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Mr Peter Murphy
Director of Children's Services
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Dear Mr Murphy

Monitoring visit of South Gloucestershire children's services

This letter summarises the findings of the monitoring visit to South Gloucestershire children's services on 31 January and 1 February 2018.

The visit was the second monitoring visit since the local authority was judged inadequate in February 2017. The inspectors were Joy Howick HMI and Emmy Tomsett HMI.

The pace of improvement in South Gloucestershire children's services is too slow. Children in South Gloucestershire continue to experience systemic delays in receiving the help that they need. Risk to children continues not to be consistently identified or addressed by social workers and their managers.

Quality assurance of casework through auditing activity is too variable and does not always identify or address poor practice. Senior managers were aware of some, but not all, of the deficits seen by inspectors on this visit.

Areas covered by the visit

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

- the appropriate application of thresholds for children in need 'stepped down' to early help services; the identification of increasing risks for children in need requiring a 'step up' to statutory intervention
- the rigour and quality of plans and work with children in need to support timely improvements in their circumstances, well-being and safety
- the effectiveness of assessment and multi-agency planning to reduce harm for children in need of help and protection, including disabled children, children who go missing from home and children at risk of sexual exploitation

- the quality of management oversight, challenge and staff supervision in these services.

The inspectors considered different types of evidence during this visit, including electronic case records, supervision files and notes, observation of social workers and senior practitioners undertaking referral and assessment duties, and other information provided by staff and managers. In addition, inspectors spoke to a range of staff members, including managers, social workers, and administrative staff.

Overview

While the local authority's detailed action plan sets appropriate priorities and actions, required improvements to practice have not yet been achieved. Senior managers are not yet providing social workers and team managers with sufficiently clear expected practice standards. Fundamental improvements required to provide consistent, safe and effective services for children and families, such as ensuring that all children are visited within timescales that meet their needs, are not yet sufficiently embedded. The application of thresholds is not sufficiently well understood or applied in response to referrals for children in need of help or protection by all managers and social workers. Poor recognition of risk in assessments and plans, particularly in relation to children living with domestic abuse, results in delays in responding to some children who are at risk of significant harm. Staff supervision and management oversight of casework, while regular, are not yet addressing these deficits.

The local authority has been successful in ensuring that all social workers have manageable caseloads, and there are now no children who do not have an allocated social worker.

The local authority has incrementally improved the quality and timeliness of return home interviews for children who go missing. This has resulted in improvements in some social work practice. The quality of children in need plans, while variable, is improving. Inspectors saw some plans that were concise, clear and purposeful, resulting in more effective interventions for children.

Findings and evaluation of progress

Progress in improving services for children in South Gloucestershire since the last monitoring visit has been too slow. Partnership working remains inconsistent and underdeveloped. Social workers do not always request timely and comprehensive information from partner agencies to plan effectively for children. When children are first identified as being in need of help, the right type of support is not always available. Senior managers recognise that the quality of strategic planning and support for children and families between statutory children services and early help

services are not well coordinated. Early help given to children and their families is not monitored to ensure that it is providing sustained improved outcomes for children. While this is part of the overall improvement plan, it is yet to start. Senior managers identified that effective tracking and monitoring of children's cases are hampered due to ongoing difficulties with the current electronic casework system. Senior managers plan to replace the current electronic system by April 2018. The new electronic system has the potential to bring significant benefits, but this alone will not significantly improve practice.

Other planned improvements, for example the implementation of the newly revised supervision framework, have been delayed. While all team managers have received supervision training, this has not improved the quality of supervision records, which do not yet include consistent, comprehensive and purposeful action plans to benefit social work practice.

