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Dear Dave

Monitoring visit of Surrey children's services

This letter summarises the findings of the monitoring visit to Surrey children's services on the 31 October and 1 November 2019. The visit was the fourth monitoring visit since the local authority was judged inadequate overall in May 2018. The inspectors were Nick Stacey and Margaret Burke, Her Majesty's Inspectors.

Inspectors evaluated: the timeliness and effectiveness of strategy meetings and child protection investigations; the quality and timeliness of assessments completed about children and families; the progress made for children who are the subjects of child in need and child protection plans; and the response to older children who are experiencing, or who are at risk of, child exploitation.

Overview

Senior leaders and managers have made substantial progress in improving the response to children who are at risk of significant harm, and children who have subsequently become subject to child protection and child in need plans, since this area of practice was last evaluated at the September 2018 monitoring visit. A new practice model is being rolled out through a phased implementation programme, and all social workers seen during the visit have undertaken some initial training and have taken part in development activities. Critically, social worker caseloads in the assessment and family safeguarding teams have reduced markedly to an average of 15 cases, and these manageable workloads are enabling social workers to undertake an improving standard of assessment, planning and direct work with children. Overall, improvements in the quality of social work, management oversight and supervision are gathering momentum, but practice is not yet consistently strong for all children.

Social workers and managers have a better understanding and approach to children who are the subject of repeated assessments and plans, often over periods of many years. The impact and durability of multi-agency work with children is more

rigorously evaluated before cases are stepped down to early help or are closed. Management oversight and supervision are visible and regular. The recording of supervision often comprises lengthy reviews of work undertaken, and rarely features evidence of proactive, inquisitive approaches, generating questions and ideas for social workers to help them address entrenched difficulties, such as domestic abuse, parental substance misuse and mental illness. The planned recruitment of a range of new specialist workers to social work teams over the next few months, who have skills in working with complex adult difficulties, including domestic abuse, adult substance misuse and mental illness, is eagerly anticipated. Some specialist workers, notably child and adolescent mental health professionals, are already working alongside social workers, helping them to formulate ideas and plans in order to strengthen their direct work with children and parents.

Findings

Most strategy meetings are attended by relevant agencies, and all known information about children is considered. Decisions about whether to continue to a child protection enquiry are well evidenced, and initial steps and safety plans are set out well. Management decisions are clearly written, and demonstrate careful consideration of information relating to previous episodes of agency involvement with families. A small number of strategy meetings were limited to discussions between social workers and the police; in these instances, not all pertinent information about children was shared in order to inform an initial assessment of risk.

The outcomes of child protection enquiries are well recorded. Children are promptly seen, on their own, and, where necessary, repeatedly to ensure that their accounts and experiences are captured and understood. Social workers engage parents and carers thoughtfully, and a wide range of multi-agency information and previous history is thoroughly evaluated. Concluding decisions are carefully recorded by service managers, providing consistent senior management oversight of early safeguarding interventions.

The timeliness of initial child protection conferences (ICPCs) has declined in recent months. Inspectors did not see any further risks to children because of short delays, but the effectiveness of these meetings is inconsistent. ICPCs are typically well attended, and the participation of children and their carers is strongly promoted. Minutes often comprise dense and highly detailed verbatim recordings rather than concise informative summaries, reducing the accessibility of these important records. The views of children are captured, but, frequently, are not used to produce a clear picture of their lives at home, and the degree of continuing risk they may be exposed to. The practice of documenting risks, strengths and worries in columns, and the prevalent use of scaling exercises, can sometimes overcrowd and obscure, rather than illuminate, children's core risks and needs. Conference chairs do not always document their analysis and evaluation of risk crisply and clearly, and this indicates a lack of rigour in their expert decision-making responsibilities. Plans often feature numerous actions that are not prioritised to help parents and professionals work on the most important elements in a sequential way.

Assessments are completed within reasonable timeframes, and the reasons for undertaking them are set out clearly alongside initial plans. The improved threshold management and gatekeeping at the children's single point of access, the local authority's 'front door', continues to be effective. This results in fewer children and families experiencing assessments that are inappropriately either discontinued or that culminate in no help being provided. Parental histories and previous episodes of involvement are helpfully summarised. This provides an understanding of recurring adult vulnerabilities that adversely affect the provision of reliable, safe and nurturing parenting. Chronologies are routinely completed by social workers, and most helpfully highlight key events and changes. Determined efforts are made to contact and include birth fathers and extended family networks, and family group conferences and network meetings are now more prevalent. Visits to children, parents and carers are conducted with purpose, and the input of other agencies is prominent and informative.

