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Dear Mr Theodoulou

Focused visit to Enfield local authority children's services

This letter summarises the findings of a focused visit to Enfield local authority children's services on 25 and 26 September 2018. The inspectors were Brenda McLaughlin, Her Majesty's Inspector, and Tracey Scott, Her Majesty's Inspector.

Inspectors considered the local authority's arrangements for children who need help and protection, in accordance with the inspections of local authority children's services framework. Specifically, inspectors looked at the 'front door' arrangements for the service that considers contacts and referrals, including decision-making within the single point of entry (SPOE) and the multi-agency safeguarding hub (MASH). They evaluated the quality of practice in the referral and assessment service, disabled children's team and early help family hub. They considered transfers to and from early help services and between teams, the effectiveness of child protection enquiries and the quality of assessments and plans for children in need of help and protection.

Inspectors looked at a range of evidence, including through case discussions with social workers and managers and through scrutiny of the work with vulnerable children by the emergency duty and edge of care teams. They met with committed specialist workers in the reconfigured early help services and representatives from partner agencies in the MASH. They also looked at local authority performance management and quality assurance information and children's case records.

Overview

Since the Ofsted single inspection in 2015, senior leaders, together with their staff and partners in the London Borough of Enfield, have continued to work extremely hard, in challenging circumstances, to help and protect vulnerable children and their families. They have made considerable progress in many areas of practice. However, this visit did find serious weaknesses in relation to the application of thresholds for a number of children who had suffered significant harm. These weaknesses were confined to one service area, and were not systemic. Some children had disclosed physical and sexual abuse, but these cases had not been progressed to a strategy discussion and child protection medical examinations had not been considered. In addition, there were delays in seeing some young children in the referral and assessment service due to high volumes of work. Inspectors also identified some delay in response to children missing from home and in day services responding to concerns raised by the emergency duty team. Senior leaders took immediate and robust action during the visit to address the concerns and developed an appropriate and time-limited action plan to tackle the identified weaknesses.

The executive director has secured extra funding and managers are actively recruiting more staff to create an additional team in the referral and assessment service. The reconfigured SPOE, MASH and early help services, augmented by the revised and relaunched threshold document, have significantly improved the quality and timeliness of responses to most children in need. Services to disabled children are progressing well, with evidence of effective social work practice.

Managers recognise that they need to do more to improve the accuracy of their data and to further develop their quality assurance of practice.

Staff who met with inspectors said that they feel well supported and listened to and are consulted about service development.

What needs to improve in this area of social work practice

- The appropriate application of child protection thresholds for children at risk of significant harm.
- Social work caseloads in the referral and assessment team.
- The timeliness of case transfer when assessments are completed.
- The quality and consistency of assessments and plans.
- The quality and effectiveness of management oversight and supervision.
- The range and accuracy of performance data and audits.

Findings

- Persistent, respectful work carried out by skilled staff in the change and challenge service, the parenting support unit, the child sexual exploitation prevention team and by highly capable early help practitioners is making a real difference to children and their parents. When risks escalate, cases are 'stepped up' to social care for an assessment, and in cases seen, these decisions were all appropriate. Management oversight of the work in these teams is established and effective. Social workers are available at children's centres on a fortnightly basis for consultation, and the recent development of a multi-agency triage meeting is intended to extend support to children and their families at an earlier stage.

- Changes to the SPOE, which include separating the early help hub from the MASH, have created additional capacity, ensuring a more timely and proportionate response to safeguarding referrals. This is supported by the relaunched multi-agency threshold document. Professionals can contact SPOE managers and advanced practitioners directly to discuss referrals, helping them to understand the thresholds for social care. While there are no formal MASH meetings, cases are prioritised using red, amber or green (RAG) ratings, and emails are sent quickly to a range of professionals to conduct MASH checks. Communication on cases of concern happens routinely. The co-location of agencies in the SPOE is a strength, as staff confer constantly.

- There is a timely response to referrals, with most cases transferring promptly from the SPOE to social care teams or to early help and universal services. While there is evidence of management direction on transfer, the rationale for decisions is not sufficiently explicit. Currently, there is too much focus on process. There is a lack of professional curiosity regarding wider safeguarding issues, both in the SPOE and in the referral and assessment service. Issues of significant harm are not always recognised or responded to appropriately, and inspectors saw a number of cases that should have led to section 47 enquiries but had not done so, as the risks had not been fully considered. Strategy discussions are mainly conducted by telephone with the police, although other agencies may be consulted. Inspectors referred a number of cases where managers had failed to adequately identify and respond to risks. Managers do not consistently provide staff with specific direction when allocating work, relying more on a list of generic tasks. This does not encourage full consideration of risk or protective factors.

- Social work caseloads in the referral and assessments teams are too high. At the time of the visit, many social workers were responsible for between 28 to 33 cases. Despite this, most social workers are managing to provide a service to many children, but this volume of work is impacting on the quality and timeliness of their assessments and visits to some vulnerable children. In addition, a number of children who have had an assessment of their needs completed and who require a statutory service are waiting to transfer to the longer-term teams. Senior managers recognise that this high volume of work is not sustainable.

Additional social workers have been recruited and are due to begin in October 2018.

- Assessments vary in quality, ranging from a good analysis of each child's individual needs and risks to superficial over-optimistic and adult-focused practice. Not all children are seen alone as part of an assessment. In better cases, the use of direct work tools informs the assessment. As a result of these inconsistencies, children's plans also vary in quality; most would benefit from being more child-focused and from identifying contingency plans linked to the child's needs.

- The high volume of work has resulted in managers concentrating on process rather than quality of practice, using a RAG rating tool to prioritise cases needing to close. Senior managers have recognised the concerns and are reviewing this system. Social workers told inspectors that they feel well supported by their line managers and benefit from regular monthly and group supervision. Inspectors were impressed by the enthusiasm of this stable and committed group of managers, who are under a great deal of pressure but are working diligently with their heads of service to improve outcomes for children. However, inspectors found that managers do not consistently provide rigorous challenge or take a fresh look at a child's circumstances.

- Earlier this year, senior leaders conducted a survey with all staff in Enfield. As a result of the findings, staff described to inspectors a change in culture, to one where they are more included and can influence services. For example, team managers and social workers are actively involved in redesigning the recruitment and retention arrangements. They have secured agreement for a month's paid sabbatical after three years' service, which is intended to help to retain staff.

- Managers are provided with a range of performance data, but this is not comprehensive enough to help them to manage effectively, and the data is not sufficiently reliable. The development of a monthly practice and performance board, involving all managers and chaired by senior leaders, is bringing additional scrutiny, but needs to be further developed. The process to quality assure the standard of practice through audits is embedded but it is not challenging enough, as there is too much focus on process.

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

Yours sincerely

Brenda McLaughlin
Her Majesty's Inspector