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Sheila Smith
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Dear Ms Smith

Focused visit to North Somerset local authority children's services

This letter summarises the findings of the focused visit to North Somerset local authority children's services on 7 and 8 December 2021. Her Majesty's Inspectors for this visit were Anna Gravelle and Neil Penswick.

Inspectors looked at the local authority's arrangements for children in need, including those who are subject to a child protection plan.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. This visit was carried out partly by remote means. The lead inspector was on site and met with local authority staff, managers and leaders in person. The team inspector worked remotely and used video calls for discussions with local authority staff, managers and leaders.

Headline findings

There has been little progress in the quality of social work practice to improve the experiences for children in need of help and protection since North Somerset children's services were last inspected in March 2020, when services were judged requires improvement to be good.

On this visit, inspectors identified weaknesses in social work practice, management oversight and supervision. While no children were identified as at immediate risk of harm, the needs of children and assessment of risk for some children are secondary to the needs of parents. Children in need and child protection plans are too wide-ranging and lack timescales and contingency plans to ensure progress. Supervision takes place regularly, but it does not always give a clear sense of direction. Actions are not consistently identified or helping to deliver timely progress for children. The quality assurance process is weak and, therefore, does not help to improve the quality of practice that improves experiences for children and families.

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

- The analysis and management of risk to children.
- Management oversight of safeguarding practice, including supervision of staff.
- The quality and timely implementation of plans for children.
- The quality assurance arrangements of social work practice.

Main findings

The COVID-19 pandemic has had a personal and significant impact on staff, with a number of staff shielding during the early stages of the pandemic. Senior managers responded to the pandemic by prioritising the needs of the most vulnerable children through increased visits as well as being mindful of staff safety. Staff were supported with protective equipment and flexible ways of working.

Staff worked throughout this period and the Director of Children's Services shared how sickness was 'masked' as many staff carried on working, albeit virtually. During this visit, inspectors saw evidence of social workers going that 'extra mile' and they spoke about their commitment to children and shared how their passion was maintained during the national lockdowns caused by the pandemic.

Assessment of risk is not always clearly evaluated and evidenced to inform decision-making. The progress and experiences for the majority of children are not given sufficient focus or priority. This is evidenced in some children's case summaries, assessments, core group meetings and child protection conference minutes. Too often, there was not a consideration of the experiences of children and what needs to happen in a timely way for them.

Social workers have an understanding of the needs of children and the risks, but the impact of their work is too often diluted through weak planning that does not address those concerns. Children in need and child protection plans are too generalised and lack timescales to prevent drift and ensure that progress is achieved for children. A lack of contingency planning means that parents may not understand what will happen if children's situations do not improve.

Social workers are committed to supporting parents and children, and ensure that extensive and flexible packages of support are provided for children and their families where needed. Some children in need of additional help and protection experience repeated episodes of child protection planning and, in some cases, for short periods. This is because decisions are often focused on reoccurring incidents and parents' needs rather than a thorough analysis and understanding of the experiences and histories of children, and the detrimental impact on their lives of harmful parental behaviours.

Social workers regularly visit children. Children are spoken to during visits and social workers spend time with children. Social workers gather the views of disabled

children using their preferred means of communication, and record these to help inform their plans. No children in the 'children with disabilities service' are subject to a child protection plan. Case records, including those for disabled children, do not consistently provide a comprehensive understanding of children's experiences or coherently detail the risks. Most records are overly descriptive and do not give a clear analysis or view of what is needed to help improve outcomes for children.

Social workers have multi-agency planning meetings with family members and capture the views of other professionals and parents to help inform and build effective relationships. Children and families who are identified as needing support from early help services are referred for these services promptly. Decisions to help families 'stepping up' to statutory services and 'stepping down' to early help are appropriate and overall timely. Thresholds for children and families receiving help through child in need and child protection plans were overall appropriate.

For some children, when necessary, pre-proceedings are considered and actioned. However, this approach is not consistent and, for a number of children, there is not a timely escalation to pre-proceedings when their situations do not improve, and they experience repeated patterns of harm that lead to drift and delay. Senior leaders do not have a robust structure in place for monitoring and decision-making around pre-proceedings or care proceedings to ensure best practice. Senior leaders acknowledged this and have plans in place for implementation in January 2022.

Children on the edge of care receive support that is timely and appropriate in addressing their needs and risks through a range of commissioned services including 'Turning the Tide', a strengths-based service that helps parents with practical advice and intensive support to increase parental capacity. Inspectors saw examples of positive and focused work that is helping children to remain with their family safely. Social workers have regular child in need review meetings and some children attend these meetings.

Children who become looked after in an emergency receive suitable levels of support through child in need and child protection planning. This includes strengths-based work with parents to prevent them coming into care. For children who become looked after, this is appropriate and is a result of the level of significant risk and parents' needs.

Social workers report that supervision is regular and that it is a helpful tool for them in their work with children and families. They spoke positively about manager support and availability. Social workers report that they enjoy working for North Somerset children's services and value their smaller caseloads. Social workers spoke a lot about relational and strengths-based social work and were enthusiastic about this approach. However, the quality of supervision is inconsistent. The impact of children's experiences is not sufficiently considered. Actions are not clearly detailed or task focused, and they lack timescales to achieve outcomes for children. Most

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supervision is not providing direction to social workers or helping them assess the risks to children.

The local authority has not made sufficient progress with its quality assurance framework. Social workers are involved in the audit process and, in some cases, carers are spoken to. However, this is not consistently recorded to help develop practice. Audits are overly focused on compliance with recording practices and do not consider the impact of social work activities and outcomes. Fundamentally, audits do not tell senior leaders about the child's lived experiences or evaluate the effectiveness of how social workers meet children's needs. Senior leaders recognise that improvement work is needed in this area and have plans in place to address the shortfalls.

There are recent and significant changes to the leadership team since the last inspection. A restructure of senior managers, services and staff sickness in a key role has slowed the pace of improving social work practice. The local authority's chosen model of practice and improvements identified at the last inspection are yet to be embedded. The workforce is generally stable with a low use of agency staff and low caseloads.

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

Yours sincerely

Anna Gravelle
Her Majesty's Inspector