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Mr Julian Wooster
Director of Children's Services
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Dear Mr Wooster

Monitoring visit of Somerset children's services

This letter summarises the findings of the monitoring visit to Somerset children's services on 24 and 25 January 2017. This is the second monitoring visit to the local authority since Somerset children's services were judged inadequate in February 2015. The inspectors were Emmy Tomsett HMI and Joy Howick HMI.

This monitoring visit focused on how casework is transferred from the referral and contact team to the four safeguarding teams. The visit assessed the quality of social work practice for children in need of help and protection.

The overall finding from this monitoring visit is that the local authority is making adequate progress in improving services for children and young people in need of help and protection in Somerset.

Areas covered by the visit

During this visit, inspectors assessed the progress made by the local authority to effectively safeguard children in need of help and protection.

Inspectors focused on the quality and timeliness of children in need plans and child protection plans and considered the effectiveness of the local authority's step-down processes and escalation procedures. In addition, inspectors assessed the quality and timeliness of assessments for children and the quality and frequency of supervision and management oversight of social work practice.

Inspectors looked at a range of evidence, including the local authority's electronic case records, supervision records and other information provided by staff and managers. In addition, the inspectors spoke to a number of staff, including managers, social workers, other practitioners and administrative staff.

Summary of findings

Children and young people in need of help and protection, following an identified concern about their welfare, continue to receive a timely and effective response to their needs from the contact and referral team. However, the quality of social work practice when casework is transferred from the assessment teams to the safeguarding teams remains too variable.

Partnership arrangements in Somerset are, on the whole, well developed. However, inspectors found inconsistency in police involvement in some aspects of the local authority's child protection arrangements. Senior leaders are meeting regularly with representatives from the Avon and Somerset police force in an effort to improve communication and joint-working arrangements.

Thresholds and the interface between Get Set (early help services) and social care are clear and well understood by the partnership. Joint working between social workers and Get Set professionals is better embedded in practice. Collaborative working is a key priority in Somerset, and this is contributing to improved outcomes for children through well-coordinated service provision.

The revised step-up and step-down protocol has been implemented. Social workers are clear about the procedures. However, there are some examples of inconsistent practice, across the four safeguarding teams, in applying the protocol. Inspectors found a small number of cases in which social workers were seen to be stepping cases down from child protection far too quickly, first to children in need and then to early help. While plans are in place to monitor children, decision-making in these cases was seen to be overly optimistic, and parents have not been able to demonstrate sufficient and sustained improvements in their parenting skills to support their children more effectively. In these examples, children have experienced ongoing exposure to harmful adult behaviour, particularly in cases of long-term domestic violence, neglect and drug or alcohol misuse. The lack of permanent staff, including managers in some safeguarding teams, has exacerbated the difficulty in making timely decisions for children and families.

Case recording remains too variable across the four safeguarding teams. Inspectors saw some examples of timely comprehensive case records by social workers. However, key decisions made by managers and records of home visits to see children by social workers are missing.

Case records and children's assessments do not routinely record or analyse issues of equality or diversity. Senior managers have acknowledged this weakness, which remains a key focus in casework audits. The need to consider the holistic needs of children in assessments is reinforced by the work of the consultant social workers who are currently delivering training to support improvement in this area of practice. In addition, revised practice standards have been issued to all staff to ensure that the diverse needs of children and their families in Somerset are fully considered in all aspects of social work practice.

Social workers demonstrate persistent efforts to engage absent parents in children's assessments and planning. The use of family group conferences is improving. As a result of this more tenacious approach, some children have been able to remain in the care of their family rather than becoming looked after.

Direct work with children is poorly recorded and not well integrated into assessments and plans in cases examined by inspectors. Inspectors saw some better examples, in which social workers were supporting children and young people to express their wishes and feelings. However, the majority of records relating to home visits to children seen by inspectors in the safeguarding teams are mostly adult or task focused. Case records do not sufficiently reflect the experiences of children. When records are more comprehensive, social workers know their children and families well and record separate observations for each brother and sister in the family.

Most children are seen regularly by a social worker. The frequency of social work visits to see children subject to a child in need plan has improved over the past 12 months, from 52% in December 2015 to 70% in December 2016. Although the majority of children in need are now seen by a social worker every six weeks, the frequency of visits is not yet consistently informed by the needs of the child.

Statutory visits by a social worker to see children subject to a child protection plan every two weeks have declined very slightly, from 92% in December 2015 to 91% in December 2016. The local authority attributes this small decline in performance to changes in the workforce in some teams. Senior managers continue to scrutinise performance data to ensure that the welfare of children is robustly monitored.

The quality of children's assessments remains too variable throughout the safeguarding teams. While some good examples were seen by inspectors in the four safeguarding teams, most assessments continue to have a poor analysis of risk and protective factors. Children's assessments are not consistently updated following significant changes or key events in their lives. This means that, in some cases, children's needs are not always robustly assessed to ensure that the right services are provided to support them. The local authority recognises that the quality of assessments continues to require sustained and consistent improvement across the service.

Child protection enquiries are mostly timely and well-coordinated. The proportion of strategy discussions taking place within the five days following notification of a concern about the welfare of a child is currently 81%. As a result, in a small minority of cases, opportunities to share information in a timely manner and develop well-coordinated section 47 child protection investigations are delayed. While the timeliness figure has remained stable for the past 12 months, the local authority is keen to achieve a target of 95%.

