More effective methods have been introduced to strengthen the recruitment of foster carers which are showing promising results.

33. An increased number of adopters have been recruited this year. Prospective and approved adopters are well supported through regular visits and effective communication. Responses to adults enquiring about adoption are prompt and

welcoming. Adoption support makes a positive difference to children and their family lives.

34. Not all care leavers are routinely informed of their rights and entitlements. A clear and accessible offer sets out the support and entitlements available to care leavers, but it is not widely understood. Some uncertainty on the part of professionals as to how the local offer should be implemented leads to some inequities for care leavers in the support they receive. The practice of transferring young people to another part of the service when they are 21 to 25 years of age disrupts important relationships with their personal advisers (PAs).

35. Care leavers are visited regularly by their PAs and are able to establish trusted relationships that are valued by most young people. Not all care leavers get the help and support that they need quickly enough, particularly if they live outside Buckinghamshire and have additional needs arising from a disability or poor mental health. Pathway plans are mostly well written and are reviewed on a regular basis.

36. The virtual school works collaboratively with the care leavers team to actively promote young people's engagement in education, employment and training (EET). Consequently, most young people secure EET opportunities and approximately 10% are attending higher education programmes. Care leavers seeking asylum are well cared for and supported into adulthood. They benefit from swift access to services that address their wide spectrum of needs.

37. Care leavers in custody are supported by visits and indirect contact, providing important emotional support for them. Transition planning for young people who are moving to adult services is not fully effective and some young people fall between the gaps of both services.

38. Most care leavers live in a range of suitable accommodation. Specialist services and their PAs help care leavers acquire independent housing and develop the skills they need to live on their own. Tenancy support, council tax relief and a leaving care grant support these early stages in their progression towards independent living. Young people who live in other local authority areas experience more erratic support, which reduces their access to secure housing in locations where they feel they belong. A small number of care leavers identified during the inspection are living in unsuitable accommodation which is not accurately reflected on the child's record.

The impact of leaders on social work practice with children and families: requires improvement to be good

39. Leaders and senior managers have achieved important improvements in practice for children in most parts of the service following two inadequate inspection judgements in 2014 and 2017. Several strengthened elements of leadership are in place, but much more needs to be done to ensure that children receive consistently positive standards of social work intervention in all parts of the service. A knowledgeable and highly committed new senior management team is providing highly focused practice leadership.

40. Managers at every level have worked tirelessly and collectively to ensure that children are safeguarded in the face of the unique and continuing challenges generated by the pandemic. These measures have safeguarded the most vulnerable children. Addressing this unprecedented public health emergency has been compounded by acute social worker recruitment and retention challenges, and increased demand to work with children subject to a referral in the 'front door' assessment and help and protection teams.

41. Social workers' workloads in the assessment and help and protection teams are relentless and highly demanding, and, as a result, some seek transfers to other parts of the service. Senior managers continue to work relentlessly to improve the quality of social work practice despite the significant challenges of staff turnover and high workloads.

42. The extent and scale of increasing waves of referrals are regularly reflected in accurate performance information. Many local authorities have experienced similar rises. Although it has reduced in the last few months, too many children are still re-referred to the service following earlier assessment and intervention. Many assessments are completed that lead to no subsequent social care service, consuming considerable amounts of scarce social work time. Senior leaders, including the chair of the improvement board, advised inspectors of the increased complexity and seriousness of many referrals featured in the demand surge. Senior managers did not persuasively explain why more substantive work has not been done to pinpoint any distinguishable local factors underpinning the high re-referral rate and of any specific measures taken to reduce it.

43. Improved strategic engagement with partners has secured much greater confidence in the local authority's decision-making and responses concerning work in the front door. Schools are referring more children when new needs and risks have emerged or intensified during recurrent lockdowns.

44. Senior managers understand the detrimental impact of numerous changes of social workers in undertaking impactful and positive work with children. This is most prevalent in the front door teams, but a quarter of social workers in the child in care team have also left in the past year. Furthermore, many children in care are allocated to social workers in the help and protection teams, where the churn of social workers is greater.

45. Senior managers are determined and persistent in their efforts to recruit and retain more social workers. Specific local factors have further diminished the already very limited number of experienced locum social workers. A planned overseas social worker recruitment programme has just reached fruition. Significant additional investment has been injected to support a cogent plan to expand the numbers of social workers produced by the local authority's academy over the forthcoming two years.

46. Quality assurance of social work with children is still at an embryonic stage and is not yet a powerful determinant in improving practice standards, although its influence and scale have gained pace and traction over the last six months.

Social workers are experiencing recent auditing work as collaborative and professionally enabling.

47. The inclusion and participation of children in helping to shape improved practice and services is underdeveloped, particularly in the corporate parenting board. This is recognised by leaders and work has recently started to strengthen the inclusion of more children in decision-making and governance structures.

48. A detailed and accurate performance management system provides managers with frequently updated and rigorous metrics about performance in most parts of the service. More recently, weekly check and challenge meetings with team managers have been introduced to promote their routine engagement and understanding of performance in their teams. There are some gaps in the intelligence and analysis emerging from this performance data, including an authoritative evaluation for the high rate of re-referrals and the poor timeliness of LADO investigation outcomes. Senior managers and leaders are highly informed about, and seek to be responsive to, demand pressures in front door teams. The impact of measures to substantially reduce workloads to manageable levels is less evident. It is recognised by inspectors that this is not easy and straightforward.

49. Children's services are at the centre of the recently unitarised council and considerable additional investment has been provided to children's social care services. Regular scrutiny provides the leader of the council and cabinet member for children with an informed understanding and they both have an inquisitive eye. The chief executive also has a sound strategic and operational overview, assisted by her attendance at monthly Improvement Board meetings.

50. Most social workers receive regular case and personal supervision and management oversight. This has been particularly important during the extensive period when most have been working from home. Case supervision is predominantly functional rather than reflective and developmental. Heavy workloads in the front door teams leaves limited time to critically reflect on the progress of plans and the influence of direct work on helping children. Many teams have also experienced changes in managers, which has resulted in professional discontinuity in the management support provided to social workers.

51. Social workers and frontline managers attend a wide range of pertinent training and development opportunities, despite their relentless workload pressures. This has continued to promote their professional knowledge and development. Despite the intensive workload demands, most social workers spoken with during the inspection like working in Buckinghamshire and reported that their managers support them and help them prioritise their work.

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