

# Surrey County Council

## Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection date: 26 February 2018–22 March 2018

Report published: 16 May 2018

<b>Children’s services in Surrey are inadequate</b>	
<b>1. Children who need help and protection</b>	Inadequate
<b>2. Children looked after and achieving permanence</b>	Requires Improvement
2.1 Adoption performance	Good
2.2 Experiences and progress of care leavers	Requires Improvement
<b>3. Leadership, management and governance</b>	Inadequate

## Executive summary

Senior leaders and elected members in Surrey have been far too slow to accept and act on the findings and recommendations of the 2014 inspection, and to respond with the required urgency to the findings of several subsequent monitoring visits. Too many of the most vulnerable children in the county are being left exposed to continuing harm for long periods of time before decisive protective actions are taken. Children and their families experience repeated assessments and interventions in different parts of the service, often over periods of many years, and these do not achieve sustainable changes. Frontline managers and social workers do not routinely analyse family histories and the negligible impact of earlier phases of help. This results in children experiencing continued neglectful parenting, often including exposure to domestic abuse, and leaving them vulnerable to both acute and longer-term risk through corrosive damage to their social, emotional, physical and educational development.

The quality of assessment, planning and reviewing for children who are on statutory child in need or child protection plans is too weak. The understanding and application of thresholds by external agencies is poor, resulting in too many unnecessary low-level contacts and referrals, and overloading social workers in the multi-agency safeguarding hub (MASH). This is partly because not enough children are helped by lead professionals in universal services. Management decisions in the MASH are made quickly and effectively, but internal thresholds in children's services are also confused, meaning that large numbers of assessments are subsequently cancelled. Serious shortcomings in frontline management oversight, identified through quality assurance work, resulted in senior managers recently commissioning a review by an experienced external assessor of over 300 children with possible unrecognised safeguarding concerns. A small number of these children required urgent measures to safeguard them from harm.

Managers at all levels, including child protection chairs, do not carefully and rigorously evaluate the progression of children's plans. While regular oversight is largely evident, it is not always responsive to escalating concerns or to a lack of progress, and it does not consistently ensure that actions are completed. This trend is particularly apparent where the level of professional concern for children is likely to warrant legal action to safeguard them. Many of these children experience considerable delay in the pre-care, public law outline (PLO) phase of proceedings. This leads to unacceptable uncertainty and anxiety for families and continuing exposure to harm for children. Independent advocates are not provided to most children on child protection plans, or who are looked after, which denies them the opportunity to receive this external support.

Very recently, leaders, managers and elected members have grasped the scale of improvement needed through an honest acceptance of the depth of practice shortcomings, and a concerted focus on improving children's experiences and outcomes. This positive cultural change is starting to build a better understanding of risk, a learning-based practice model and more confident, informed social work with children. However, these improvements are yet to be embedded, and have not yet led to sustained, widespread reform on the scale required for consistently effective

and safe frontline services. Changes in senior leadership, political scrutiny, the improvement board and the Local Safeguarding Children's Board (LSCB) are vital elements in this new system-wide approach to improvement. The likelihood of long-overdue improvements gaining the necessary momentum is now greater than at any point since the 2014 inspection.

Many children experience lasting harm and arrive in care too late. Some children experience delays in early placement planning, and a large majority do not undergo timely initial health assessments. This is a serious and longstanding failure in Surrey's corporate parenting. However, the large majority of children, once they are in care, live in stable, well-supported foster placements and are regularly visited by their social workers, who do some thoughtful and valuable direct work with them. Children have clearly stated, though, that they have too many changes of social worker and this is a serious concern for them. Helpfully, children who are looked after have early access to a dedicated mental health service.

Early permanence planning for children who could be looked after for longer periods is too inconsistent, meaning that a small number arrive in permanent long-term homes later than they should. The adoption service is tenacious and effective at finding permanent parents for children with highly complex needs, and supports adopters well if future difficulties arise.

Older children looked after aged 16 years and over do not have sufficient support from personal advisers, working alongside their social workers, to construct clear pathway plans that ensure firm arrangements after they turn 18 years of age.

Personal advisers working with young people who have left care are overstretched, meaning they cannot meet all the commitments they make. Despite this shortcoming, they do important work with young people, and this is appreciated by them. More young people leaving care are in employment, training and education than in other local authorities: apprenticeships are highly developed across the council, strengthened by innovative collaborations with some local employers.

