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Ms Julie Fisher
Deputy Chief Executive and Director of Children's Services
Surrey County Council
Penrhyn Road, Kingston upon Thames
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Dear Ms Fisher

Monitoring visit of Surrey children's services

This letter summarises the findings of the monitoring visit to Surrey children's services on 10 and 11 January 2017. The visit was the sixth monitoring visit since the local authority was judged inadequate in June 2015. The inspectors were Linda Steele HMI, Donna Marriott HMI and Natalie Trentham HMI.

Based on the evidence and cases seen by inspectors during this visit, the local authority is continuing to make progress to improve services for children in some areas. This is particularly evident in improving education, employment and training opportunities for care leavers. The local authority and its partners have been effective in prioritising and developing a response to child sexual exploitation in Surrey. However, more work is required to improve assessment of risk, safety plans and the quality and timeliness of return home interviews. There has been insufficient progress to ensure care leavers have access to their health histories.

Areas covered by the visit

During the course of the visit, inspectors reviewed services to care leavers and to children missing from home or care and at risk of sexual exploitation, with a particular focus on:

- the effectiveness of arrangements for keeping in touch with care leavers, the quality of pathway plans, suitability of accommodation and the use of health passports
- assessment and planning processes for children at risk of exploitation and missing and the quality and timeliness of return home interviews
- management oversight and supervision.

The visit considered a range of evidence, including electronic case records, supervision files and notes, performance management reports and other information

provided by staff and managers. In addition, inspectors spoke to young people, as well as managers, social workers, personal advisors, partner agencies and administrative staff.

Summary of findings

- There is evidence of a continuing drive by senior managers to improve services for children.
- There remains variability in practice, particularly in respect of services for children missing or at risk of sexual exploitation.
- Staff report they feel well supported, have confidence in the senior leadership team and morale has improved.
- Performance data available to help managers monitor the delivery and quality of service that children receive is improving.
- Inspectors agreed with the judgement of the local authority in case audits carried out for the purpose of this visit. This is an improvement from previous visits.
- The large majority of care leavers have a pathway plan in place but plans are not reviewed according to the changing needs of the young people and the quality is too variable. The majority of plans lack timescales or contingencies.
- Senior managers have taken action to improve the format of the pathway plan in response to feedback from the staff and young people. A new pathway plan is being piloted which care leavers have been involved in developing.
- Pathway plans clearly consider and identify young people's health needs. However, too many care leavers have not received information regarding their health histories. During the last inspection, work had commenced to address this deficit, but progress in this respect has been too slow.
- The quality of case recording does not consistently evidence the work undertaken with care leavers. Chronologies lack detail and are not used consistently to inform case planning or ensure an accurate record of the young person's history.
- Supervision is not always reflective and does not rigorously drive planning for young people.
- A placement officer responds to young people's accommodation needs effectively. At the time of the monitoring visit, managers' report that no care leavers are living in bed and breakfast and the large majority (93%) of young people are living in suitable accommodation.
- Young people are effectively encouraged to stay in their foster placements after they reach 18 years through staying put arrangements. Currently 80 young people benefit from this.

- Arrangements to strengthen the response to children who go missing are evident, but more work is required to improve the quality and timeliness of return home interviews and to ensure that all children who require one have one.
- There is demonstrable progress in improving the strategic arrangements for children at risk of sexual exploitation. A new strategy and action plan are now in place.
- Child sexual exploitation risk assessments are evident in the majority of cases, but vary in quality, with limited analysis and safety planning.
- Managers have been particularly effective in challenging the use of language by professionals that had previously suggested a lack of understanding of child sexual exploitation.

Evaluation of progress

A permanent senior leadership is now in place. The pace of change continues to gain much needed momentum. Managers are unrelenting in their drive and ambition to improve services for children; they understand the key priorities, and take proactive and robust action to respond to identified shortfalls. Performance management information continues to improve. The recent development of a new performance information system will provide managers with much needed real time data.

Quality assurance, including case auditing by managers, has improved. Themed case audits, such as the recent care leavers' audit, identify good and inadequate practice, and mirrored the vast majority of inspectors' findings. There has been a strong and necessary focus on ensuring compliance with basic standards, which is now starting to be effective. The local authority's own audits reflect continuing inconsistency of practice. During this visit, inspectors referred two children's cases back to the local authority because of unassessed risk.

