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Ms Chris Sivers
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Dear Ms Sivers

Focused visit to South Gloucestershire children's services

This letter summarises the findings of the focused visit to South Gloucestershire children's services on 9 to 10 November 2021. Her Majesty's Inspectors for this visit were Tracey Scott and Tracey Ledder.

Inspectors looked at the local authority's arrangements for 'front door' services, including decision-making for contacts and referrals about children, child-protection enquiries, decisions to step up or down from early help, and assessments for children in need.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. The lead inspector and the director of children's services agreed the arrangements beforehand. Both inspectors were on site. They held face-to-face discussions with local authority staff and used virtual technology to hold discussions with partner agencies.

Headline findings

Delays in children being seen, in the completion of assessments of their needs, and in carrying out child-protection enquiries mean that some children are left in situations of unassessed risk. For a few children, this has meant that they have been left in situations where they are known to be at risk of significant harm but are not receiving the help and support they need.

The pace of improvement at the front door since the last inspection in 2019 has been too slow and, in some areas of practice, the quality of work has deteriorated. During the spring of 2020, senior leaders recognised that significant improvements in the front door were needed. An improvement plan was developed and implemented over the rest of the year, but those improvements that were made were not sustained, and the quality of practice has subsequently declined. This lack of sustained improvement is compounded by the ongoing impact of the COVID-19 pandemic, increasing demand, a high turnover of social workers and difficulties in recruiting

permanent staff. In recent months, leaders have implemented a number of actions aimed at improving practice at the front door. Staffing capacity has been increased and leaders have clarified and restated to staff their expectations of the procedures and timescales which should be followed. However, a number of these measures are too recent to have had sufficient impact. Consequently, many children continue to receive a response that takes too long or is not well matched to their needs when first referred to children's services.

Areas for priority action

- The effectiveness and timeliness with which risks to children are assessed and with which action is taken to address known risks.
- The effectiveness of senior leaders in achieving timely and consistent improvement in the quality and impact of social work practice at the front door.

What needs to improve in this area of social work practice?

- The timeliness and quality of visits to children, assessments of risks and needs and the effectiveness of interventions.
- The understanding and application of thresholds across the service.
- The quality and accuracy of children's records to ensure that decisions are based on full and accurate information.
- The quality and effectiveness of management oversight and supervision to ensure that decisions are timely and support the progress of children's plans.
- The size of social worker caseloads.
- The timeliness, quality and effectiveness of quality assurance.

Main findings

The front door has two main functions. The Access Team undertakes initial decision-making for contacts and referrals about children received by the local authority, and the Response Team undertakes child-protection strategy discussions, assessments and child-protection investigations.

Referrals to the front door are mostly timely and appropriate. Most provide sufficient information to inform decision-making. Parental consent is recorded in most referrals, and when it has not been recorded, it is appropriately sought from parents by social workers. Effective systems and processes are in place for the oversight of initial decision-making in the Access Team.

Improving the timeliness of decision-making by the Access Team has been a recent area of focus by the local authority. Although the recorded performance has significantly improved, this does not accurately represent the reality experienced by many children. When additional information is required to inform initial decision-making about contacts and this is taking longer than the 24 hours expected by statutory guidance, some contacts are closed while further information is gathered. A subsequent new contact is then opened once the information is gained. This leads to unnecessary delay for children.

Thresholds are not consistently understood or applied by the Access and Response Teams. Subsequent disagreements and escalations between the Access and Response parts of the front door lead to unnecessary delay in some children getting the help that they need.

The quality of decision-making about contacts and referrals by the Access Team is variable. For a significant minority of children, insufficient weight is given to both presenting concerns and children's histories when considering next steps. Some contacts are prematurely or inappropriately closed without children getting the support they need and, as a result, many of these children are subsequently re-referred. When decision-making is stronger, social workers consider children's histories and provide comprehensive analysis of risk and next steps. Appropriate actions identified by the Access Team in response to referrals are not always progressed by the Response Team.

Daily domestic incident review meetings enable prompt and effective decisions to be made to support children to get the help they need at the time they need it. However, records of decisions for children who do not meet the threshold for a referral to children's social care are not kept. This means that there is no formal record in children's social care that is available to support future decision-making.