Senior managers have devised a thorough, multi-faceted quality assurance system through which the quality of frontline practice is evaluated more accurately. This approach constructively engages social workers to learn through the spotlight on their practice. However, this system has only recently been implemented and it has yet to demonstrate the capacity to improve frontline practice across the county.

The turnover of staff remains a significant difficulty, compounded by the additional recruitment and retention pressures also faced by a number of other local authorities in south-east England in close proximity to London. The local authority is purposefully addressing this with continuous centralised recruitment initiatives, and in carefully supporting significant numbers of newly qualified social workers in their first year of practice through a highly regarded social work academy.

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## The local authority

### Information about this local authority area<sup>1</sup>

#### Previous Ofsted inspections

- The local authority operates 10 children's homes. Seven were judged to be good or outstanding in their most recent Ofsted inspection.
- The last inspection report for the local authority's children's services was published in August 2015. The judgements for the local authority were:
  - Overall effectiveness: Inadequate
  - Children who need help and protection: Inadequate
  - Children looked after and achieving permanence: Requires improvement to be good
    - Adoption performance: Good
    - Experiences and progress of care leavers: Requires improvement to be good.
  - Leadership, management and governance: Inadequate.

#### Local leadership

- The interim director of children's services (DCS) has been in post since October 2017.
- The chief executive has been in post since March 2018.
- The chair of the LSCB has been in post since December 2017.
- The local authority uses the signs of safety model of social work.

#### Children living in this area

- Approximately 259,000 children and young people under the age of 18 years live in Surrey. This is 22% of the total population in the area.
- Approximately 10% of the local authority's children aged under 16 years are living in low income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 8% (the national average is 14%)
  - in secondary schools is 6% (the national average is 13%)

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<sup>1</sup> The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- Children and young people from minority ethnic groups account for 13% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian and Asian British dual heritage.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 13% (the national average is 21%)
  - in secondary schools is 11% (the national average is 16%)
- Surrey looks after the third highest number of unaccompanied asylum-seeking children of any local authority in England. At January 2018, there were 111 unaccompanied asylum-seeking children. Additionally, there are 228 care leavers in Surrey who arrived in care as unaccompanied asylum seekers.

### **Child protection in this area**

- At 31 January 2018, 6,120 children had been identified through assessment as being formally in need of a specialist children's service.
- At 31 January 2018, 985 children and young people were the subject of a child protection plan (a rate of 38 per 10,000 children). This is an increase from 843 children (33 per 10,000 children) at 31 March 2017.
- At 31 January 2018, nine children lived in a private fostering arrangement. This is an increase from five at 31 March 2017.
- In the two years prior to the inspection, 18 serious incident notifications had been submitted to Ofsted and five serious case reviews had been completed. Five were ongoing at the time of the inspection.

### **Children looked after in this area**

- At 31 January 2018, 930 children are being looked after by the local authority (a rate of 36 per 10,000 children). This is an increase from 870 (34 per 10,000 children) at 31 March 2017. Of this number:
  - 445 (or 49%) live outside the local authority area
  - 135 live in residential children's homes, of whom 57% live outside the local authority area
  - 31 live in residential special schools<sup>2</sup>, of whom 71% live outside the local authority area
  - 657 live with foster families, of whom 46% live outside the local authority area
  - 10 live with parents, of whom 10% live outside the local authority area

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<sup>2</sup> These are residential special schools that look after children for 295 days or less per year.

- 111 children are unaccompanied asylum-seeking children
- In the last 12 months:
  - there have been 46 adoptions
  - 50 children became subject of special guardianship orders
  - 361 children ceased to be looked after, of whom 8% subsequently returned to be looked after
  - 40 children and young people ceased to be looked after and moved on to independent living
  - two children and young people ceased to be looked after and are now living in houses of multiple occupation