Management oversight is now evident in the majority of case records but more needs to be done to ensure management oversight influences practice and improves outcomes for children. Supervision is generally occurring but practice is not yet consistently effective.

Overall, inspectors agreed with the findings of the case audits undertaken for the purpose of this monitoring visit. The local authority accurately graded one of these as inadequate, identifying weaknesses in practice to assess and respond to risk and to ensure a coherent joined up approach to planning. Senior managers took robust action to respond to identified concerns, auditing 62 cases held in this part of the service, as well as developing an action plan to address shortfalls.

Personal advisors are tenacious in building and maintaining relationships with young people, and are committed to improving outcomes for them. However, the quality

and effectiveness of practice remains mixed and managers need to continue to focus on improving the quality of services.

During 2016, the service experienced increasing pressure on capacity, resulting in a small number of young people inappropriately held in managers' names, with work completed by a series of duty workers. Consequently, some young people have not received a good enough service, experiencing gaps in contact from personal advisors and delays in the completion of their pathway reviews. One young person fed back to the local authority that he felt 'forgotten' during this period, exemplifying the impact this has on young people. Senior managers have taken appropriate action to resolve the capacity issues through investment in additional personal advisors.

The local authority is not in touch with 12% of young people. A number of these are unaccompanied asylum seeking children who left the area without trace very soon after arrival. Personal advisors make active efforts to trace these young people and resume contact. One young person spoken to by inspectors said that their personal advisor was the best person that had come into their life. They support, guide, and really care for them.

Personal advisors value the introduction of the specialist mental health, placement, and education officers, which frees their time to focus on meeting young people's welfare needs, as well as providing expertise and support for young people.
The proportion of care leavers in education, employment and training has increased since the last inspection, up from 40% to 66% (September 2016). Increasing numbers of care leavers are moving into higher education, and 11 care leavers are in apprenticeships.

Pathway plans identify care leavers' health needs. However, too many care leavers have not received information regarding their health histories. During the last inspection, work had commenced to address this deficit, but progress has been too slow. There is now a system in place to ensure that all children looked after receive their health history before they leave care. However, for those children who left care previously, there is an expectation for them to approach their own General Practitioner to access their health history. This approach is not reflective of good corporate parenting.

Since the last inspection, arrangements for responding to children who go missing have been strengthened. The multi-agency safeguard hub now record all missing notifications. A new weekly multi-agency missing children panel considers all children missing in the last seven days and reviews information from return home interviews to identify patterns and trends and inform service provision. However, it is too soon to demonstrate any impact. A commissioned service undertakes the majority of return interviews. These are not timely and the take-up by children is not good enough. There are delays in uploading return home interviews onto the electronic social care record, in some cases up to two months, which means information is not

readily available to social workers and the emergency duty team. The quality of interviews is variable, with stronger practice evident in the small number of return interviews for children looked after seen by inspectors.

There is a performance dataset for children who go missing, aligned across key agencies. However, there has not been sufficient strategic analysis of performance reporting regarding the timeliness of return interviews for all children, or for identifying higher risk indicators, such as those missing on more than three occasions in 90 days. Senior managers have recently taken action to respond to this shortfall and begun to develop a comprehensive dataset.

The local authority has more recently taken action to strengthen the strategic arrangements in response to child sexual exploitation. There is evidence of effective disruption activity, driven by targeted multi-agency coordination. Improved data analysis has supported increased knowledge around the local child sexual exploitation landscape. Arrangements to identify and monitor children at risk of sexual exploitation are in place. The quality of the information presented to Monthly Missing and Exploitation Children's Conferences (MAECC) has improved, but further work is required to ensure actions from these meetings are sufficiently robust and diligently tracked and progressed to reduce risks.

Child sexual exploitation risk assessments are evident in the majority of cases, but vary in quality, weaker examples include limited analysis and poor safety planning. There is evidence of improved management oversight for children at risk of sexual exploitation. Managers have been particularly effective in challenging the use of language by professionals that had previously suggested a lack of understanding of child sexual exploitation.

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

Yours sincerely

Linda Steele

Her Majesty's Inspector

The letter is copied to the Department for Education [at SocialCare.INSPECTION-IMPROVEMENT@education.gsi.gov.uk]