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Dear Ms Deeks

Monitoring visit of South Gloucestershire children's services

This letter summarises the findings of the monitoring visit to South Gloucestershire children's services on 22 and 23 May 2018. This was the third monitoring visit since the local authority was judged inadequate in February 2017. The inspectors were Joy Howick and Emmy Tomsett, Her Majesty's Inspectors.

Since the last monitoring visit, the local authority has continued to implement its improvement plan. Recent progress has been made in some areas to improve services for children and young people in care in South Gloucestershire. The pace of improvement has started to increase and now needs to be accelerated. Significant recent investment by the council has supported the improvements seen by inspectors during this visit. The senior management team recognises that a number of areas continue to require improvement and there is still much to do.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of children looked after, with a particular focus on:

- The impact of thresholds and timeliness of admission into care.
- The appropriateness of decisions made for children on the edge of care.
- The effectiveness of multi-agency plans to improve outcomes and reduce risks for these children.
- The quality of management oversight, challenge and staff supervision in these services.

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

Overview

The local authority is implementing its detailed improvement plan, which is now resulting in some improvements in the quality of services for children looked after. The recently launched 'Ten core practice standards', 'Decision making and visiting standards', 'Permanence planning protocol' and supervision guidance have been effective in raising standards in the recording and frequency of social workers' visits to children, as well as helping to improve managers' tracking of children's cases to permanency. However, decisions for children to come into care are not always timely. The impact of challenge and scrutiny by independent reviewing officers (IROs) is not sufficiently effective. Team managers do not always take steps to remedy poor social work practice in children's assessments and plans. A new model of social work practice has recently been implemented, but it is too early for this to have demonstrated any impact.

The recent change of the electronic case recording system has been well managed and successfully implemented. Staff turnover has reduced and the council's recent financial investment to increase the number of social workers is appropriately reducing the work load of staff. These recent actions by senior managers provide a strong foundation for the improvement of social work practice and outcomes for children.

The local authority has made improvements in the management information provided to staff, has reduced caseloads in locality teams, and has improved the focus on permanency planning for children. Supervision is now consistently timely and is beginning to ensure that weaknesses in practice are identified and remedied. The quality and timeliness of assessments are improving and statutory visits are now purposeful and in line with required visiting frequency. The quality of child sexual exploitation risk assessments and safety planning is improving. However, social work practice is not yet consistently good.

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 we considered progress has not yet been made.

The senior management team has established a cycle of audit activity of individual children's cases and themed audits. Audit activity is improving but does not consistently provide an accurate overview of all practice, learning or professional development needs. The majority of audits seen by inspectors are comprehensive and accurate in their analysis. However, a minority of audits do not identify key

weaknesses in children's cases, such as when children have been exposed to risks for too long. As a result, professionals do not have the opportunity to learn lessons and improve practice. Senior managers are regularly involved in auditing cases. While social workers report that they are often involved in auditing, they had not been able to contribute to the audits discussed with inspectors. Social workers value such opportunities for effective learning, so this is a missed opportunity.

The use of performance information by senior managers to monitor how well the service is working is now embedded. The impact of this scrutiny is beginning to improve outcomes for children more consistently. Monthly performance reports show that the timeliness of initial health assessments for children in care is improving, but is not yet good enough. Senior managers are working with health partners to address this poor performance.

Social workers report good management support and that morale is high in South Gloucestershire. However, social workers told inspectors that their standard of work declines in relation to high workload. For example, chronologies are not kept up to date, which means that a potentially effective tool is not used well to make the best decisions for children. The senior management team is taking appropriate action to increase the number of social workers with the creation of an additional locality team. Social workers, including agency staff, told inspectors that they have good access to a variety of training and they are supported to attend.

Supervision is now regular and evident in the vast majority of children's cases seen by the inspectors. Nevertheless, the quality of oversight and level of challenge provided by managers remain too variable. Managers and IROs are not always effective in ensuring that children's plans properly identify individual needs and that agreed actions are taken promptly by social workers.

IROs do not have sufficient impact on improving services or ensuring the timely progression of some children's care plans. The timeliness of children's reviews is improving. The cause of late reviews is consistently evaluated so lessons can be learned. Managers of the reviewing service acknowledge the need to increase the challenge where practice is poor, so that all children's needs are identified and appropriately met within reasonable timescales. The Quality Assurance Service has started to address deficits in the quality of children's care plans but it is too early to see evidence of improved practice. The IROs' dual role of chairing child protection conferences and children's looked after reviews provides good continuity for children who become looked after.

Pre-proceedings work, once begun, is mostly timely, and decisions for children to come into care are appropriate. However, for some children the decision is made too late. Poor management oversight and inconsistent planning hampers timely decision-making for some children. Social workers and managers sometimes miss opportunities to intervene at the earliest point, and inspectors saw children left exposed to risk too long. Once social workers and managers make the decision for a child to come into care, actions are timely.

When children's cases are in the court process, they are well managed by social workers and managers. Social workers report being well supported by their solicitors. The quality of viability assessments is good. Social workers carefully consider contact arrangements between children and their families. Managers effectively track all children to ensure that permanency plans are timely and appropriate.

Social workers know the children and families they work with well and have a good understanding of children's wishes and feelings. Inspectors saw some examples of skilled, timely engagement with children by social workers, dealing with complex sensitive issues, conducted at the child's level and pace. However, good-quality direct work is not always reflected in children's case notes.

The assessments of children seen by inspectors are of variable quality. In weaker examples, assessments are not consistently comprehensive or analytical, and some do not identify important risk factors. As a result, these assessments do not adequately inform children's plans. Assessments do not always reflect the views of key professionals, parents or children. Not all assessments reflect the day-to-day lived experiences of children. Assessments are not routinely updated when concerns escalate and risks to the child increase. In the better assessments, good quality analysis and timely appropriate actions improve outcomes for children. Children's views are always included by their social worker in the planning for the child.

Child sexual exploitation risk assessments are evident on children's case files, but they vary in quality and impact on reducing risk to children and young people. Some risk assessments are carried out to a high standard and provide an effective analysis of risk and safety planning. More work is required to improve the overall quality and timeliness of return home interviews for children.

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

Yours sincerely

Joy Howick
Her Majesty's Inspector