## Recommendations

1. Leaders should urgently review the alignment of strategic and operational plans with improvement board objectives to ensure that these are streamlined and complementary. These efforts should aim to quicken the pace of providing consistently safe and effective services for the most vulnerable children.
2. The local authority should put children's voices at the centre of its improvement work and further embed the recently developed systemic quality assurance framework to prioritise improvements in frontline practice. The feedback provided by children, such as their dislike of the frequent changes of social workers and living in foster placements too far from their family homes, should attract concrete responses, as well as acknowledgements.
3. Leaders should urgently renew efforts to engage universal partner services, such as schools and health, to undertake lead professional roles and to form teams around children and families when difficulties emerge. These measures should aim to reduce the number of children requiring local authority targeted early help and the high volume of inappropriate low-level referrals to the MASH.
4. Improve the quality of management oversight across all services, and specifically assure that the family history, the impact of previous interventions and any delays are always considered and addressed. Frontline managers should only step down or close cases when there is substantial evidence that children's circumstances and outcomes have improved and that these improvements are likely to last.
5. Improved management decision-making should include more visible responses to alerts and escalations by child protection conference chairs, independent reviewing officers (IROs) and actions arising from multi-agency risk assessment conferences (MARAC) and multi-agency public protection meetings (MAPPA).
6. Senior managers and leaders should scrutinise and measure performance more effectively and ensure that compliance with important statutory requirements is met. These requirements include ensuring that information from all agencies involved with children is considered at strategy meetings, that initial child protection conferences are held promptly and that children who come into care have their health assessed within the first month.
7. Senior leaders and managers must improve the understanding and application of internal thresholds and transfers of cases across the service. These measures should include stopping inappropriate transfers for assessments from the MASH which are subsequently cancelled or discontinued. When safeguarding issues are identified for children with disabilities, they should receive skilled and well-informed risk assessments from social workers who know them.

8. The timeliness and oversight of work for children in the PLO pre-care proceedings phase should be quickly strengthened to reduce a long-established pattern of delay for many of the most vulnerable children.
9. The local authority should ensure rigorous adherence with Surrey Police to the joint Surrey protocol for the provision of local authority accommodation when children are charged and denied bail in custody, in accordance with the provisions of the Police and Criminal Evidence Act 1984.
10. The quality of assessments and plans for children should be improved. Assessments should analyse the already helpful collation of risks and needs with greater coherence and clarity to inform well-defined and measurable child protection and child in need plans.
11. All staff should receive training on the assessment of neglect, and use specific tools in their direct work with children experiencing neglect. Child in need, child protection reviews and core group meetings should evaluate children's progress more concisely, in addition to sharing and updating information.
12. The local authority should strengthen early planning for children who may need permanent care, with a sharper focus on all options, including foster to adopt.
13. The local authority should urgently improve the quality of personal education planning for children in care and closely analyse the impact of the pupil premium in improving children's educational progress.
14. Managers should improve the knowledge and confidence of social workers regarding the suitability and application of statutory guidance concerning connected person's assessments. Decisions concerning the prompt temporary approval of family and friends carers should be strengthened.
15. Children and young people who are on child protection plans or in care should understand the role of independent advocates and have easy access to them if they choose to seek their help.
16. Young people in care who are aged 16 and 17 should be offered better support by personal advisers to prepare pathway plans for their arrangements when they turn 18 years of age.
17. The care leavers' service should provide all young people with clearer information on their entitlements and their health histories. Personal advisers should routinely check that young people are aware of their detailed entitlements when important changes are in process, such as moving into independent accommodation and starting a further or higher education course.
18. The workload of personal advisers in the leaving care service, and social workers in some parts of the children's service, should be reduced. Caseloads should be manageable and allow time for frontline workers to regularly meet with children and young people and complete all the necessary work.

