18 July 2022

Sophie Wales, Interim Executive Director of Children's Services, Barnsley Metropolitan Borough Council
Chris Edwards, Accountable Officer, NHS Barnsley Clinical Commissioning Group
Alan Billings, Police and Crime Commissioner for South Yorkshire
Lauren Poultney, Chief Constable, South Yorkshire Police
Jean Imray, Independent Scrutineer

Dear Barnsley Safeguarding Children Partnership

Joint targeted area inspection of Barnsley

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency response to identification of initial need and risk in Barnsley.

This inspection took place from 23 to 27 May 2022. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

Headline findings

Most children in Barnsley receive the right support at the right time to identify risk and meet their needs across the 'front door' services. The recently formed Barnsley Safeguarding Children Partnership (BSCP) demonstrates ambition and commitment to improve outcomes for children and their families. However, it is too early to evidence consistent progress to improve services for all children.

What needs to improve?

- The quality and consistency of all agencies' gathering, recording and responding to the expressed wishes and feelings of children with whom they work.
- The quality of referrals to the multi-agency safeguarding hub (MASH), including the timeliness of those from general practitioners (GPs).
- The timeliness of the local authority sharing information with partner agencies, including the outcome of referrals and the minutes of child protection strategy meetings.
- The consistent application of thresholds for children stepping down to early help services.
- The provision of an appropriate adult when children are arrested by the police.

- The timeliness of the police response to all incidents when there is an identified risk to children.
- The availability of and the quality of the emergency duty team's (EDT) response to children and partner agencies.

Main findings

The BSCP has recently experienced changes to all its executive partners. This has resulted in some delay in agreeing future priorities. However, partners have used this delay constructively to review their structure and how they oversee front door services across the partnership. The partners are committed to working together and are ambitious for children and improving their lived experiences. A new independent scrutineer is supporting the partnership to review its priorities and how it functions to support children in Barnsley. Partners have started to make progress. For example, they have increased the frequency of meetings, created a MASH operational and strategic group, and are reviewing the performance data that the partnership receives. However, the pace of change has not always been sufficient to have a positive impact on improving children's lives.

The BSCP has a broad core membership, and this means that a range of professionals offer their knowledge and experience of front door services for children and contribute to forward planning. However, the private, voluntary and independent education providers are not currently represented on the BSCP. This is a missed opportunity to have these significant education providers contribute to future planning.

Partners in Barnsley are proactive in responding to local and national issues relating to safeguarding children. They have collectively commissioned external scrutiny to challenge and review their current practice to improve outcomes for children. Partners respond in a timely manner to significant incidents for children and jointly review children's circumstances to appropriately identify learning across the partnership workforce. However, the commissioning of child safeguarding practice reviews does not always provide partners with all the information they need to implement learning from significant incidents.

The staff training offer from the BSCP and individual agencies is highly valued by the wider workforce. Staff reported training to be easily accessible, including after-school hours and bite-sized learning sessions. School leaders reported an increased confidence and competence in leading early help plans for children and their families following training events.

The BSCP escalation policy is not used effectively. Strong professional working relationships in Barnsley often lead to informal conversations outside the agreed

policy. This means that there is a lack of transparency and recording of decisions made in relation to the safeguarding of children and young people.

Multi-agency referrals to the MASH are mostly timely. However, they vary in quality, detail and analysis. This means that MASH practitioners often need to seek further clarification or do more research to fully understand the concerns. For a small number of children, social workers do not seek this additional information from referrers, contributing to the delay in the decision-making for these children. This also means that some decisions are not always based on the full information available.

A number of health professionals reported that GPs do not refer concerns for children to the MASH at the earliest opportunity. Risks identified are too often passed to other health professionals to respond to and refer on to MASH, should they decide to do so. This means that some children will experience delay in having risk to them assessed in a timely way.

The MASH is resourced by the co-location of key social care, early help, police and health partners and appropriate virtual partners from other agencies. Although there is an education representative in the MASH, the effectiveness of this role is restricted because it provides limited information. The education representative's role does not require them to contribute to decision-making for children. The BSCP responded to concerns raised during this inspection and took action to ensure that a probation service representative would be available for future decision-making in the MASH.

Information-sharing processes between multidisciplinary health professionals are effective. However, social workers do not always inform all safeguarding partners of the outcome of their referrals. This means that professionals are too often required to chase the MASH staff for a response or might not be in receipt of important information that could inform their response with those children and families.

Concerns for children raised at the front door are responded to quickly. Most partners use the child and family's history well to inform decision-making. Consent is gained from parents to seek and share information and, when necessary, management oversight is clear to override consent when in the best interests of children. The MASH arrangements are effective in making immediate safeguarding decisions for most children to ensure that they receive the support and protection they need.

