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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 26 and 27 April 2017. The visit was the seventh monitoring visit since the local authority was inspected in 2014 and the third under the new arrangements. The inspectors were Linda Steele HMI, Natalie Trentham HMI and Mandy Nightingale HMI.

Since the last monitoring visit, the local authority has continued to implement its improvement plan, with notable progress in some areas. However, the initial work to respond to the inspection findings was not sufficiently proactive and, as a result, the pace of change has been too slow. The current leadership team has taken action to accelerate the delivery of the improvement plan. However, a number of areas continue to require development.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the areas of:

- Thresholds for entry to care, the quality and support provided to children looked after, management oversight and recording on children's case files.
- The quality of assessment and planning for children looked after.
- The effectiveness of the independent reviewing service.
- The effectiveness of the Public Law Outline.
- The response to children looked after who go missing and/or are at risk of sexual exploitation.

The visit considered a range of evidence, including electronic case records, supervision files and notes, observation of social workers and senior practitioners, as well as other information provided by staff and managers. In addition, we spoke to a

representative of the children and family court advisory service and the judiciary, and a range of staff including managers, social workers, other practitioners and administrative staff.

Overview

Despite a slow start, leaders and managers are now more effectively tackling deficiencies in children's services. However, this is only just beginning to have an impact and, consequently, children are not yet receiving a consistently good enough service. Significant challenges remain across the service. Management oversight, including scrutiny by independent reviewing officers (IROs), is not yet consistent in driving all children's plans. The quality of assessments and care plans requires improvement. Assessments are not routinely updated in response to children's changing circumstances. Plans are not specific enough, and do not focus on all risks or the complexity of a child's needs and behaviour. Health assessments are not consistently timely. Permanence planning is not yet sufficiently robust.

Managers are taking action to manage performance issues across the service. The majority of social workers' caseloads in the children looked after service have been reduced to a reasonable level. The workforce is beginning to stabilise and there has been a reduction in the use of agency staff. Staff seen by inspectors are positive about working for Surrey County Council and morale is good. The local authority has invested in a model of social work practice and staff are enthusiastic about this approach, but it is at an early stage of roll out and it is too early to demonstrate impact.

In the majority of children's cases seen by inspectors, children's outcomes are improving. Recent decisions made to bring children into care are appropriate, and most are made promptly. However, too many children spend extensive periods at the pre-proceedings stage with no review against progress. As a result, children have experienced drift and delay.

Children live in safe and stable placements and have contact with their families, particularly their brothers and sisters, when this is in their best interests. Social workers know the children whom they are working with well.

Senior managers have taken action to strengthen services for children missing from home or care. This is beginning to lead to improved timeliness of return home interviews for children. More work is required to improve the quality of these and to engage with harder-to-reach children and young people. The quality of child sexual exploitation risk assessments and safety planning remains too variable.

Findings and evaluation of progress

Based on the evidence gathered during the visit, we identified areas of strength, areas where improvement is occurring and some areas where the pace of progress needs to be accelerated.

The local authority has an established cycle of learning from audit activity that includes both individual case and themed audits. Senior managers are regularly involved in auditing cases alongside social workers, and consult with individual children to gain their perspective regarding the help that they receive. Audits seen by inspectors were comprehensive and identified critical issues, which result in improved outcomes for the large majority of children whose cases were tracked by inspectors.

Social workers consistently report good management support and regular supervision, noting in particular improvements over the past six months. Supervision is evident on most children's case files. However, the quality of oversight and level of challenge provided by managers are too variable, and are not always effective in tracking actions and driving children's plans. As a result, drift and delay are evident.

IROs are having insufficient impact on improving services or ensuring the timely progression of planning for children. IROs identify drift and delay in reviews, but do not consistently escalate issues to senior managers if they are not resolved. Senior managers have recognised that the caseloads of IROs have been too high and have increased the team's capacity. This has resulted in recent reductions in the IROs' caseloads.

Significant delays at the pre-proceedings stage mean that some children experience drift and delay in achieving permanent care arrangements. Inspectors saw examples of delays of many months between the decision to issue pre-proceedings and action taking place. Senior managers had already recognised the need to strengthen this critical work and have an action plan in place. However, poor management oversight and inconsistent planning have hampered timely decision making about the need for applications for legal orders for too many children. Once children's cases enter the court process, they are managed effectively and, despite a rise in care proceedings over the past year, timescales remain under 26 weeks for 70% of children. The local authority has completed a review of all children who are subject to section 20 arrangements and taken action to obtain legal orders where these are needed to secure permanence for children.

Social workers know the children whom they work with well. They visit children regularly and have a good sense of their wishes and feelings. Social workers can articulate the direct work that they undertake with children, but this is not always reflected in case notes.

The assessments seen by inspectors are of a variable quality. They are not consistently comprehensive or analytical, and some do not identify important risk

factors. Care plans for most children are not specific enough, and do not focus on all risks or the complexity of a child's needs and behaviour. Better quality plans are clear, with updated measurable outcomes, and show evidence of timely care planning, particularly for younger children and those in care proceedings. Children's looked after reviews are timely and well attended by relevant partners. Children are actively encouraged to participate in their reviews. Inspectors saw examples of children supported to chair their own meetings. Recent practice is stronger and demonstrating improvements in early planning for children.

Monthly performance reports show that routine health monitoring for children looked after is improving from a low starting point, but overall performance is not yet good enough. Senior managers are working with health partners to implement a new process to address this.

The quality of child sexual exploitation risk assessments continues to be variable, with poorer quality assessments failing to provide an effective analysis of risk and safety planning. Processes for children who go missing have been strengthened, and more recent performance information demonstrates some improvements in the timeliness and take up of return interviews by children. However, more work is required to improve the overall quality of interviews and to reduce further the number of children who decline to participate in them.

Children have appropriate and supported contact with their families, particularly with their brothers and sisters. In all children's cases sampled, including plans for adoption, careful and sensitive consideration of contact arrangements was evident. The use of a comprehensive electronic tool to assist staff, children and foster carers to record memories is positively helping children to understand their histories. Inspectors saw examples of innovative and creative life-story work for children, including contributions to life-story books from birth parents, memory boxes and the use of books to help children to understand their experiences.

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