## Summary for children and young people

- Since the last Ofsted inspection in 2014, which found that services to help and protect children were very poor, Surrey local authority has taken too long to make services better for its most vulnerable children. This means that too many are still not protected from harm quickly enough, or given the right help when it's needed.
- It's good that the council has made big changes in the last six months and that help is just starting to get better. There is a real chance now that this will carry on and that all children who need help will be safer and will be given better help.
- Children and families are given earlier help, but this is usually when things at home have already become quite serious. Schools and health and other services that often see children need to help them even earlier, and stop sending lots of smaller worries they have for social workers to deal with.
- Surrey local authority tries to help children with more serious and worrying problems at home, but it does not do this well enough for many. This means that they shut down cases before they are sure that children's lives have got better. This then leads to more referrals and offers of help that can go on for a long time.
- Social workers and their managers don't always notice that families have the same problems over and over again, so they keep doing things to try and help which haven't worked before. This means that some children carry on being neglected and harmed in their families for too long.
- Some children should be looked after earlier. They sometimes come into care because of a crisis rather than in a more planned way, and when this happens, it causes even more distress. It takes Surrey local authority far too long to check that children's health is ok when they start being looked after. This is bad practice because many children will have things that need quickly sorting, such as immunisations that haven't been done and having their teeth checked.
- About half of children who are looked after live outside Surrey because there are not enough foster carers in the county. Most live with kind carers who do their best to compensate for things that children may have missed out on. This can be helping with their school work and doing activities and hobbies they enjoy, or that they may not have had the chance to do before.
- Surrey local authority tries very hard and does well in trying to find permanent, loving families for children who cannot go home, whether this is with adoptive parents or with special guardians. This also includes children with more complex issues and those who are disabled and have special needs, as well as older children and brothers and sisters.
- When young people reach 18 years of age and get ready to leave care, they are helped by caring personal advisers. Plans to help young people are clear, but personal advisers have too much work and can't do all the things they want to help. Surrey is good at helping young people into jobs, training or higher

education and has found apprenticeship openings inside the council and with some local firms to help get young people on the road to getting proper jobs.

<p><b>The experiences and progress of children who need help and protection</b></p>	<p><b>Inadequate</b></p>
<p><b>Summary</b></p> <p>There are widespread and serious failures in the assessment, planning and management of risk, particularly escalating risk, in the provision of help and protection for children in Surrey. Consequently, there is significant drift and delay for children at every stage of their journey, particularly for children who are exposed to chronic neglect and domestic abuse.</p> <p>Overall, early help is making a positive difference to children’s lives. However, due to a lack of multi-agency involvement, early help is not yet reaching all the children who would benefit from it, and it is not reducing the number of referrals to children in social care.</p> <p>A high number of inappropriate referrals made to the MASH by partners are placing unnecessary pressure on this service. However, thresholds are understood and effectively applied by the professionals in the multi-agency safeguarding hub (MASH). This means that children in need of an urgent response are correctly identified.</p> <p>Most children have assessments and plans in place, but many are of a poor quality. Social workers are not effectively identifying risk in many cases. There is a lack of understanding of changing and increasing risk, particularly when children experience neglect and domestic abuse. Managers and social workers are not always curious enough in considering past history when assessing risk.</p> <p>Children’s circumstances are often poorly considered at child protection conferences. In too many cases, social workers, directed by their managers, cease their involvement with children too soon, or step down their cases too quickly to early help services, and before there is evidence of sustainable improvements. These children are frequently referred back again for further help as their circumstances have failed to improve.</p> <p>Supervision and management oversight lacks appropriate curiosity and challenge, and does not reliably recognise the need for decisive measures to protect children. As a result, children remain exposed to risks of significant harm. Social workers in some teams have high caseloads, which compounds these weaknesses.</p>	

The response to children who go missing or who are at risk of sexual exploitation is improving, supported by new, stronger operational arrangements with partners. Return home conversations are also improving and are starting to be used to inform plans to reduce risks to children.

## Inspection findings

19. The local authority has made poor progress since the last inspection in 2014, and services for children in need of help and protection remain inadequate. Initial safeguarding decisions in the MASH are timely and effective. However, poor practice concerning assessments, planning and management oversight was seen in too many cases, leaving children at risk of significant harm. Senior leaders accepted inspectors' concerns and took immediate action to review and safeguard children referred back to them during the inspection.  
(Recommendation)
20. Thresholds for early help are inconsistent. Where children are experiencing neglect, social workers do not consistently consider the family's previous history of involvement with services. For some children and families, there is delay in quickly providing early help services to support them. Surrey provides a wide range of targeted early help services where difficulties are already evident. A lack of partnership engagement limits the provision of a wider spectrum of early help. Universal services such as schools and health rarely undertake the lead professional role before deciding if a referral to children's services is required.  
(Recommendation)
21. Early help professionals undertake some good-quality direct work with children, which helps to progress the outcomes sought. However, with more complex, entrenched difficulties, the work is less successful. Early help professionals complete assessments in a timely way, but they vary in quality. The local authority has evaluated the early help offer and identified areas of duplication and fragmentation. It is too early to see the impact of improvement activities in this area.
22. When children are in need of help and protection, the MASH is the central point of contact for members of the public and professionals. Staff in the MASH have a clear understanding of thresholds, and risk assessment is effective. However, many partner agencies do not effectively triage concerns internally before they refer to the MASH. This results in valuable time being lost by staff in the MASH dealing with a large volume of inappropriate contacts and seeking more basic information because the detail provided in many contacts is poor.  
(Recommendation)
23. Children in need of an urgent response normally receive a timely, effective service from the MASH. Parental consent is always sought, or appropriately overridden to quickly protect children. Social workers do impressive work to create a positive initial engagement, especially with resistant and avoidant

