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Ms Alison Williams
Interim Director of Children's Services
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Shire Hall
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Dear Ms Williams

**Monitoring visit of Gloucestershire County Council children's services**

This letter summarises the findings of the monitoring visit to Gloucestershire County Council's children's services on 16 and 17 January 2018. The visit was the second monitoring visit since the local authority was judged inadequate in March 2017. The inspectors were Nicola Bennett HMI and Emmy Tomsett HMI.

The local authority is making variable progress in improving services for children and young people. It has taken appropriate action to address some areas for development identified at the previous monitoring visit. Senior leaders have recently implemented a wide range of improvement frameworks and these have been well supported by significant financial investment and additional resource in children's services. However, this investment is too recent to demonstrate improved services and outcomes for children and, overall, the pace of change remains too slow. Necessary changes of senior leadership within children's services following the findings from the inspection in March 2017 have contributed to this delay.

## Areas covered by the visit

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

- the quality and timeliness of information gathering and decision-making within the recently developed 'front door' service and multi-agency safeguarding hub (MASH) within the local authority
- the timeliness of social work visits to see children and ascertain their welfare
- the effectiveness of assessment, planning and interventions for children in need of help and protection
- the quality of management oversight challenge and staff supervision in these services

- the accuracy and quality of the performance management information used by senior leaders and managers to oversee practice, and how effectively it is used to improve outcomes for children
- the quality assurance of social work practice through auditing of casework and the contribution it makes to practice improvement.

A range of evidence was considered during the visit, including electronic case records, supervision files and notes, observation of social workers and senior practitioners undertaking referral and assessment or case work duties and other information provided by staff and managers. In addition, we spoke to a range of staff, including managers, social workers and other practitioners.

**Overview**

While inspectors saw some improvement since the last monitoring visit, children in need of help and protection in Gloucestershire continue to experience delay at every point of their involvement with children's services. Some children remain in situations of unassessed risk for too long, and others experience chronic neglect or continue to be exposed to risk without effective action being taken to protect them, this is particularly the case for young people experiencing or at risk of sexual exploitation.

The local authority has been successful in recruiting suitably qualified and experienced social workers and managers. The majority of social workers now have manageable caseloads and the number of children without a named social worker has decreased. However, in some parts of the service social workers do not always have the level of skills and experience required to provide effective interventions for children's complex needs. While managers' oversight of practice and staff supervision are regular, managers are not yet providing staff with sufficient challenge or direction and too often fail to address deficits in practice.

The quality of performance management information has continued to improve and senior managers now have available the majority of information needed to understand the effectiveness of services provided to children and families. However, further refinement is required to ensure that all information is accurate and to give senior leaders and managers the clear overview that they need of practice.

The local authority has continued to develop its quality assurance framework. It is comprehensive and focused on improving outcomes for children. There is a well-established cycle of casework audits and the local authority has both reduced the number of staff undertaking audits and provided appropriate training. As a result, the majority of audits seen on this visit were of good quality and accurately evaluated children's experiences.

Staff morale and confidence in the senior leadership team has improved since the last monitoring visit and this has been assisted by more manageable caseloads, improved technology and accessibility of line managers.

## Findings and evaluation of progress

Delay in responding to children's needs is widespread in every part of the service seen in this visit. While delays in decision-making within the MASH and the front door service are often no more than a few days, children experience further delay within the receiving social work teams and, consequently, often wait too long before they are visited by a social worker and their needs assessed.

The local authority has improved response times in decision-making in the MASH and is working to co-locate the MASH with the one front door service to further reduce delays in decision-making for children. For most children referred to the MASH, decisions are now made within 24 hours. The timeliness of decision-making for children within the front door service has also improved, although some children experience a short delay before decisions are made about next steps. The recent introduction of a professionals' helpline has reduced the number of inappropriate referrals from partner agencies and improved their engagement. However, there is insufficient oversight by managers of this service of the application of thresholds and quality of advice provided by social workers. In a number of cases seen by inspectors, advice provided to professionals led to delay in undertaking enquiries and timely protective action being taken. Senior managers have acknowledged the need for appropriate management oversight and records for this newly developed service.

Since the last monitoring visit, good strategic engagement between the local authority and the police has been effective in reducing delay in police notifications of children considered to be at medium risk of domestic abuse. The practice of sending notifications in batches has ceased. However, there continues to be some delay in police notifications for individual children and in a minority of cases notifications are received after an investigation has been undertaken.

Strategic engagement to improve joint work between police and children's services when children are at risk of significant harm has been less effective and police officers do not routinely attend strategy discussions or jointly undertake child protection enquiries where there is clear evidence of significant harm.