Effective systems and processes are in place to transfer children's cases between statutory social work services and early help services. Relationships and communication are strong, and this supports a smooth transition between teams for children and their families. Some children are stepped down to early help too quickly following weak or over-optimistic social work assessments and, as a result, have to be quickly stepped back up again as further worries are identified. This means further delay before some children receive the right support and help. Children under five benefit from continuing support from early help services after they are stepped up to statutory social work services. This ensures consistency and continued support for children. Partner agencies value the advice and support given to them by the Compass Team in signposting children and families to a range of community resources.

Multi-agency child-protection strategy meetings for some children are delayed. This means there are delays and gaps in understanding risk, planning child-protection

enquiries in a multi-agency context and ensuring that children are safeguarded from risk effectively. When the meetings are convened, they facilitate comprehensive information-sharing, effective risk assessment and shared decision-making about next steps.

Overall, the timeliness and quality of child-protection enquiries are weak. Stronger examples are timely, comprehensive, capture the child's experience well and demonstrate effective safety-planning. Weaker examples are significantly delayed and the effectiveness of safety-planning and subsequent intervention is weak, leaving a small number of children at risk of further harm.

Some children's records are confusing, and it is difficult to understand what is happening for them and why. These records are incomplete and important information is not included in key documents. There is a risk of information being lost, decisions being made without the full picture and children's experiences not being fully understood. The quality and usefulness of chronologies in understanding significant events and their impact for children are weak.

First visits to a few children by the Response Team are delayed and there are also significant gaps in the frequency of subsequent visits to some children. This includes children where the level of risk is unassessed, children at potential risk of harm and children known to be at risk of significant harm.

The timeliness and quality of assessments are inconsistent. Some children experience significant delays in an assessment of their needs being completed. Overall, assessments are too narrow in focus, some lack depth and analysis is weak. Very few assessments authentically capture the child's voice and lived experience. A small number of stronger assessments are informed by direct work with children and give a clearer picture of their experience, wishes and feelings.

Responses to children who are missing or at risk of exploitation have been strengthened. The timeliness and quality of return home interviews when children go missing remain variable but have improved. Inspectors saw examples of strong, creative and effective multi-agency working to reduce risk to children and to improve their safety, including for care leavers aged over 18.

Increased senior leader oversight and focus on practice is not, at this point, sufficiently effective in improving the quality and impact of responses to children at the front door. However, the local authority's senior leadership team, backed by political support, is committed to strengthening practice. An Enhanced Performance Board, established in June 2021, is beginning to provide stronger oversight, scrutiny and support for implementing improvement actions.

The quality assurance of social work practice and its impact for children is weak. The quality of audits is variable. Many are overly descriptive and lack an evaluation of

practice and its impact for children. A high number of audits are downgraded by moderators and a significant number conclude that the quality of practice and impact for children are inadequate. Managers' compliance with the completion of audits is low. Audit activity is not having a tangibly positive impact for children. Practice learning is identified and disseminated but is not effective in securing positive change. Actions identified from audits are not always followed through.

Caseloads in the Response Team are too high. Leaders are appropriately focused on the recruitment and retention of staff. Significant financial investment has recently substantially increased social worker and team manager capacity at the front door. Systems and processes for recruitment have been streamlined, and the offer to staff has been reviewed and significantly strengthened. While team manager stability has improved, additional social work posts are primarily covered by agency staff who stay for short periods of time and then move on at short notice. The turnover of social workers has meant a small number of children have been unallocated for short periods of time, while awaiting reallocation. This adds to the delay in children's needs being understood and children getting the help they need at the right time.

Regular management oversight provides updates of children's situations, social work activity and clear next steps. Although weaker practice is identified by managers and clear next steps are identified, this does not consistently translate into ensuring positive change for children. Many subsequent actions are not completed and this adds to the delay for children.

Staff feel supported and are optimistic for the future. Supervision is reported by practitioners as helpful and challenging. However, supervision records are largely absent in children's case records and, where they are present, many are weak and do not assist social workers well to unpick complex issues and progress children's assessments and plans.

Some team managers are benefiting from intensive mentoring and a 'leaders in practice' programme. Some social workers have benefited from practice workshops as part of the improvement plan and say that this has had a positive impact on their practice.

Live performance management dashboards have recently been implemented and work is underway to further develop the breadth of reports available. The use of performance reports is not yet fully embedded within teams. However, team managers are now beginning to use these reports to support their oversight and day-to-day management of social work in their teams.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

We have notified the Department for Education of the areas for priority action. You should submit an action plan that responds to this area within 70 working days of receiving this letter. It would be very helpful if you can share an early draft of the action plan with us within 20 working days of receiving this letter.

Yours sincerely

Tracey Scott
Her Majesty's Inspector