families, without compromising the safety of children who may be at risk of harm. Management oversight is consistent but would be considerably improved by routinely synthesising previous histories of involvement with families. (Recommendation)

24. Subsequent work in the assessment social work teams is less rigorous, with significant deficits in the quality of basic social work practice. Strategy meetings rarely include other partners involved with families other than the police and children's services. Therefore, not all significant information is available to inform decision-making. Historical information is frequently poorly collated, meaning that repeating patterns of abuse and earlier interventions are not considered, resulting in an incomplete analysis of risk for too many children. However, social workers and managers do recognise risks to other connected children and make good efforts to engage absent or separated fathers. The outcome of child protection enquiries are well documented. (Recommendation)
25. Too many assessments are of a poor quality. Most do not consider any needs arising from children's cultural or religious backgrounds, and they do not rigorously analyse risk through a close evaluation of the impact of previous involvements. Consequently, subsequent interventions are often repeated when their earlier limited success in improving children's circumstances is clearly apparent. This has led to some children living in harmful situations for too long, and experiencing abrupt, unplanned entries to care through crisis interventions. Decisive, planned measures at earlier stages may have prevented these children experiencing the additional anxiety and stress of family breakdown. (Recommendation)
26. Some assessments are not sufficiently focused on children with more complex needs, leading to poor subsequent planning, particularly in cases of neglect. The use of a widely recognised practice model does capture worries, risks and strengths well. However, these helpful evaluations do not consistently translate into cogent analyses and recommendations to support targeted planning. Many assessments are not completed in timescales that are commensurate with the particular circumstances of each child and family. Staff in the teams that undertake this work have high caseloads, and this further compounds these practice weaknesses. Avoidable additional work is created by the high number of assessments opened in error each month, and which are subsequently cancelled due to poor earlier decision-making. (Recommendation)
27. A trend of over optimism, repeat service provision and a lack of understanding of disguised compliance within families is evident at both initial and review child protection conferences. Some older children do attend their child protection conferences. On these occasions, they are sensitively and well supported by their social workers and the chairs of child protection conferences to present their views. A face-to-face advocacy service is not provided for children subject to child protection. This means that children's voices and views are not always effectively heard at child protection conferences. (Recommendation)

28. Social workers visit children who are on child protection plans regularly and they see them alone. The purpose of visits is not always clearly recorded. Some children on child in need plans are not receiving regular visits. Difficulties and confusion in electronic case recording systems complicate the uploading of documents, including direct work undertaken with children. This creates potential risks for children, and, in particular, difficulties in access to information for the out-of-hours service. Nevertheless, the service for children and their families who need support and intervention out of hours is sound. In cases seen, the response to risks out of hours was timely, sensitive and proportionate, resolving immediate problems for children. Information is appropriately and promptly passed to daytime teams for further actions. The follow-up from daytime teams is sometimes unclear. Records and safety plans are not always up to date, or in place, to support the emergency duty team should further referrals arise out of hours.
29. Many assessments and plans concentrate disproportionately on adults' problems, including multiple difficulties concerning poor mental health, drug use and domestic abuse. While it is essential for these issues to be understood, many assessments do not evaluate the corrosive impact of these difficulties on children's development, safety and well-being. Children's experiences are not central or strongly considered. (Recommendation)
30. The majority of child protection and child in need plans seen by inspectors were poor. They do not describe what has to happen and by when. Actions are not always linked to specific risks and needs, and are confusing. In some plans, there are numerous actions for parents and professionals and this does not help them to prioritise those that are more important. Contingency plans are generally weak. Core groups share information well, but do not progress the plans for children effectively through focusing determinedly on whether their circumstances are improving. In some cases, children on plans remain exposed to continuing harm for long periods. (Recommendation)
31. Management oversight is often of a poor quality, primarily because it does not demonstrate sufficient curiosity, reflection or analysis. At all levels, managers are not consistently responsive to or aware of escalating concerns, nor do they ensure that directed management actions are always completed. As a result, some children experience delays in becoming looked after or they remain in unacceptable situations at home for too long. (Recommendation)
32. The use of the PLO has improved, but there is still too much delay for children in pre-proceedings. Family group conferences are often not held early enough to be effective. Letters before proceedings to parents and carers are specific about the concerns for children, but there is delay in dispatching them and further time lost in arranging PLO meetings. Managers and legal advisers do not always notice or take action when deadlines are missed. The legal care threshold is not always rigorously evaluated and parents' capacity to change is sometimes not well understood. For some children, this leads to unhelpful