The outcomes and concluding analyses of assessments are of a mixed quality. Most encapsulate the main risks, worries, needs and strengths, but they often feature lengthy bulleted columns rather than a coherent summary of salient themes and findings. Children's views are documented but are frequently not evaluated to generate well-informed questions and hypotheses about future levels of risk that should be considered in subsequent plans and interventions.

The quality of child protection and child in need plans is improving, but further work is required to ensure that they are consistently SMART (specific, measurable, achievable, realistic and timely). Danger statements crisply and incisively outline the main risks that children are exposed to. Child protection conference chairs' summaries and explanations are not consistently strong and sharp, particularly when plans are ended or stepped down to lower intervention levels. Some plans are too lengthy and are saturated with dense professional language. Comprehensively recorded core groups are held regularly for children who are subject to child protection plans. Many would be further improved by a greater concentration on the progress and measurement of plan objectives, and fewer lengthy activity descriptions.

Children are seen promptly and regularly by social workers, both during assessments and when they are the subjects of statutory plans. Imaginative approaches are often used by social workers to engage with children of all ages in order to understand their daily lives. This work could be further strengthened if plans and management supervision were more explicit about the objectives of direct work, and provided more guidance on how it should be approached. Nevertheless, social workers who have been allocated to children for longer periods undertake constructive and insightful work with children to elicit their feelings, worries and interests and what they would like to change in their family lives. Social workers record their visits to children conscientiously and many records appropriately align the purpose and content of visits to the progression of plan objectives.

The impact on children of living in neglectful home conditions is not conveyed clearly enough in all cases. This means that the extent, severity and adverse impact on children's daily well-being and safety is not explained clearly enough. Some social workers very precisely observe and record unhygienic features in homes and in the standard of physical care provided to children. Other records are too generalised, using terms such as 'unsatisfactory' or 'dirty'. Senior managers are aware of this and are appropriately introducing a well-known neglect assessment tool to develop this area of safeguarding practice. Children living in homes where there are longstanding patterns of domestic abuse, parental mental ill-health or substance misuse are starting to benefit from child protection and child in need reviews, which evaluate the capacity of their parents and carers to make and sustain positive changes. This sharper focus is starting to address the substantial legacy of cases where repeated referrals, assessments and plans over many years have not improved the lives and damaging circumstances experienced by many of the most vulnerable children.

Older children who are at risk of or who are experiencing child exploitation are quickly assessed and engaged by social workers, family support and targeted youth support workers. These workers are predominantly situated in adolescent safeguarding teams. Nearly all children who go missing from home are offered timely return home conversations, and workers follow up with those who decline. Useful information provided by children in return home conversations is immediately passed to specialist police officers, who use it to undertake intelligence mapping, disruption and dispersal activity. Regular multi-agency risk management meetings review and oversee risk reduction work with those children who are at the greatest risk, but the information and intelligence from these meetings is not always easily discernible in social work case records and intervention plans. Senior managers recognise that assertive, persistent outreach work with children who are at acute risk needs to evolve and improve further, and they have realistic plans to build on the current constructive direct work carried out.

Management oversight of frontline practice is consistently evident in strategy meetings, child protection enquiries and assessments. Threshold decisions are largely explicit, proportionate and well evidenced. Management supervision of cases allocated to social workers in family safeguarding teams is regular and recorded. Senior managers' decisions are well documented when children's difficulties at home escalate. The pre-proceedings stages of the public law outline and care proceedings are initiated when needed. Social workers appreciate the advice and support provided by their managers. Written supervision records illustrate that the work undertaken is reviewed and that further tasks are clearly set out. There is limited evidence, however, of reflective, curious questioning evaluating how the cumulative impact of busy multi-agency interventions are improving children's lives, and scant evidence that managers are advising social workers about how they should approach their direct work.

Social workers enjoy working in Surrey. This includes many longer-serving agency workers, some of whom are actively considering applying for permanent positions. Senior managers' efforts to increase the proportion of permanent social workers continue to be successful, and these staff now comprise the large majority of the

workforce. A substantial number of skilled non-social work qualified workers are being supported through social work degree programmes in a fruitful partnership with a local university. Social workers recognise that the major recent structural changes in the service, and the ongoing implementation of a new practice model, present valuable opportunities to provide evidence-based interventions and sustainable improvements in the lives of the most vulnerable and disadvantaged children. They are embracing the changes willingly and constructively. Permanent managers have been appointed through all layers of the service, presenting a solid base on which to build continuous practice improvements.

An extensive audit programme continues to provide managers with a comprehensive and accurate assessment of the quality of social work practice and frontline management oversight. The significant time and effort invested in a high standard of quality assurance activity is a cornerstone of continuing effective improvement work. Inspectors agreed with the findings of a small sample of audited cases they evaluated and recognised the rigour and quality of the local authority's auditing work.

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

Yours sincerely

Nick Stacey
Her Majesty's Inspector

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