An internal quality assurance of casework through audit is in place, but auditing of casework and the dissemination to staff of the lessons learned are not yet sufficiently influencing practice or leading to improvements in outcomes for children. The quality of audits seen on this visit was poor and shows significant decline since the previous monitoring visit. Not all audits of casework seen on this visit identified practice deficits, such as delay, poor risk assessment and poor planning, and auditors were insufficiently focused on children's experiences. The majority of audits seen on this visit did not provide an accurate overview of practice, identify learning needs or support professional development. Audits completed by external moderators were of a significantly better standard. Moderators accurately identified poor quality outcomes for children, poor planning and insufficient management oversight where appropriate. The themes from auditing of casework identified by external moderators are shared with staff. However, social workers do not routinely discuss outcomes of individual casework with the moderator. This is a missed opportunity for professional development.

The response to children in need of protection continues to be inconsistent and, in a small number of cases seen, managers and social workers' poor identification of risk delayed strategy meetings. As a result, some children remained in circumstances of continuing or unknown risk before protective action was taken.

The majority of assessments of children seen by inspectors are not sufficiently comprehensive or analytical enough to inform good planning for children. In some assessments, all risks to children or the complexity of a child's needs and behaviours are not sufficiently considered. Assessments of children do not always include the views of key professionals, parents or children. Children's day-to-day lived experience and their history are not sufficiently considered in decision-making or in assessing parents' capacity to change.

Although the timeliness of initial child protection conferences has recently significantly improved, the quality of child protection plans in cases seen is poor and plans lack clear contingency arrangements. Child protection plans are poorly written, and are difficult for parents to understand. The purpose and timescale of actions are not always clear, making it difficult to hold parents or agencies to account. Plans are often predominantly adult-focused, particularly where domestic abuse is a key feature. Frequency of visits to children on a child protection plan is decided on a case-by-case basis. The visiting frequency set is not always sufficient to adequately monitor the safety and welfare of the child.

Child in need plans have improved from a low base and those seen by inspectors were mostly specific in the actions, timescales and outcomes required. Language used was explicit and clear. Safety plans written with children included their words and are easy to understand.

Although regular management oversight of social work practice is well established, it is predominantly focused on process compliance and task completion and rarely challenges poor practice. Effective challenge from chairs of child protection conferences is not routinely evident on children's cases files. Consequently, staff do not receive the clear practice direction that they need and some children still do not receive appropriate timely support.

Inspectors saw examples of social workers undertaking good creative direct work with young children and sensitive effective work with older children, but children's case files do not always describe this work. The structure of the electronic case work system is a barrier to effective recording and retrieval of this information. In a few children's cases, records simply note that children have been seen. Most children's records are unclear as to the purpose or outcome of a child protection visit, and recording, when done by social workers, focuses predominantly on adults' issues. As a result, despite the time taken listening to children, their lived experience is not always fully understood.

Senior managers are taking appropriate steps to improve the workforce's understanding of child sexual exploitation by providing training for all staff and by appointing champions around the issue of child sexual exploitation. As a result, the number of child sexual exploitation risk assessments has increased. However, the quality and impact of these assessments are not yet consistently sufficient to reduce risk to children in a timely and well-coordinated manner. Stay safe work with children and safety planning are not sufficiently focused on reducing risk.

Since the last monitoring visit, senior managers have made notable improvements in the quality of practice with children who go missing from home or care. The timeliness and the take-up of return home interviews by children have both improved. The quality of information given in the return home interviews is much more comprehensive. However, senior leaders recognise these interviews are not yet sufficiently analytical on the 'push-pull factors' to support plans to reduce further episodes of going missing. Further improvement work is underway for all staff to build on this progress.

Social workers' caseloads have reduced since the last monitoring visit. Staff seen by inspectors are positive about working for South Gloucestershire and morale is good. Social workers consistently report good management support, manageable workloads and regular supervision that identifies their training needs. They have access to a variety of good quality training and their managers support them to attend. They recognise the need for significant improvement in service provision. While social workers recognise the need to develop their practice and improve outcomes for children, current social work guidelines and expectations of practice do not sufficiently support this. For example, a locally agreed minimum frequency for visiting children is yet to be implemented.

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

Yours sincerely

Joy Howick
Her Majesty's Inspector