- differences in opinion and disputes about recommendations between legal advisers and social workers and their managers. (Recommendation)
33. Applications to court when care proceedings are initiated are often delayed. Documents and statements are not always filed in a timely way when cases are listed. This means avoidable repeat hearings for some children and families.
  34. The children with disability team is not providing an effective safeguarding service. The transfer of children to the assessment or safeguarding teams when any safeguarding concerns arise creates avoidable change and disruption for children at a difficult time. As a result, some weak practice is evident, with uncertain, confused safeguarding responses. (Recommendation)
  35. MARAC meetings to consider victims at high risk of domestic abuse and the children exposed to this are held regularly, and are consistently attended by children's services and the police. The meetings are not as effective as they should be because other key partner agencies do not attend regularly and do not contribute sufficiently to plans to reduce risks. Although children's social workers are routinely updated following these multi-agency meetings, social work assessments do not always reflect the information shared within them. As a result, too many subsequent plans do not adequately safeguard these vulnerable children. (Recommendation)
  36. Effective arrangements are in place to monitor those children who are electively home educated and those who go missing from education. Checks are prompt and effective to identify whether the child is missing education or missing from home. Surrey is effectively reducing the comparatively large number of children who are home educated by parents.
  37. Responses to children who go missing and are at risk of child sexual exploitation and other vulnerabilities such as female genital mutilation and the risk of radicalisation have recently improved. Return home conversations are much improved since the recent commencement of new arrangements. Refreshed guidance and the appointment of a coordinator for missing children and child sexual exploitation support this progress.
  38. A comprehensive joint protocol with housing for the assessment and provision of help for homeless 16- and 17-year-olds is not always applied effectively. The quality of assessments is variable. Better assessments evidence risk and resilience factors for the young people and include clear management oversight and decision-making, compliant with the 'Southwark judgement'. It is not always obvious from case records whether young people have been provided with a clear explanation of their right to be accommodated under section 20 of the Children Act 1989.
  39. In the last year, efforts have been made to sharpen inter-agency awareness of children who are in private fostering arrangements. However, numbers are low and efforts to raise awareness have not been sufficiently assertive or creative.

40. Arrangements for responding to allegations about risk presented by adults in a position of trust or working with children are broadly effective, but there are continuing divergences between local authority designated officer and human resources advice. This is unhelpful and confusing in some cases. Actions to resolve this are not yet fully apparent.

