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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 services on 30 and 31 January 2018. The visit was the second monitoring visit since the local authority was judged inadequate for overall effectiveness in July 2017. The inspectors were Louise Warren HMI and Tara Geere HMI.

In the aspects of practice considered during this visit, the local authority is continuing to progress and consolidate recent improvements to services for children and young people seen during the first monitoring visit. Senior leaders and managers are appropriately focused to improve and embed good quality social work practice.

During this visit, inspectors found strengthened practice within the multi-agency safeguarding hub (MASH). This is leading to a more consistent approach to the application of thresholds, information sharing and improvements to the timeliness of decision-making. The duty and assessment teams and intervention and planning teams are beginning to improve practice for children in need of help and protection, although improvements are not consistent across the service. In most cases considered, there is a more timely identification of risk and appropriate immediate actions to protect children. However, longer term planning to improve outcomes for children remains variable and in too many cases remains inadequate.

Areas covered by the visit

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

- the effectiveness of the MASH in responding to concerns for children including the application of thresholds for statutory intervention and early help
- the quality and effectiveness of strategy discussions and section 47 enquiries leading to initial child protection conferences (ICPCs)

- the quality and timeliness of assessments leading to child protection and child in need work and plans

- the quality and effectiveness of practice for children subject to children in need and child protection plans

- the quality and timeliness of management oversight and decision making of case work, including compliance with statutory guidance.

Inspectors considered a range of evidence during this inspection, including electronic case records, supervision records, case management records, performance data, audits and progress reports. Inspectors spoke to a range of staff, including managers, social workers, practitioners and professionals from partner agencies.

Overview

Senior leaders and managers understand the widespread nature and scale of the improvements required within the service. They continue to appropriately prioritise activities, with a strong focus on improving social work practice and embedding the cultural change required to achieve this. The improvement board and the local authority improvement partner are providing expertise and support to senior leaders in order to implement and manage improvements. Inspectors found improved quality assurance processes, including an increase in internal auditing. This is providing valuable information for senior leaders and managers to monitor progress in the areas for development.

Social workers report to inspectors that they are able to access relevant and helpful training, that their case loads are manageable and that they enjoy working in Barnet. Many staff expressed support and commitment to the changes the local authority is making to promote better and more effective practice for children and their families.

During this visit, inspectors found some positive improvements in practice. This was particularly apparent within the MASH. Inspectors also found some very recent and limited improvements within the duty and assessment and the intervention and planning teams. Both the MASH and duty and assessment teams have been supported through additional resourcing that has increased levels of staffing, including managers. This has made a positive difference to operational capacity and managerial oversight of case work. Within the MASH, this has enabled the more timely progression of contacts and referrals and less variability in the application of thresholds.

For children at risk of harm, inspectors found that responses within the MASH were appropriate, including clear identification of risks and decision-making to address these. The duty and assessment teams also responded appropriately to risks to children, providing effective and immediate safety plans to safeguard them.

In the cases considered, practice was weaker and there was more limited improvement for children subject to child protection plans or child in need plans. Assessments of children's needs and the plans to support them are not thorough or effective. This leads to drift and delay in achieving improved outcomes. Some very recent practice improvements are in place for some children, but these had not yet made a significant difference to them or their families.

Findings and evaluation of progress

Managers and social workers report that staff morale is good. The recruitment of permanent staff and managers has continued and turnover of staff is stabilising. This offers more continuity to children and families and is beginning to assist in improving levels of practice, managerial oversight and case direction.

Strengthened quality assurance processes are becoming increasingly embedded into the culture of the service. This is assisting the identification and monitoring of the areas that require improvement. The cases tracked and audited by the local authority for the monitoring visit were completed during this visit without the oversight of the improvement partner. They were thorough and accurately identified practice deficiencies and set clear expectations for practice improvements.

Further developments within the MASH have consolidated improvements since the last monitoring visit. Staff are increasingly confident in their roles. The systems and processes to manage workflow and recording are better aligned. This is facilitating faster and more effective decision-making, communication and the sharing of information. Recent improvements, including the introduction of the 'daily meeting', are effective in checking and ensuring that thresholds are consistently applied. Arrangements for signposting cases to early help services are appropriate for children and their families, enabling them to access help and support.

Inspectors found that practice deficits identified and shared with the local authority during the previous monitoring visit have been addressed. The use of the BRAG (blue, red, amber and green) rating system is now more rigorous and key decisions and oversight are more robust. This is ensuring that nearly all children are safeguarded effectively and in a timely manner.

Section 47 enquiries are timely, and thresholds are consistently applied and are appropriate to the levels of assessed risk. In cases considered by inspectors, social workers are visiting children and parents quickly and making effective safety plans for them. Decision-making to consider the needs of children at initial child protection conferences were considered, in the cases seen, to be appropriate.

Strategy discussions are timely, although the quality of these remains variable. While inspectors note improvements in police attendance at strategy meetings, the attendance of health professionals is still inconsistent. Social workers therefore need

to follow up with health partners outside of strategy meetings to obtain relevant advice and information.

The standard of case recording remains too variable. Inspectors considered some case files where documents were not available and case notes not updated, despite some social workers clearly knowing the children and families well. There is evidence of case summaries on files, although chronologies are not consistently updated or sufficiently thorough to evidence all significant events. Some audits identified that case notes must be updated but progress to achieve this was still not evident on case files.

Inspectors did not find evidence of improved assessments for children and their families. The quality of assessments considered was mostly weak. Assessments lack a thorough understanding of family relationships and parental capacity and do not always include a thorough analysis of the risks to children. The views of family members, particularly fathers, were not adequately sought to inform assessments and planning. Children are being seen more regularly by social workers and alone where this is appropriate. However, their views are not always clearly represented and there is a lack of focus on a child's lived experience.

A lack of engagement by parents requiring specialist assessments contributes to drift and delay and ineffective decision-making. This is particularly apparent within the public law outline (PLO). The diverse needs of children and their families was poorly represented in assessments and case recording generally. Insufficient consideration is given to their family heritage or other protected characteristics.

In the cases considered, the quality of child protection planning is variable and children in need planning is mostly weak. Plans do not address core concerns and actions are therefore not clear or specific, or always updated. Inspectors found that a lack of planning was leading to significant drift and delay for some children. Lack of parental engagement or delays in convening core groups and children in need meetings are not always challenged and lead to drift and a lack of progress. This was particularly evident within the PLO process. The local authority has recently taken action to address this deficit in the appointment of a permanence assurance manager. The impact of this action is yet to be seen.

Inspectors found that the supervision of staff remains too variable. It is not always consistent, regular or evident on case files. It is not used to provide challenge, reflection or accountability. Evidence of management oversight by senior managers, team managers and quality assurance officers is being appropriately recorded on case files. However, this does always offer effective case direction or address inadequate practice in order to ensure that children and their families are able to receive the help and support they require.

The pace of change has remained consistent and focused and is beginning to raise practice standards. However, social work practice remains inadequate in some areas

considered during this visit by inspectors. The process of changing the culture to promote acceptable practice is continuing, but remains a significant challenge.

I am copying this letter to the Department for Education.

Yours sincerely

Louise Warren
Her Majesty's Inspector