Social care managers do not always convene strategy discussions where the threshold has been met and social workers therefore visit and speak with children without the benefit of a clear multi-agency plan. As a result, children often need to repeat their disclosure several times and there is delay in identifying risk and in safety planning. Records of strategy discussions that are held are generally of poor quality; meetings are not consistently attended by key agencies such as health services and the rationale for subsequent decision-making and the actions taken is not clear in the majority of cases seen. Plans arising from strategy meetings do not routinely include timescales, making it difficult to hold professionals and families to account. Records of child protection enquiries do not consistently demonstrate whether children have been seen.

The quality of social work practice is too variable. Inspectors saw some children whose needs and risks were clearly identified and whose outcomes were improving as a result of more effective practice. However, some children live in circumstances in which they continue to be exposed to risks as a result of sexual exploitation, domestic abuse or neglect, with little or no evidence of sustained positive change.

The local authority has addressed a large backlog of unallocated cases and regularly risk assesses the circumstances of the small number of children who wait a short time for a named social worker. It has reduced caseloads through successful recruitment of suitably qualified and experienced staff and has increased management capacity to improve oversight and direction of social work practice. However, these actions have not yet resulted in demonstrable improvements in social work practice or outcomes for children.

The delay that children experience at the referral and assessment stages is adversely impacting on the effectiveness of care planning for them. While the local authority has established baseline timescales for seeing children, a significant number of visits occur outside these timescales, including visits to children on a child protection plan considered at high risk of further harm. Timescales for visiting children are not informed by the urgency of the child's situation or level of concern. Managers are not routinely tracking statutory visits to children to ensure that they are seen. Consequently, too many children are not visited soon enough for social workers to ascertain their circumstances, and they remain in situations of unassessed or continuing risk for too long.

The majority of assessments are now completed within the maximum national timescales of 45 working days. However, further improvements are necessary to ensure that children's needs are assessed and that they receive effective services within a timescale that is right for them. The quality of assessments is too variable. Inspectors saw some assessments that contained detailed analysis leading to effective planning, but weaker assessments were over-reliant on parental self-reporting, and few effectively captured or were informed by the views and experiences of children. Assessments did not always include significant figures in children's lives and lacked a consideration of history to inform future planning. In the vast majority of assessments, risk analysis was poor or absent.

Action plans continue to be too variable in their quality and do not assist effective care planning and decision-making. The rationale for decision-making and interventions is not consistently clear. Although some more recent plans contain timescales, this practice is not yet consistent nor embedded, making it difficult to hold workers, agencies and sometimes parents to account. Plans do not often address all identified risks and needs in assessments, and it is difficult to measure whether an action has been achieved or has resulted in an improvement in children's circumstances.

Inspectors saw some good examples of direct work with children, and the majority of social workers knew children well, but this is not always evident from written

records. Social workers were not always clear about the outcomes required for each child in a family. Social work visits to children do not always have a purpose and the majority of case records do not include the daily lived experiences of the child. Some children continue to experience frequent changes of social workers and do not have the opportunity to develop lasting trusting relationships.

Since the last monitoring visit, the local authority has increased management capacity to improve the effectiveness of social work practice and performance. While inspectors saw some examples of timely case work with clear management oversight and case direction which is contributing to improving outcomes for children, this was not consistent across all teams. Management oversight of decision-making by social workers, as well as the quality and timeliness of assessments and plans requires further strengthening to improve the quality of practice across the service. Supervision continues to be largely action centred, and is rarely challenging or effective in improving practice or outcomes for children.

The quality and range of performance management information used by the senior leadership team to understand and monitor children's experiences has improved significantly. The use of this information is leading to some practice improvements such as the timeliness of assessments and reduction in delays in-decision making in the front door service and the MASH. However, the local authority recognises that further refinement is required to measure the effectiveness of the early help service, professional advice line, and the timeliness of visiting children from the first point of contact to them receiving appropriate interventions and services. Performance information for frontline managers is detailed and regularly made available. However, not all managers are using performance information effectively to monitor and improve social work practice.

The use of auditing of casework is now well established and the quality of the audits has improved since the last monitoring visit. This is because audits are undertaken by a smaller number of auditors, who all have the appropriate level of skill and experience. Auditors accurately identified deficits in practice, including delay for children. However, actions to address identified deficits are focused on ensuring compliance with processes rather than improving the child's experiences or ascertaining their safety or welfare. Social workers and managers are not consistently interviewed as part of the audit process; this is a missed opportunity to learn from and improve practice. Consequently, the contribution that auditing of casework makes to practice improvement is not yet strong enough.

Staff morale is improving and most staff spoken to by inspectors expressed growing confidence in actions taken by the senior leadership team to improve working conditions and support social work practice. These actions include reducing caseloads, increasing manager accessibility and making improvements in technology to support mobile working.

The local authority has now put in place the appropriate foundations to improve practice through the successful recruitment of social workers, increase in management capacity and establishment of systems for monitoring performance. The local authority recognises that the pace of change must now accelerate to ensure that children in need of help and protection receive a timely and effective response.

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

Yours sincerely

Nicola Bennett
**Her Majesty's Inspector**