The timeliness of initial child protection case conferences held within 15 days of the strategy discussion, at which a section 47 investigation was instigated, remains stable and is currently 96%. This ensures that children receive a swift, well-coordinated response from all partners to protect them better. Arrangements to

protect children before the conference is held are generally robust and clear. Most case conferences are well attended, and partners share information effectively, contributing well to the Signs of Safety model used in Somerset to identify key strengths and weaknesses within families.

Across the four safeguarding teams, the quality of children in need and child protection plans is too variable. Plans are not consistently specific or measurable and do not explicitly describe what parents must do to change their behaviour and protect their children better. Contingency planning within both children in need and child protection plans is poorly considered and recorded.

Child protection plans are, in most cases, reviewed regularly. However, 36% of children in need do not have a child's plan in place or have not had the plan reviewed within the last three months. This performance has steadily improved over the last 12 months from 47% in December 2015. As a result, more children are having their changing needs or circumstances reviewed. However, further improvement in performance is still required.

The proportion of children who became the subject of a child protection plan for a second time is stable, and is currently 18%. This exceeds the local authority target of 15% and remains an area that senior managers monitor closely to ensure that the level of decision-making about risk to children is effective.

Arrangements to monitor the length of time that children are subject to a child protection plan have improved. Management oversight of this area of work has been strengthened to ensure that children are not exposed to ongoing risk and unnecessary delay in planning for their future. There are currently no children who have been the subject of a child protection plan for longer than two years. This is an improvement from a figure of 5% in December 2015.

There is a good use of advocates for children and parents in Somerset, and social workers actively promote advocacy services. Case records and minutes of multi-agency meetings demonstrate that advocacy has successfully enabled parents and older children to share their feelings effectively, and thus to contribute fully to their assessment and planning arrangements.

The quality and frequency of supervision across the four safeguarding teams are inconsistent. While staff spoken to by inspectors reported feeling well supervised by their managers and noted that supervision is regular, the quality of the recording of supervision remains too variable. This concern also pertains to the assessment teams at the last monitoring visit, and there is no evidence of any substantial improvement since that time. Decision-making and subsequent action plans arising from supervision are not routinely documented. Supervision records do not sufficiently reflect challenge or management scrutiny, and key weaknesses in practice, in a minority of cases, were not identified by managers.

The local authority completed an audit of supervision records in October 2016, and an action plan to address identified shortfalls is now in place. The supervision policy

has been revised and reintroduced. Supervision will be the subject of an annual audit, with frequent reporting through the quality assurance framework in the interim.

Audit activity across the service is well embedded, and approximately 40 children's and families' cases are audited bi-monthly. Learning from audit activity is disseminated effectively across the workforce to improve learning and practice. Social workers are encouraged to engage in audit activity and are required to identify areas for their own development, as well as strengths, within their practice. While the audit tool is comprehensive, it does not facilitate the local authority's monitoring of performance and outcomes for children by easily identifying how frequently the child has been seen by the social worker.

The local authority continues to monitor social work caseloads, with the aim of ensuring that social workers do not support more than 14 children at any one time. While a minority of social workers have caseloads that reflect this figure, the vast majority of caseloads exceed it. Caseloads continue to be described as manageable by social workers and managers. However, turnover of agency staff has temporarily increased caseloads, and this has adversely affected some areas of social work practice. For example, case recording is not sufficiently timely, and the frequency of visits to see children is too variable.

Workforce stability across children's services is continuing to improve, although senior managers acknowledge that over the past few months there has been some movement, which has meant that some children have experienced several changes of social worker. Agency social workers currently make up 30% of the overall workforce, and 26% of team managers are recruited from an agency. However, arrangements are monitored effectively by senior managers, and the workforce development strategy has been revised to encourage staff retention and to promote 'grow your own' within the existing workforce.

Evaluation of progress

Based on the evidence gathered during this monitoring visit, inspectors identified areas of strength and areas in which improvement is occurring. Overall, the pace of change is adequate. The key challenge for Somerset is to embed fully all practice developments and to ensure a level of consistency in social work practice across the service.

Senior leaders in Somerset continue to have an accurate overview of the key strengths and weaknesses across the service. The strategic improvement plan continues to support strategic and operational developments, driven by a realistic and measured senior leadership team. Senior leaders are clearly committed to an ongoing programme of improvement coupled with a well-targeted and comprehensive staff retention and recruitment policy. Overall, outcomes for children are improving. However, the local authority rightly recognises that notable room for improvement remains.

Across the four safeguarding teams, direct work with children is still limited. Case records, seen by inspectors, do not properly reflect the lived experiences of children. Too many assessments contain insufficient analysis of risk and protective factors. In addition, since the first monitoring visit, the local authority has been too slow to address the variability of case recording.

Children in need and child protection plans lack important detail about the actions that parents must take to reduce risk and to protect their children better.

The use of audit activity and quality assurance mechanisms and the scrutiny of performance information are well embedded, and are used effectively to track progress against the improvement action plan. However, this scrutiny has been adversely affected by the absence of consistent and permanent frontline team managers to drive improvement at the operational and practice level.

The local authority continues to work hard to secure a stable workforce. While social workers feel well supported and morale is generally good, improving effective management oversight within the four safeguarding teams is a key priority for the service. However, the quality, frequency and recording of supervision remain inconsistent.

I am copying this letter to the Department for Education.

Yours sincerely

Emmy Tomsett

Her Majesty's Inspector