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Dear Mr Allen

Monitoring visit of children's services provided by Doncaster Metropolitan Borough Council (DMBC) and Doncaster Children's Services Trust (DCST)

This letter summarises the findings of the monitoring visit to Doncaster on 31 July 2017. The visit was the fourth monitoring visit since the local authority was judged inadequate in November 2015. The inspectors were Her Majesty's Inspectors, Graham Reiter and Jan Edwards.

The local authority and the Trust are continuing to make clear and continuing progress in improving services for its children and young people.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in help and protection, with a particular focus on:

- contact and referral arrangements
- strategy meetings and section 47 enquiries
- assessments
- child protection and children in need plans and reviews.

These areas were based on the recommendations and areas of inadequacy identified in the original single inspection and took into account progress identified at previous monitoring visits. Further to this, wider performance and briefing information was considered across the range of services provided for children in Doncaster, to achieve an overview of overall progress being made.

The visit considered a range of evidence, including electronic case records, supervision files and notes, and observation of social workers and managers undertaking referral and assessment duties. Performance management, quality assurance and briefing information provided by staff and managers were also

considered. In addition, we spoke to a range of staff, including senior, middle and first-line managers and social workers.

Overview

Continuing progress is evident in the quality of services for children who require help and protection. Recommendations from the single inspection have been thoroughly addressed, and clear improvements have been seen in areas identified for further development from previous monitoring visits. The views and lived experiences of children come through very strongly in cases seen, facilitated by effective engagement and direct work from social workers. Prompt and thorough responses have ensured that no children were found to be in situations of unassessed or unmanaged risk, and timely progression of work on cases seen has meant that risks for children are reduced effectively. Timely first-line management oversight of work was evident in all areas of practice covered on this visit, although, in some cases, the rationale for decisions was not clearly recorded. Performance management and quality assurance information remains a key strength, which continues to evolve, and its effective use is embedded in all levels of the organisation.

Findings and evaluation of progress

Based on the evidence gathered during the visit, we identified areas of strength and areas of continuing improvement, and significant progress is evident since the single inspection.

Risk is responded to well and threshold decisions are made appropriately in the current front-door arrangements. Timely and thorough management oversight is evident in all cases seen, providing direction to social workers at the outset of the triage and in decision-making following the social work recommendation. The use of a nationally recognised practice framework further supports effective risk analysis at the front door. Consent is understood and obtained appropriately.

Inspectors found evidence of persistent engagement by social workers in following up enquiries in a timely way. Thorough analysis and good practice knowledge ensured that social workers were able to identify issues that were not immediately evident from the presenting information, and this underpinned effective service responses.

The multi-agency safeguarding hub (MASH) benefits from the co-location of partners from police, health and education. This enhances decision-making based on the most up-to-date and proportionate information available. An example of added value to the co-location of partners is the ongoing monitoring by the health representative of children identified as having complex health needs, to ensure that they were fully understood within the assessment undertaken by the locality team.

When risk is heightened, referrals are sent immediately to the locality teams for a safeguarding response. Strategy discussions take place promptly and, when partner agencies are unable to attend, information is obtained from them to support

appropriate decision-making and actions for section 47 enquiries. The enquiries seen were undertaken promptly and thoroughly, and there were appropriate outcomes in all cases seen.

Further improvements were seen from the single inspection and previous monitoring visits in the consistent quality of assessments. All assessments seen on this visit were thorough, with clear descriptions of children's views and their lived experiences. These included thorough consideration and observations of children who were unable to communicate verbally, because of either age or disability. There were good engagement and involvement with significant adults and wider family, whose views were incorporated effectively into the assessment and analysis. Genograms were evident in the majority of assessments. Thorough analysis was seen in all assessments, underpinned effectively by the use of the nationally recognised practice framework. Appropriate outcomes and decisions were evident in all assessments seen.

Management oversight was evident both at the start and conclusion of assessments. Initial oversight gave clear direction with timescales predicated on children's needs and the complexity of the work. While all assessments were quality assured and signed off by managers, in the majority of cases seen, the rationale for the management decision was not clearly recorded.

Improvements from the single inspection and previous monitoring visits were also seen in the consistent quality of plans. In the vast majority of cases seen, plans were appropriately focused and detailed in relation to what needed to change for risk to be reduced and how children's needs were to be met. Actions and responsibilities with timescales were clearly identified, and contingency planning was sufficiently detailed for families to be clear about what would happen if changes were not made. In a small number of cases seen, a simpler and more structured statement of risks would have made the plan clearer for families and agencies.

Thorough safety plans were evident, and there were good examples of children being fully aware and involved in the planning. In one case seen, the child took action as planned as part of ensuring safety. The safety plans were also detailed in case summaries and recording, so that actions required would be clear to any staff member dealing with the case. However, key elements of safety planning had not been consistently integrated into the overarching child protection or children in need plan. While this did not have a negative impact in any of the cases seen, this integration would enable regular multi-agency monitoring and reviewing of the safety plan as part of, or at least alongside, the overarching plan, with all involved staff and family members.

Timely progress was seen in the vast majority of cases sampled. Core groups were regular and effective in reviewing and updating the plan, and there was appropriate multi-agency and family participation. The effectiveness of core groups would be further enhanced by consistent evaluation of risk at each core group, to underpin ongoing planning.

Child protection and children in need reviews seen were timely, with appropriate family and multi-agency participation, and the reviews ensured appropriate progression of the work. Child protection conferences used the practice framework effectively to facilitate child and parental engagement and to underpin the evaluation of progress and subsequent planning and decisions.

Effective and coordinated engagement and work with children and adults were seen in families in which domestic abuse was an issue, and in particular work with, and by, the domestic abuse navigators (DANs). Culture and individual family dynamics were sensitively and thoroughly considered and addressed. Children's safety was appropriately managed during the work. This evidences the progress and impact of innovations funding in developing responses to domestic abuse in Doncaster, and future funding has been identified to mainstream this.

Senior leaders have successfully developed a culture across the workforce of high support and high challenge, with clear practice expectations to improve outcomes for children. Performance management and quality assurance have been identified on previous monitoring visits as a particular strength. This continues to be the case, and there is an increasing and effective focus on quality and the embedding of the positive performance and quality assurance practice by first-line managers and frontline staff.

Findings from previous monitoring visits in relation to the approachability and visibility of senior managers and the effective support of line managers have been replicated by workers spoken to on this visit. Workforce stability continues to improve, and this has been reflected in the more consistent quality of practice seen on this monitoring visit.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website on 31 August 2017.

Yours sincerely

Graham Reiter

Her Majesty's Inspector