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Mr Chris Spencer
Director of Children's Services
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Dear Mr Spencer

Monitoring visit of Gloucestershire children's services

This letter summarises the findings of the monitoring visit to Gloucestershire children's services on 2 and 3 October 2018. The visit was the fourth 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 has accelerated progress in improving services for its children and young people, albeit from a delayed start. There is now a permanent senior leadership team in place, which is beginning to establish a clear vision and implement improvement plans, underpinned by significant financial investment and additional resource in children's services. This is leading to service improvements and better outcomes for children, although this is not consistent and there are areas of practice that the local authority has not yet successfully addressed. These areas include seeing children regularly and within timescales that reflect their circumstances and ensure their safety.

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 established multi-agency safeguarding hub (MASH)
- 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 staff, social workers and managers 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

During this monitoring visit, inspectors saw some improvements in the timeliness of responses to children in need or in need of protection. A legacy of delay in responding to children where risks remain unchanged or escalate is starting to be addressed. However, further improvement is needed to ensure that all children get the right help at the right time. In the recently established multi-agency safeguarding hub (MASH), thresholds are not always consistently applied, leading to delays in effective safeguarding planning and action being taken to protect children or ascertain their welfare. Visits to children where there are safeguarding concerns are not consistently timely and, as a result, some children remain in situations of unassessed risk for too long. Child protection processes are not always followed where there are clear disclosures of abuse, and this is particularly the case for older children.

The local authority has made considerable progress in establishing an environment in which good social work practice may flourish. The vast majority of social workers have manageable caseloads and only a small number of children experience delays in being allocated a social worker. Social workers report feeling supported within their teams and by line managers, and were positive about working for the local authority. Increasingly, social workers have the appropriate level of skill and experience required to provide effective interventions for children, supported by a comprehensive training and development framework. Managers' oversight of practice and staff supervision is now more regular and frequent, although this is not yet consistently providing staff with sufficient challenge or direction in order to identify and address deficits in practice. Despite the positive progress made, significant challenges remain for the local authority in establishing a permanent workforce, and there is a high turnover of staff. As a result, too many children experience frequent changes of social workers.

The quality and range of performance management information used by senior leaders to understand and monitor children's experiences continue to be refined and now provide a clearer picture of performance. However, information is not always complete or up to date and does not yet give senior leaders and managers the comprehensive overview of performance that they need.

The local authority has established a cycle of auditing activity to consider specific areas of practice as well as individual casework audits that are increasingly being

used to identify practice deficits and target improvements. The quality of audits seen on this inspection were good and accurately evaluated children's experiences.

Findings and evaluation of progress

The recently established MASH has brought together a number of 'front door' activities. This is resulting in more streamlined processes and improved timeliness in decision-making. The majority of decisions regarding next steps are made within a 24 hour period or less in more urgent cases. However, application of thresholds by social workers is inconsistent and managers' oversight of decision-making is insufficient. This has led to delays in protective action being taken to safeguard some children. Daily MASH meetings consider new referrals that have come in overnight. However, attending partners are not always sufficiently prepared and information gathered to inform decision-making is sometimes incomplete. As a result, discussions can often lack clarity regarding the immediacy of any risk to children, leading to delay in appropriate safeguarding action being taken.

The professionals' helpline has now been in place for six months and provides signposting as well as advice to professionals and to members of the public with queries or concerns about children. Senior leaders are not yet ensuring effective oversight of the consistency of advice, decision-making and the application of thresholds, and there is an absence of recording of safeguarding queries and resulting advice provided by social workers on the helpline. These are key risks. This was raised by inspectors with senior leaders during a previous monitoring visit and has yet to be addressed.

There are often delays in convening strategy discussions to consider risk to children and plan protective action, and they are not always convened where the threshold has been met, including where there is a clear disclosure of abuse. This is particularly the case where older children are the focus of concern. Multi-agency attendance and information-sharing by partners have improved overall. However, records of strategy discussions do not consistently evidence that risk of significant harm has been considered, and the rationale for subsequent decision-making is not always clear. While inspectors saw a number of examples of clear planning arising from strategy meetings, the majority of records do not routinely include timescales or sufficiently reflect identified issues, making it difficult to hold professionals and families to account. Children for whom there are safeguarding concerns are not always seen with sufficient urgency and records of child protection enquiries do not consistently demonstrate whether children have been seen.