<p><b>The experiences and progress of children looked after and achieving permanence</b></p>	<p><b>Requires improvement</b></p>
<p><b>Summary</b></p> <p>It takes too long for some children to come into care, but they make progress once they are looked after. When children return home, the majority do so after a thorough assessment and with appropriate support. Edge-of-care work is effective in preventing some children from entering care and in supporting children when they return home from care.</p> <p>Children in care placed with their parents receive a variable service. Some children continue to thrive and make steady progress. This means that social workers are confident to make applications for revocation of care orders. However, the local authority has recognised that there is insufficient monitoring and oversight of the circumstances of other children.</p> <p>Court work is improving but more needs to be done to increase the pace of document preparation and confidence in undertaking assessments. It is taking too long for some children to reach their permanent homes. Despite a number of emerging improvements, a sharper focus is needed to develop a more effective whole-system approach.</p> <p>Social workers help children to make good progress once they are in care. Direct work is purposeful. The use of the local authority’s practice model results in a thoughtful and analytical approach to understanding concerns for children. Contact arrangements are sensitively considered, and IROs maintain oversight of children’s progress. Children have waited too long to have their health needs assessed, and these delays have not been purposefully addressed over many years.</p> <p>The local authority fails to properly monitor the educational progress of children looked after, and the use and impact of pupil premium funding allocated to schools. Personal education planning is extremely poor. Attendance had been rising, but has now dropped to below comparators. The educational achievement of children looked after is mixed.</p> <p>Adoption is considered for all children, and where this is the plan it is pursued swiftly and children move quickly to live with their adoptive families. Children who are adopted and their adoptive families access a wide range of support.</p> <p>Care leavers get very good individual support from their personal advisers, but this is often not timely because of their high caseloads. Pathway planning in the care leaver service has improved and is now good. Pathway plans completed by social workers in other parts of the service still require improvement.</p>	

## Inspection findings

41. The threshold for children entering the care of the local authority is appropriate and there are no children in care who should not be looked after. An increasing number of applications to court indicates the recent emergence of a more focused approach to proactively protecting children. This is particularly evident for children living for long periods in circumstances in which many of their primary needs are neglected. While many children experience drift and delay before coming into care, they are safe and make progress when they arrive in their placements.
42. There is a lack of placement choice when children first come into care, but many children respond well to their initial emergency foster placements. A few children settle into these temporary placements so well that they experience further anxiety at having to move again to a longer-term placement within a few days. This anxiety is often amplified when the next move is far away from their family and friend networks and requires a change of school.  
(Recommendation)
43. Children and their families are largely well prepared when children return home from care. Children benefit from sensitive support during phased transition periods, and most children continue to make progress at home. In the majority of cases, social workers conduct careful assessments and listen to children's worries about moving from care to home. They provide appropriate reassurance, which reduces children's anxieties.
44. Edge-of-care work is effective in preventing the small number of children who receive intensive support from this service from entering care. It is also beneficial in supporting the return home plans for some children.
45. In some cases seen by inspectors, the return home of a few children was either unplanned or hurriedly planned. In these examples, there was insufficient exploration or understanding of the risks that children faced and their expressed concerns were not fully recognised. This lack of understanding or action meant that children experienced further harm, or continued to be at risk of further harm.
46. A small number of children on care orders live with their parents, and children whose cases were sampled by inspectors were making progress and benefiting from regular oversight and contact with their social workers. The local authority is making appropriate applications to court to revoke or substitute care orders when their assessments confirm it is safe to do so. Children appreciate the opportunity to go home and parents feel proud of the validation of the progress they have made.
47. Children who have been charged with a criminal offence are regularly detained overnight in police stations because of a shortage of suitable emergency local authority accommodation. The local authority and the police are not

implementing the joint Surrey protocol rigorously. A much larger number of children who have been arrested and not charged are also held overnight in police stations. Although the local authority has no duty to provide accommodation for the latter group, the practice of detaining children overnight to continue police investigations within prescribed timescales is highly concerning. (Recommendation)

48. The quality of court work is improving, but there are continuing delays in producing documents, and an over reliance on independent social worker and other expert assessments. There is further work to do to improve the quality and confidence of social workers' preparation of evidence in care proceedings.
49. Despite some emerging improvements, early permanence planning remains underdeveloped. Oversight of this work is inconsistent and not rigorous enough. A lack of proactive, decisive assessment and planning prior to entering care means that some children wait too long to move into a permanent home. Shortcomings in preparation of evidence in care proceedings adds further delay. Children who have recently started to be looked after are discussed at a permanence planning meeting, attended by the adoption team, within several weeks of entering care. Following this initial meeting, however, children's progress toward a permanent home is reliant on the variable oversight of individual teams rather than regular subsequent tracking and reviewing. (Recommendation)
50. Social workers carefully consider connected person and special guardianship arrangements in their permanence plans for children and young people. They make thoughtful approaches to family and friends at the outset to consider the suitability of care for children. While this is appropriate, these arrangements need greater rigour. Inspectors noted some confusion about the point at which family arrangements become temporary foster care placements. Some staff across the local authority do not fully understand the expectations and standards related to connected person procedures and assessments. Further delays in assessments impede progress in securing permanence for some children who may be able to live with a connected person. Further work is required to ensure that all staff understand the purpose of a connected carer assessment. (Recommendation)
51. Some fundamental business processes at the point of children's entry to care are not well understood by social workers. These important tasks can overload social workers in assessment, as well as court teams, whose caseloads are high and breadth of work wide. Prompt notifications to IROs and immediate requests for initial health assessments are examples of delayed administrative tasks which can impede children's timely progress. It is positive that increasingly widespread use of the local authority's practice model is having a noticeable impact on faster decision-making and informing difficult conversations with families at an earlier stage.

