

# South Gloucestershire

## Inspection of children's social care services

**Inspection dates: 4 March 2019 to 15 March 2019**

**Lead inspector: Emmy Tomsett  
Her Majesty's Inspector**

<b>Judgement</b>	<b>Grade</b>
The impact of leaders on social work practice with children and families	Requires improvement to be good
The experiences and progress of children who need help and protection	Requires improvement to be good
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Requires improvement to be good

Since the local authority was inspected in 2016 and judged to be inadequate, senior leaders have, following a slow start, made some gains in improving the majority of services for children and young people in South Gloucestershire. Recently accelerated progress against the improvement plan has ensured that outcomes for most children are now improving in most areas of the service, but not all recommendations from the inspection in 2016 have been fully addressed. The quality of service for care leavers has recently declined. While management arrangements have been strengthened under the leadership of the current director of children's services, this has not had a demonstrable impact on the quality of practice in some areas of the service and a significant improvement journey remains.

Emerging strengths are evident in the quality of direct work with children and a greater focus on achieving early permanence for children. A culture of learning and self-reflection is being embedded. Senior leaders have significantly strengthened quality assurance arrangements. Effective use has been made of improvement partners, and key messages and findings from audit activity and performance

information have enabled senior leaders to target areas for development. While performance information is routinely scrutinised by managers at all levels, it does not always result in practice improvements.

A newly introduced electronic recording system is beginning to contribute to improvements in the quality and timeliness of case recording. Social workers ensure that they see children regularly and within timescales that are appropriate to children's needs. Corporate parenting is well embedded, and leaders have made progress in developing the quality and skill of social workers as well as reducing staff turnover. Caseloads have reduced and are now manageable. Social workers report feeling well supported by their managers in South Gloucestershire.

When agencies first contact the local authority to request a service for children, decision-making is not always swift or proportionate to the needs of individual children. Early help is not routinely considered, and some children who need access to preventative services experience delay. The quality of management oversight of casework is too variable and does not always result in improvements in practice. The quality of assessments and plans for children is inconsistent and does not always lead to well-coordinated support for young people. The timeliness and quality of pathway plans to prepare care leavers for independence are not consistently effective. Health passports are not yet in place for most young people who need them.

## **What needs to improve**

- The implementation of sustainable improvements across all parts of the service.
- The timeliness of decision-making at the first point of contact with children's services.
- The quality of analysis of assessments of children's needs.
- The timeliness of preventative services provided to children referred to the FYPS.
- The timeliness of return home interviews when children go missing from home or care.
- The timeliness and quality of preparation of care leavers for independent living and the use of bed and breakfast accommodation for extended periods of time.
- The quality of children's child in need and protection plans so that they include clear measurable actions, with timescales as well as contingency arrangements.
- Sufficiency of local placements to meet the needs of children with complex needs as well as older children.

- The effectiveness of supervision and management oversight in progressing work in a timely way.
- The quality and range of performance information available to senior leaders to track performance.
- The impact and effectiveness of the virtual school, including monitoring by the virtual school of young people who are not in education, employment or training.
- The health information provided to older care leavers.
- The oversight of permanence arrangements for individual children.

### **The experiences and progress of children who need help and protection requires improvement to be good**

1. Senior leaders have now introduced a revised framework with clear pathways to early help services, and an updated early help strategy is in the process of being implemented. While these have been slow to establish, children and young people in South Gloucestershire are starting to benefit from increasingly timely and well-targeted early help services. Over the last year, the local authority has worked hard to better engage with partner agencies and to strengthen early help services. The early help partnership support team (EHPST) responds to referrals for early help swiftly and effectively and provides good advice to schools and other partner agencies to support them in providing help. Referrals from children's social care to early help are low when social care thresholds are not met, and opportunities to provide children who do not require a social work service with early help are missed.
2. The local authority's family and young people support teams (FYPS) provide a broad range of help, from parenting advice to one-to-one work with children. Their work is generally thorough and child-focused, and this means that, for most children, the help that they and their families receive makes a positive difference. Staffing shortages in the FYPS teams, particularly in the north team, mean that although timeliness is improving, many children and families are still waiting too long to receive a service.
3. Decisions on contacts take too long to be made. South Gloucestershire procedures allow five days for decision-making. While South Gloucestershire aims to ensure that a qualified social worker reviews each contact within 24 hours of receipt, 21% of decisions on contacts take even longer. For some children and families, this is too long to wait for a response. Thresholds are not always applied or understood by partners and, consequently, a high number of contacts result in no further action.

