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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 14 and 15 November 2017. The visit was the first 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.

The local authority is starting to make progress to improve services for children and young people, from a very low base. Senior managers have appropriately prioritised improving practice and ensuring the consistent application of thresholds within the multi-agency safeguarding hub (MASH) and the intervention and planning teams. Most children in need of help and protection have benefited from these actions. In most cases considered, it was evident that there is more timely identification of risk and associated actions to protect children and prevent further harm.

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 quality and timeliness of management oversight and decision-making, including compliance with statutory guidance, particularly in relation to section 47 enquiries and strategy discussions
- the effectiveness of the MASH in responding to concerns about children, including the application and understanding of thresholds
- the quality and timeliness of assessments leading to child protection and child in need work and planning.

The visit considered a range of evidence, 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

Meetings with senior leaders, including the very recently appointed permanent operational directors, demonstrate greater understanding of the improvements required to raise the standard of social work practice. The scale of the task is now more apparent to leaders, informed by the increasing use of, and findings from, internal audits that are verified by the local authority's improvement partner. Such activity serves to reveal practice that is mostly variable, and too often inadequate.

Overall, the visit found limited improvement in practice, although there is improvement in some areas. During this visit, this was particularly apparent within the MASH, which has been subject to some structural changes, including and supported by additional levels of staffing. This has increased capacity that, in turn, has improved and consolidated partnership working. Social workers reported to inspectors that they have benefited from increased training, staff conferences and communications from senior leaders. Staff morale was found to be positive, and the vast majority of staff expressed support for the changes implemented or proposed since the last inspection.

The pace of improvement and change is appropriate and commensurate with the size of the task facing the authority. There have been significant changes to staffing and the organisation's structures since the last inspection. This has caused some instability, particularly in the duty and assessment teams. However, all staff interviewed during the monitoring visit reported that the changes made following the inspection have started to improve practice for children and young people. Those social workers spoken with reported that this is impacting positively on morale within the service.

Findings and evaluation of progress

The appointment of operational managers has begun to assist in improving leadership and managerial oversight across key services. During this visit, the positive impact of these appointments was particularly evident within the intake and assessment, and intervention and planning services. In the cases reviewed, the application of thresholds was almost always appropriate.

Work within the MASH to improve processes and practice is aligned to an increased capacity, and is showing signs of an early positive impact. This has been supported by the introduction of an electronic recording system to facilitate improved communication. This is further supported by daily threshold meetings and fortnightly team meetings. The daily threshold meetings are effective in providing more

continuity and consistency to ensure that children and families are offered an appropriate level of support and advice.

Managers and social workers reported that they now have more manageable caseloads and a greater capacity to progress their work. However, the timeliness of decision-making remains inconsistent and, in some cases, there were significant delays for children. Some children are not being seen in a timely manner following initial referral. In such cases, children are not always seen alone or provided with the appropriate support to ensure that their wishes and feelings are fully considered in assessments. Inspectors also found errors in the use of the BRAG (blue, red, amber, green) rating system. Greater rigour in checking these key decisions is required to ensure that children are safeguarded effectively in a timely manner.

Notably for those children who are subject to a child in need or child protection plan, practice is more robust and they are seen more regularly. Practice for these children has improved because managers are better able to track the timeliness of actions, using newly established performance reports.

The quality of strategy discussions and section 47 enquiries remains variable. Enquiries are not always timely, and not all records evidence the rationale for decision-making. Inspectors have noted improvements in attendance of partners at strategy meetings and within case discussions. However, this was not consistent, and some strategy discussions took place only between police and children's social care.

Case recording has improved, although it remains of a variable standard. Inspectors generally found evidence of case summaries on files, although in some cases the notes were not up to date. Chronologies are not consistently updated or sufficiently thorough. In some cases, partnership working is not comprehensive enough, and key partners are not always involved in providing support to children or parents when required.

The quality of assessments seen by inspectors was mostly weak, and the views of family members, particular fathers, were not adequately sought to inform assessments and planning. Weaker assessments did not always include a comprehensive analysis of risks for children, and they demonstrated a poor understanding of family relationships and parental capacity. Such poor assessments lead to plans that are also weak, as they fail to identify core concerns and the means to address these.

Inspectors found evidence that management oversight is being recorded more frequently on some, but not all, documents and case files. However, this variability also revealed gaps in management oversight. This deficit impedes the efforts to raise the overall quality of assessments to inform interventions. For some children, this leads to inadequate practice. A number of managers who met with inspectors acknowledged that they had not previously considered sufficiently some fundamental

aspects of practice, including the meaningful engagement of children and family members, including fathers.

Inspectors found evidence of very recently improved individual supervision. Two cases were also found to have been appropriately discussed within group supervision. However, generally there was a variability in the quality of supervision records, as evidenced by case files. Some records were too brief and insufficiently detailed for the complexity of the case. Supervision was not found to be reflective.

Strengthened quality assurance processes are assisting in the identification and monitoring of the areas requiring improvements within the service. The cases tracked and audited by the local authority for the monitoring visit were thorough and realistic in their findings. This demonstrates an insight into the quality of practice that is needed to reach the higher standard of practice required. The appointment of practice development workers, the training of existing staff and the recruitment of more experienced team managers are essential to support the improvement journey.

During this visit, inspectors found evidence of improving quality assurance processes. It was also evident that there has been productive engagement with the local authority's improvement partner and that additional resources have been secured to increase capacity within the service. The pace of change has been consistent and focused, and has started to raise practice standards. However, social work practice remains inadequate in many areas. The process of changing the culture of acceptable practice remains a significant challenge if the children and young people in Barnet are to be safeguarded effectively and their welfare promoted.

I am copying this letter to the Department for Education.

Yours sincerely

Louise Warren
Her Majesty's Inspector