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Ms Rose Durban
Interim Director of Children's Services
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Dear Ms Durban

Monitoring visit of Surrey local authority children's services

This letter summarises the findings of the monitoring visit to Surrey children's services on 31 October and 1 November 2017. The visit was the ninth monitoring visit since the local authority was inspected in 2014 and the fifth under the new arrangements. The inspectors were Linda Steele and Donna Marriott, Her Majesty's Inspectors.

Inspectors have consistently identified shortcomings in the quality of services to children, including a lack of effectiveness in managing risk. The local authority has made some progress to implement the necessary improvements, but the pace of practice improvements for children in need of help and protection is too slow. Senior managers know the scale and urgency of the work required to ensure consistent, safe and effective practice for children.

Areas covered by the visit

During the course of this visit, inspectors reviewed progress made in the area of help and protection, including:

- The quality and provision of early help support, and the effectiveness of the arrangements for 'stepping up' or 'stepping down' between different levels of intervention.
- The effectiveness of assessment and planning for children in need of help and protection.
- The quality of management oversight, challenge and staff supervision in these services.

Different types of evidence were considered during the visit, including electronic case records, supervision notes, observation of early help staff and social workers and

other information provided by staff and managers. In addition, inspectors spoke to a range of staff members, including managers, social workers and other practitioners.

Overview

The local authority is taking too long to address critical weaknesses. Where changes have occurred, they are very recent and remain fragile. Too much social work practice remains of a poor standard. Weaknesses in managerial oversight at all levels, including by child protection chairs, mean that deficits in practice go unchallenged. Consequently, children's needs for help and protection are not consistently met. Senior managers know what they need to do to improve the quality of services for children and are working to ensure that the necessary infrastructure is in place to achieve this. However, substantial work remains necessary to ensure that social work practice is consistent and of the required standard.

An inconsistent application of thresholds for children who need help and protection, and a lack of recognition of risk, are common features in too many children's cases. These critical weaknesses mean that children do not receive the right service at the right time or, in situations that are more serious, children are not safeguarded effectively. Overall, children and family assessments lack a clear analysis of risk and planning for children is not outcome-focused.

The local authority has recently improved its early help provision to children, and services are increasingly reaching more children. Nevertheless, more work is required to ensure effective coordination of services.

Findings and evaluation of progress

In the majority of children's cases audited by the local authority for the purpose of this visit, there were significant deficits in the quality of basic social work practice. In two children's cases, protective action was necessary to ensure that they were safe. It is of serious concern that poor decision-making and a lack of recognition of risk have left children at risk of harm. Although the local authority's audit process had picked this up for the purpose of the monitoring visit, this had not been identified as part of its routine quality assurance work, in particular through supervision and management oversight.

The local authority has taken action to strengthen the early help offer. A review of services, detailed needs analysis and the development of early help hubs have improved the support to families. The co-location of early help staff, alongside statutory children's services in the multi-agency safeguarding hub (MASH), is beginning to deliver a more coordinated approach. However, thresholds are not yet appropriately or consistently applied. In a significant number of early help children's cases sampled for the monitoring visit, children were not receiving the right support. These children needed statutory intervention to ensure that their welfare was promoted or they were protected. Over recent weeks, an increase in demand for

early help support has resulted in delays in the early help coordination hubs progressing referrals for the allocation of services. This is a concern given the issues about the inaccurate application of thresholds.

Surrey Family Services, which draws together a range of support from early years to youth services, ensures localised early help provision. Further work is required to increase partners' active participation in early help work, including taking on the role of lead professional. Professionals across the children's workforce are completing early help assessments, though these are of variable quality, with some lacking clarity regarding children's assessed needs and the purpose of actions to meet them. Children's needs for targeted support are responded to through provision of early help services in the community, though there are delays in some families receiving a service due to some pressures in capacity. This is particularly an issue for those families who need a service from the family support programme in some parts of the county, though other services are provided in the interim.

Child and family assessments are generally timely but the quality is not consistently good. Some lack clarity regarding purpose and objectives and not all result in the right outcome for children. The majority of children's plans are not of a good enough quality. Key actions in plans are not always progressed, for example parenting assessments, family group conferences, risks assessments and updated child and family assessments.

Social workers take time to make sure that they understand children's wishes and feelings. Visits to children is generally purposeful and most are visited in accordance with their plans. However, in a small minority of children's cases sampled there were unacceptable delays in visits taking place. In the worst case, this was a delay of seven months.

The timeliness of initial child protection conferences has improved from a low base to 72% held within 15 working days of the strategy discussion. Most core groups take place regularly, but professionals in these meetings do not ensure that plans are used to measure progress and that timely action is taken to prevent drift and delay. Children do not routinely attend child protection conferences. Independent advocates are available to children involved in child protection processes, but the take-up of this support is low.

Professional relationships between team managers and child protection chairs are not constructive, weakening quality assurance and practice improvement. The use of formal escalation is low, with 12 alerts raised by child protection chairs in the last six months. Child protection chairs report that they have informal conversations with social workers and team managers which are not consistently recorded. This means that it is difficult to monitor agreed actions or the progress made.

The frequency of management oversight of practice and staff supervision has improved, but it is not rigorous and lacks sufficient or effective challenge to address

shortfalls in practice. This remains an area for development and senior managers acknowledge this as a priority for the service.

Inspectors saw some improvement in the quality of case recording in most children's records sampled. Case summaries, chronologies and genograms are becoming embedded and are useful in identifying risks.

Performance management, strategic improvement planning and quality assurance processes have been strengthened. Although quality assurance processes are embedded, they are not followed through consistently to act as a force for improvement. For example, auditing activity takes place regularly but managers do not systematically follow up on agreed actions. Audit reports do not provide sufficient clarity about the deficits in practice to fully inform practice development.

Overall, this visit found limited progress in some areas, with insufficient progress in most. Senior managers have a realistic understanding of the challenges facing children's services and are taking action to address the significant deficits identified during this visit. Nevertheless, many of the improvement measures have been too recent or have not yet made a tangible difference. Senior managers accept inspectors' findings that too many children are being insufficiently safeguarded. The pace of change requires considerable acceleration to ensure that children's needs are responded to effectively and their outcomes improved.

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