4. Children receive a swift response when there are clearly presented safeguarding concerns. Appropriate decisions are made, and subsequent actions are mostly timely. Historical information from all agencies is carefully considered to inform decision-making. Most referrals, including domestic abuse notifications, are well managed. Managers effectively oversee and record their decisions on children's records. Partnership working is now embedded and provides good opportunities for joint working. Consent is routinely sought.
5. In some cases, managers and social workers show insufficient professional curiosity at the referral stage. As a result, further work is required before decisions are made, and responses to the needs of children are unnecessarily delayed. A small minority of referrals are closed without sufficient information gathered for that decision to be made. During the inspection, senior leaders took immediate remedial action to address this weakness and have strengthened management oversight in this part of the service.
6. Child protection enquiries are timely and thorough. Strategy meetings and discussions are consistently timely and are well attended by a range of agencies that all contribute appropriately. Strategy meetings result in clear, time-bound action plans that are well targeted to protect children. Case conferences and core group meetings are well attended, and the timeliness of initial case conferences has improved.
7. While improving overall, the quality and timeliness of assessments of children remain inconsistent. The majority of assessments identify all risks, but do not include a clear analysis of this risk. Some assessments are overly long and repetitive and therefore not clear enough for parents to understand the risks or concerns.
8. The quality of child protection and child in need plans remains weak. The vast majority of children's plans are not sufficiently focused, specific or time bound. Consequently, progress cannot always be measured because of a lack of clearly recorded actions designed to improve outcomes for children. Contingency planning is not always clearly recorded in plans. Some plans are too long, and so it is difficult for parents to understand what needs to change, or the consequences of not changing.
9. Safety plans for families to self-manage risk are routinely in place, but variable in quality, because they do not always set realistic expectations of parents, particularly in circumstances where domestic abuse is a feature. Some good examples were seen of colourful and highly personalised plans created with children and families that are easy for them to use in their daily lives.
10. Children in the 0–25 disability service receive a significantly improved service compared with that seen at the time of the previous inspection in 2016. Social workers are skilled and make sustained efforts to gather the views of children to ensure that their views are understood and listened to. This includes those

children who have communication difficulties.

11. Once children's cases are allocated, social workers visit children regularly to understand their daily lived experience. Direct work undertaken with children by workers is an emerging strength. Social workers routinely see children alone and use a range of creative and innovative approaches to build positive relationships, including with disabled children. Children's views routinely influence their own assessments and plans.
12. The use of the Public Law Outline (PLO) is improving. Letters before proceedings appropriately outline concerns and actions required of parents, and are closely aligned to child protection plans. However, these letters follow a standard template and are not sufficiently tailored for each child. Some letters are too general in their description of support provided and are difficult for parents to understand. The pre-proceedings tracker is not currently an effective tool for senior leaders to track individual children effectively.
13. Children who go missing are routinely offered a return home interview. However, children do not always receive timely return home interviews, which was a recommendation made at the previous inspection. Multi-agency intelligence is used well to create effective plans that reduce further episodes of going missing.
14. Responses to individual children identified as being at risk of exploitation, including sexual exploitation, are mostly timely and effective. Sexual exploitation risk assessment tools (SERAFs) are of good quality and are updated as risks change. However, well-coordinated strategic arrangements to gather local intelligence, contribute to local mapping and create a more robust intelligence profile of the area are in their infancy. A newly formed, effective, multi-agency meeting now identifies links and patterns between children, places and perpetrators of exploitation involving some children.
15. The number of children educated at home has increased substantially in the last 18 months. Senior leaders have recognised the need for additional capacity in the attendance, exclusions and licensing team, as well as in the virtual school team, and while capacity has increased, the impact of this has yet to be fully realised. Not all children receive a timely initial visit, so the safeguarding arrangements for these children are not evaluated in a timely manner.
16. Children in private fostering arrangements receive a swift assessment and response to their need and are well monitored. The number of children in private fostering placements has reduced. Senior leaders have recently acted to raise the profile of private fostering in South Gloucestershire, but notifications to the local authority remain very low.
17. Arrangements to manage allegations against professionals are timely, comprehensive and effective. Allegations management meetings are well