Early help is appropriately recognised and provided to support children and families when concerns or difficulties first arise. Assessments involve a varied range of statutory, community and voluntary services that are child-focused and are used well to meet children's needs effectively. For many children, early help support prevents an escalation of concerns to statutory services. However, for a small number of children, decisions to step down to early help are overly optimistic regarding the

sustainability of parental change and would be managed more effectively through statutory child in need intervention.

Daily MASH meetings review the needs of children who have gone missing, have been arrested or have presented at the emergency department overnight. They include a range of professionals who share relevant information to make appropriate decisions to progress interventions for these vulnerable children.

Child protection concerns are appropriately identified, and strategy meetings are held swiftly for most children. For these children, the key agencies involved in their lives attend strategy meetings, share information effectively and make decisions to reduce risk and safeguard them. For a small number of children, some key specialist agencies are not always invited to, or do not always attend, strategy meetings. This means that decisions are made without this potentially essential information being shared about the child.

The agreed actions from strategy meetings are too often generic and do not address all of the information shared at the meeting. Children's social care professionals do not share the minutes of strategy meetings in a timely manner. This means that professionals rely on their own written records without the benefit of accessing the multi-agency agreed account of the meeting.

Children are mostly visited promptly by social workers, and their views are sought; for some children, this influences decision-making. Social workers' observations of non-verbal or pre-verbal children are recorded well, and this provides a better understanding of what life is like for those children. However, some children are not seen quickly enough when there is a reported police incident and there is an identified risk to children. The delayed response from police officers has left these children at potential risk of harm.

Child and family assessments of need are comprehensive. They include the views of relevant professionals and clearly outline what life is like for the child. Children are visited at home and school, and alone when this is appropriate.

Practitioners in adult mental health and adult substance misuse services appropriately demonstrate professional curiosity to identify risk for children. Police officers take appropriate immediate action to safeguard children living in neglectful homes. However, for a small number of children, this could be better planned with social workers, prior to police protection powers being used.

When children are reported missing from home, their immediate needs are responded to promptly at the front door services. Police officers use the THRIVE police risk assessment tool consistently and effectively, and this means that risk is well understood. Children receive prevention interviews from police and are

encouraged to engage in return home interviews. This information then informs wider planning at a strategic level.

Professionals within the partnership submit intelligence about vulnerable children and their circumstances directly to the police. This approach means that, when decisions are made about risk and safety planning, they can be based on multi-agency information. This is positive practice and not always seen in other areas.

The provision of an appropriate adult for children arrested in Barnsley is ineffective. Out of hours, the appropriate adult service relies on volunteers who do not attend the police station to advocate for children unless to do so would expedite their release from custody. This means that children detained during those hours do not receive the appropriate support.

The structure and current function of the EDT mean that it does not routinely provide partners or children with an effective response to meet the safeguarding needs of all children outside normal office hours. This means that some children do not receive the most timely response to safeguarding concerns.

Workload demands for individual professionals across the partnership affect their capacity to consistently provide the right help at the right time. Most health professionals receive regular and supportive clinical and safeguarding supervision. For others, the variability in the quality and regularity of supervision affects how professionals progress their interventions to improve children's outcomes.

Inspectors saw some highly effective individual direct work with children from a variety of professionals, including police, education staff, health staff and social care. However, the gathering, recording and acting on the voice of the child are too variable, from individuals, single agencies and across the multi-agency partnership workforce. This means that not all children's views are being heard or their lived experiences fully understood by professionals.

The single and multi-agency audits carried out for this inspection by partners demonstrate professionals' ability to identify strong practice and areas that could be improved. However, it is of concern that a decision to reopen or change the direction of the planned intervention was identified for more than half the children of the sample. This means that the partnership cannot be wholly confident about the level of effective single agency management oversight and decision-making to safeguard all children.

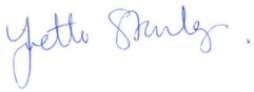
Next steps

We have determined that Barnsley Metropolitan Borough Council is the principal authority and should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving

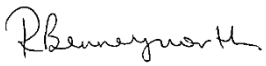
the individuals and agencies that this report is addressed to. The response should set out the actions for the partnership and, when appropriate, individual agencies. The local safeguarding partners should oversee implementation of the action plan through their local multi-agency safeguarding arrangements.

Barnsley should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by Tuesday 25 October 2022. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

Yours sincerely



Yvette Stanley
National Director Regulation and Social Care, Ofsted



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