Social work practice within the assessment and safeguarding service is improving in quality and consistency. Inspectors saw numerous examples where children's needs and risks were clearly identified and where their circumstances were improving because of effective and timely social work interventions. Most social workers know their children well and undertake purposeful visiting and direct work to understand children's lived experiences. Social workers spoken to by inspectors demonstrated a

good understanding of risk and parental factors that impact on children's well-being as well as changes required to improve their circumstances.

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. The vast majority of social workers have manageable caseloads. However, in the absence of a stable, permanent workforce, too many children experience frequent changes in their social worker, reducing opportunities to build trusting relationships and progress plans. Furthermore, despite an extensive training programme, frequent staff turnover impacts on the local authority's ability to ensure that all social workers are equipped with the skills that they need to deliver effective practice and improve children's circumstances.

The local authority has an established baseline of timescales for seeing children, and these are reviewed within teams on a regular basis. However, a significant number of visits still occur outside these timescales, including visits to children considered at high risk of further harm. The local authority's performance information records that some children have not been seen for a number of months. Senior leaders have yet to take sufficient steps to be assured that these children are safe and that their needs are being met.

Increasingly effective oversight by managers has led to improved timeliness in the completion of assessments, the vast majority of which are now completed within the national maximum timescale of 45 working days. Assessments are now of better quality, and they routinely include consideration of risk and protective factors and historical information, as well as detailed analysis. Children's views and experiences are effectively captured in the vast majority of assessments. However, while the quality of assessments has improved, they are not yet consistently contributing to effective planning.

Action plans continue to be too variable in their quality. The rationale for decision-making and interventions is not consistently clear, reducing the effectiveness of care planning. Plans do not routinely include timescales, 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. Children and young people, particularly older children, are not effectively engaged in planning and because of this, plans are not always realistic. The quality of contingency planning is improving and is increasingly reflected in plans. Social workers spoken to by inspectors were more able to clearly articulate what needed to change and how progress would be measured than is recorded in written plans.

Since the last inspection, the local authority has reconfigured children's services, reducing the size of teams and increasing management capacity to improve the effectiveness of social work practice and performance, as well as management availability to staff.

Increasingly, effective management oversight of decision-making by social workers and the quality and timeliness of assessments are leading to improvements in children's circumstances. However, further work is required to improve consistency in the quality of practice across the service. While inspectors saw a number of examples of timely case work with clear management oversight and case direction that is contributing to improving outcomes for children, this is not consistent across all teams. Recent action undertaken to protect children has often followed periods of significant delay that had not been identified and addressed by managers. Supervision of staff is not yet providing opportunities for reflection and continues to be largely action-centred. It 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 continued to be refined. There is now a clearer picture of performance across the service in most areas of practice, leading to improved oversight and prioritisation of areas for development. Frontline managers have access to, and are increasingly making effective use of, available performance to develop and improve social work practice. However, performance information is not capturing the effectiveness of decision-making and application of thresholds in the MASH and professional advice line or the difference that the advice line is making to the timeliness, quality or appropriateness of referrals.

Auditing of casework is firmly established, and audits are now more consistent in their quality and accuracy in identifying weaknesses in practice. Actions identified by auditors to address deficits are increasingly focused on improving children's circumstances in addition to ensuring compliance with processes. However, actions are not consistently progressed. Social workers and managers are not routinely involved in the audit process, and nor are children and their families. This limits opportunities for social workers and managers to learn from the experiences of parents and children and to reflect on and improve their practice. Consequently, auditing of casework is not yet having an impact on practice improvement.

Staff morale is good and social workers spoken to by inspectors talked positively about the support that they receive from managers and the training that they have received to assist them in developing their practice.

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

Yours sincerely

Nicola Bennet
Her Majesty's Inspector