attended and result in consistently well-coordinated action plans that protect children and ensure that investigations are thorough and purposeful.

**The experiences and progress of children in care and care leavers requires improvement to be good**

18. Decisions for children to come into care are timely and proportionate and are based on appropriate assessments and analysis of need. When there is escalation of risk, next steps are considered through legal planning meetings and the PLO process. Applications to court are timely. Children who come into care are not always found the most appropriate placement quickly enough. In a small number of cases, the local authority has struggled to find the right placement, and this has resulted either in placement breakdown or in children having to return home prematurely or while an appropriate placement is found.
19. When children are in care, assessments of their needs are mostly detailed, with appropriate understanding and application of history and analysis of risks and impacts on children. The quality of children's plans is variable, but most are appropriately detailed, with a focus on permanency and progress in placement. While almost all plans detail actions required for further progress, these are not sufficiently specific or timebound and do not help to measure timely completion of key tasks. Reviews are timely and comprehensive, and appropriately consider the full range of children's needs. While young people often attend reviews, there is little evidence of proactive engagement by independent reviewing officers with young people outside of reviews.
20. Social workers build meaningful relationships with children. In most cases, statutory visiting takes place within timescales. Some good examples have been seen of direct work with children, which has been well recorded and is having a positive impact on their well-being, but not all direct work is recorded well. Life-story work is undertaken with children with long-term care arrangements, enabling them to understand their history and family connections.
21. An independent provider has been commissioned to provide advocacy and independent visitors for children in care, and this provides good support to children and young people. There are established groups for children in care and care leavers: Teen Care Council (TCC) and Experienced Panel in Care (EPIC). There is a robust corporate parenting strategy, and children in care and care leavers have been able to contribute to changes in policy and practice, including successfully lobbying the council to agree that care leavers should not pay council tax. Children's achievements are celebrated, and the council holds a Christmas day event for any care leavers who are alone on that day. This event is attended by the Leader of the Council and the Cabinet Member for Children and Young People.

22. Support is available for young people with mental health issues through Child and Adolescent Mental Health Services and other interventions such as breakthrough mentors, personal counselling and therapeutic life-story work. There are examples of sensitive work with young people who feel they are being bullied. 'Thinking Aloud', an in-house therapeutic service, further strengthens the range of services available to meet the mental health needs of children and young people. Responses to young people in care who are felt to be at risk of sexual exploitation are effective, and well-coordinated plans contribute to reducing risk to young people. Young people in care who go missing receive support from a consistent worker, although the return home interviews are sometimes subject to avoidable delay.
23. The health of children in care is routinely considered in children's reviews. Health passports have only recently been developed, and there are plans for a gradual roll-out over time. Currently, only 30 young people at the point of leaving care have their health information in an easily accessible format.
24. The process for gathering assessment information about the progress and attainment of children in care lacks precision. Currently, the virtual school's monitoring process is not sufficiently accurate and so does not provide sufficient detail about pupils' attainment and progress. The virtual headteacher is not able to provide enough level of detail about the academic progress of post-16 students. Communication with the transition to independence team is improving, but is not yet good enough for this age group.
25. A bespoke personal education plan for all students has been developed and this is a positive development. However, the emphasis on pathway planning for the end of Year 11 is not happening soon enough. The number of fixed-term exclusions of children in care is too high. The number of care leavers who are in education, employment and training has improved from a very low base. The work of the virtual school to understand the quality of care leavers' educational experience, and to ensure that they are making expected progress, is in its infancy.
26. Senior leaders recognise that, despite an increase in foster carers, they do not have sufficient foster carers to meet the diverse needs of children in care. There is a renewed focus on the recruitment and retention of foster carers, and finance has been secured for an increase in foster carer payments, but this is yet to have a significant impact.
27. Current recruitment of adopters meets the needs of children. Timely and professional support provided by skilled adoption workers enables adopters to understand the process from enquiry to placement. Most adoption records are up to date and provide confidence that processes are being followed in a timely manner. Prospective and approved adopters are supported well through regular visits, good communication and information-sharing by professionals.

