Piccadilly Gate
Store Street
Manchester M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted

18 May 2018

Mr David Haley
Director of Children's Services
Swindon Borough Council
Euclid St
Swindon
SW1 2JH

Dear Mr Haley

Focused visit to Swindon children's services

This letter summarises the findings of a focused visit to Swindon children's services on 25 and 26 April 2018. The inspectors were Emmy Tomsett, HMI, and Karen Wareing, HMI.

Inspectors considered the local authority's arrangements at the first point of contact for children who need help and protection in accordance with the Inspection of Local Authority Children's Services framework (ILACS). Specifically, they considered contacts, referrals and decision-making within the multi-agency safeguarding hub (MASH), as well as the quality of work completed by the designated officer.

Inspectors considered a range of evidence, including case discussions with social workers, designated officers, managers and a number of partner agencies. They also looked at local authority performance management and quality assurance information, as well as children's case records.

Overview

Swindon's children's services were last inspected by Ofsted in 2014, when the overall effectiveness of services was judged to require improvement to be good. Since then, the quality of decision-making when children are first referred for help or protection has declined, and there are significant weaknesses in the responses that children

receive. Social workers in the MASH do not always identify risk, and inspectors found some children at risk of harm. Many decisions made by social workers and managers are not sufficiently swift and do not take account of all relevant information. In some cases seen by inspectors, opportunities to intervene had been missed historically, and recently.

Since the director of children's services (DCS) was appointed nine months ago, he has commissioned both internal and external reviews to assess the performance of the MASH. A well-targeted programme of improvement has begun, including the revision of early help pathways, increasing senior leadership capacity and management training for all managers, but these are not yet ensuring that the 'front door' is providing a consistently safe, well-targeted and timely response to children. Swindon children's services receive strong corporate support and leaders recognise that significant improvements to the service are required. In light of this, senior leaders have committed significant additional funding of £7.5 million over the next three years.

The DCS acknowledges that the service has lacked a culture of rigorous challenge and accountability by managers at all levels and is working to embed the use of performance information and quality assurance processes. However, current performance information and quality assurance processes are being undertaken but are not yet sufficiently comprehensive to enable senior leaders to accurately assess the quality of practice in the MASH. As a result, senior leaders were not fully aware of the severity of weaknesses identified by inspectors during this visit.

Areas for priority action

The local authority needs to take swift and decisive action to improve the following areas of child protection practice:

- the identification of risk. Currently, there is delay in decision-making when children are at risk of harm as well as delay in visiting and assessing their needs, and decision-making and progression of the work undertaken by the designated officer

- the quality of management oversight and decision-making in relation to safeguarding practice.

What needs to improve in this area of social work practice

- The local authority and partners through the local safeguarding children board need to improve the understanding of thresholds for referral to children's services and the quality of information contained in referrals.

- Managers' use of performance information and quality assurance processes.
- The quality and timeliness of case recording and planning for children.

Findings

- Thresholds for intervention are not well understood by partners and are inconsistently applied by staff within the MASH. As a result, children do not always receive a proportionate or swift response to their needs. Senior leaders are aware of this significant weakness and are in the process of working with partners to strengthen threshold arrangements and application.

- Partners do not always often provide sufficiently detailed and accurate information to enable social workers to properly understand the presenting concerns.

- Inspectors saw delays in children receiving support when their cases transfer between statutory and early help services. Senior leaders had recognised prior to this visit that early help pathways need improvement; work to achieve this has begun but is not yet embedded and is consequently not yet having a positive impact for children. Once services are provided, they are mostly well targeted and children receive helpful support.

- Risk to children is not identified in all cases. Inspectors saw a number of cases where children were exposed to potential risk for too long without assessment. When children are referred to the MASH, decision-making, including that from the out-of-hours service, is not always responsive or timely. Decisions by social workers and managers do not sufficiently consider children's histories or the impact of previous interventions. Managers do not record a rationale for decisions made, and, as a result, it is difficult for senior managers to assess the quality of decision-making and satisfy themselves that children receive a proportionate response to their needs.

- Rag ratings applied to referrals in the MASH do not always correctly reflect the level of risk, and, as a result, some children do not receive a timely response. Timescales associated with the rag rating are not always adhered to and management scrutiny does not consistently identify or address slippage in responding to children's needs.

- In most cases seen by inspectors, case recording is consistently poor, and it is not always up to date or sufficiently comprehensive. Information from partner agencies, while used to inform decisions, is not well recorded and this does not enable social workers or managers to monitor the progress of children's cases effectively. Case records reflect limited consideration of the experiences of the child.

- Referrals to the designated officer do not always receive a timely response. Drift and delay is a key feature in cases seen by inspectors. The designated officer has not ensured that referrals result in well-coordinated multi-agency investigation or support to children. When strategy meetings are held, action plans resulting from these meetings are not specific, clear or routinely accompanied by a timescale.

There is a lack of coordination between the designated officer, the MASH and the assessment teams, resulting in children not receiving an assessment despite being at risk of potential harm. Management oversight and scrutiny of the effectiveness of the designated officer's arrangements are poor; currently there are no effective quality assurance arrangements or audit activity to review the quality of this work.

- Management oversight in the MASH is poor. While scrutiny of casework is reported to take place, there is very limited evidence of this on case records. Management oversight does not identify or address unidentified risk or the delay experienced by children. When actions are set by consultant social workers or the team manager, they are not time bound and are not routinely tracked by managers to ensure that outcomes for children are improving.

- Social workers who spoke to inspectors report regular, reflective supervision and easy access to managers, including senior managers, who support them in their roles. Social workers describe manageable caseloads. The MASH is a stable team and most staff are permanent. Staff are able to access an improving suite of training opportunities.

- Quality assurance arrangements within the MASH are underdeveloped. While some audit activity has taken place, this has not been used to identify weaknesses in practice or training requirements of staff. Lessons learned from audit activity are collated and disseminated to staff. However, staff spoken with were unable to reflect how this had improved their practice. Audits seen by inspectors varied in quality and most focused on compliance and not the quality of work or outcomes for children. Audits that identify weaknesses in practice are not accompanied by an improvement plan.

- The quality of performance information has been strengthened, and managers at all levels now have access to a suite of performance information. However, while this is now in place, it is not being used effectively enough to ensure that outcomes for children are improving or to identify areas for practice development and training delivery. Senior leaders recognise that further work is required to ensure that managers use this information purposefully and to robustly scrutinise performance across the service.

Ofsted will take the findings of this focused visit into account when planning your next inspection or visit.

Yours sincerely

Emmy Tomsett
Her Majesty's Inspector