28. There is a clear focus in plans on achieving permanence for children. Permanence plans are routinely developed. The full range of permanence options are considered, including return home, special guardianship orders and adoption, as well as long-term fostering. Most, but not all, children who have plans for long-term care have been matched formally with their foster parents. While a permanence tracker is in place, it is not developed sufficiently to ensure that progress can be measured easily by senior managers. Child permanence reports and prospective adoption reports are of good quality and provide sufficient detail and analysis of needs and strengths to inform good decision-making. Later-life letters deal with complex histories and issues well and with sensitivity. Adopters and children benefit from well-constructed life-story book work.
29. The quality of the service for care leavers has declined since a monitoring visit to the local authority in October 2018. For too many, it is poor. The local authority is taking steps to improve the quality of work with care leavers, but some significant areas of practice have not been sufficiently addressed. Successfully preparing care leavers to live independently remains a critical area of development. Care leavers report that emotional well-being and mental health support is not sufficiently accessible and that preparation for independent living is not always effective or timely.
30. The quality and timeliness of pathway plans for care leavers is too inconsistent. Pathway plans are not sufficiently detailed or specific, and many lack timescales and clearly defined outcomes for young people. A third of care leavers either do not have a plan or they have a plan that has not been reviewed in a timely manner. Personal advisers and social workers, therefore, do not always have a sufficiently clear overview of the work being completed with young people.
31. The recently implemented leaving care guide, produced in partnership with care leavers, clearly outlines the local authority's 'pledge' to care leavers and contains a good range of information and advice. There is a good range of resources to support care leavers, including the Kingswood drop-in centre, which is used increasingly by care leavers to access advice and information.
32. Management capacity within the team is not sufficient, and while supervision takes place this is not always timely. This oversight does not ensure weaknesses in practice are identified or remedied. For some care leavers, work is not well progressed and for a few, more serious weaknesses are not identified or addressed as quickly as they should be.
33. The local authority is in touch with almost all care leavers. Senior leaders engage well with care leavers, and the work of personal advisers and social workers is underpinned by a strong relationship-based approach. Most care leavers live in accommodation that is well matched to their needs, and they



have access to appropriate support. However, a very small number of care leavers live in bed and breakfast accommodation and this situation has remained the case for the last six months. This is very poor practice.

## **The impact of leaders on social work practice with children and families requires improvement to be good**

34. Overall, the pace of progress since the single inspection in 2016, which judged the service as inadequate, has been slow. Improvement is clearly demonstrable during the past six months, under the leadership of the recently appointed director of children's services, and senior leaders have taken determined action to improve the quality of services in South Gloucestershire. While strengths are emerging in several areas, for example the quality of direct work with children, consistency in the quality of practice continues to be a key challenge for senior leaders. A significant number of issues remain, including a lack of urgency in decision-making on contacts and ineffective oversight of children's educational progress by the virtual school.
35. Good use has been made of peer support, external reviews and work with the safeguarding board. Leaders have demonstrated a realistic overview of key strengths and weaknesses, and improvement plans to address all weaknesses, identified at this inspection, were already in place prior to the inspection, albeit at various stages of implementation.
36. Several recommendations from the previous inspection have not been fully addressed, for example the timeliness of return home interviews and the number of care leavers who are not in education, employment or training.
37. The quality of services for care leavers has declined in recent months, and while senior leaders are aware of the decline and that increased management support is required, additional capacity is not yet in place. Consequently, the quality and timeliness of preparing young people to live independently is not sufficiently effective and is a significant area for development.
38. Although slow to establish, South Gloucestershire now has a revised framework for the implementation of early help, and the early help strategy is in the process of being implemented. Individual responses to identify and respond to young people at risk of exploitation have improved, and well-coordinated strategic arrangements are now in place.
39. Senior leaders have ensured that the 0–25 service, supporting children with disabilities, has been strengthened through additional management and social work capacity, and the vast majority of children in the 0–25 service now receive a timely and effective response to their needs. A new electronic recording system has been implemented, along with a new practice model, and both are ensuring that the quality of case recording is beginning to improve.

40. Senior leaders have introduced a revised and strengthened supervision tool and supervision policy. However, this activity has been slow to be implemented. While the timeliness of supervision of social workers has significantly improved, the impact of this management oversight remains variable and does not always result in delays in casework being identified and remedied as a matter of urgency. Senior leaders recognise that further work is required to ensure that all managers challenge social workers effectively and that weaknesses are routinely translated into timebound action plans.
41. Effective governance arrangements are in place, and strategic leaders have ensured that relationships with partners have been strengthened. Political leaders have demonstrated a commitment to improving outcomes for children, and this has been translated effectively into the improvement plan as well as through significant investment. Leaders have a clear vision for continued improvement, and the needs of children and young people are central to strategic planning arrangements. Significant financial investment has secured additional management capacity across the service and increased investment in the fostering service. Strategic intent has not yet been fully translated into tangible improvements in the quality of services that children receive.
42. The local authority has a revised workforce development strategy which sets out recruitment and retention strategies. Social work stability over recent years has been a significant challenge in South Gloucestershire. Senior leaders have implemented a number of incentives to attract more experienced, permanent applicants and the impact of these incentives has very recently started to be reflected in a more stable workforce. While the overall number of agency workers has increased, many have been in post for extended periods and have therefore developed consistent relationships with children.
43. Caseloads have significantly reduced. Social workers and managers feel well supported and have access to a comprehensive range of well-targeted training opportunities. The local authority has developed an assessed and supported year academy, and this provides good support to newly qualified social workers as well as demonstrating an investment in the future workforce.
44. The positive impact of the work of the principal social worker is clear across the service, for example in refining audit activity as well as in ensuring the training needs of staff are well identified and matched with high-quality training provision. The principal social worker has a good awareness of ongoing areas of social work practice that require improvement and works systematically to ensure that weaknesses are addressed.
45. Staff morale is good, and staff value the strengths-based practice model that is now well embedded and has ensured a clearer focus on delivering improved outcomes for children. Leaders have ensured that the quality and impact of direct work with children in South Gloucestershire is an emerging strength, and

social workers employ a range of creative and innovative mechanisms to build meaningful relationships with children.

46. Quality assurance arrangements have been significantly strengthened since the previous inspection. Senior leaders have introduced revised audit tools, delivered comprehensive training on auditing activity, and findings from a wide range of quality assurance mechanisms are collated and scrutinised by the quality assurance group. Multi-agency audit activity is routinely undertaken, and has further contributed to improvements in practice across the partnership. Learning from these audits has been effectively collated and disseminated to staff. An increasing number of staff are able to reflect on the impact of this learning and translate it into improving their individual practice.
47. Performance management arrangements have been strengthened, and the use of performance information to target service development is beginning to improve. Senior leaders have an increasingly accurate understanding of key strengths and weaknesses in South Gloucestershire. However, further refinement of this is required. Senior leaders are not able to gather enough detail to see performance and trends in-year and must resort to manual collection of data in certain areas to establish end-of-year performance data. In part, this can be attributed to the introduction of a new electronic recording system, which is still not completely embedded. The resulting confusion over data and gaps in data collection inhibits senior managers' understanding of overall performance.
48. Senior leaders have demonstrated a sustained and sharp focus on gathering the views of children and young people and using this to inform strategic and operational planning across the service. Children and young people greatly enjoy the accessibility of senior managers, including the director and the chief executive, and this level of commitment was well demonstrated by the Christmas Day party for care leavers. Corporate parenting in South Gloucestershire is a strength.



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