52. Children benefit from strong and important relationships with social workers, who understand them well and demonstrate genuine care and ambition for their well-being and future progress. Increasing use of the local authority's practice model is improving the quality of assessments. Social workers use a range of focused tools and playful activities to earn children's trust and talk to them about their circumstances and hopes for the future. Children benefit from regular visits and the opportunity to speak with their social workers alone. This is the case for children living in Surrey, and for children in care who are placed outside the county. Sensitively completed life-story work helps children to understand how and why they are in care. A pool of independent visitors provide children with opportunities to try new activities and to have fun. Children know how to complain, and independent advocates do support a very small number of children in care, but the provision is not comprehensive enough. (Recommendation)
53. The care council is an active, reflective and well-supported group. Young people with care experience provide peer advocacy for children entering care through face-to-face meetings. An advocacy helpline and widespread provision of 'total respect' training has increased understanding across the local authority, and partner agencies, of what it is like to be a child in care.
54. Care council members told inspectors that, while they value their current social workers, many children in care have experienced numerous changes of social worker. This sometimes makes it difficult for children to build trust with the next social worker, or to believe that they will stay. The Care council also told inspectors about the variable access to resources, such as leisure centres, gyms and the availability of laptops to support learning, across different districts of the county council. This means that not all children looked after in Surrey receive the same level of help and support. (Recommendation)
55. The quality of practice provided for children who are looked after who go missing is not sufficiently rigorous. Return home conversations are not always timely, or of a good quality, and they are not always subsequently cross-referenced to intelligence-based planning to reduce risks to wider numbers of children. Where practice is stronger, there is competent recognition of indicators of risk. Gaps in information are followed up, alongside tight effective multi-agency planning and activity to reduce risks. IROs are punctually notified when children in care go missing, triggering additional oversight of their safety.
56. Children have good relationships with their IROs, and benefit from the stability of this service and their detailed knowledge of children's personal histories. This is particularly important for children when their social workers change. Children attend and participate in regular reviews and their wishes and feelings are clearly taken into account. IRO challenge and curiosity are evident on children's case records, as well as in their reviews. IROs' increasing capacity to conduct midway reviews is an additional helpful layer of oversight of children's progress. IROs sought legal advice and successfully challenged the local authority when it was decided not to provide children looked after with personal advisers at the

age of 16. However, overall, IRO scrutiny and challenge is not widespread or consistent enough to achieve sufficient impact and value for the majority of children in care. (Recommendation)

57. The quality of children's care plans is mixed. Appropriate and helpful use of the practice model methodology supports the assessment and understanding of children's needs. The majority of plans, however, lack specific timescales, or they contain vague and generalised outcomes. This means that there is a risk of drift and delay for children in making progress towards their goals. Social workers generally capture children's views well and use their wishes to inform plans. Stronger examples of plans feature comprehensive and specific recommendations which enable professionals to measure children's progress more readily. (Recommendation)
58. Contact arrangements take account of children's views and their individual needs and are responsive to changing circumstances. Children benefit from being able to have safe contact with parents who may present a risk to them because contact is well supervised and managed. Focused observation by skilled supervisors provides strong evidence of the level of parental commitment and the quality of the relationships with their children. These arrangements help children to maintain important bonds, including with former foster carers and brothers and sisters. Parents are supported and assisted financially to visit children placed outside Surrey.
59. The majority of children live in placements which are stable and which support them to make progress to independence. There is an appropriate intent and focus on keeping brothers and sisters together. Foster carers are well supported to achieve this aim. Children thrive in long-term matched foster placements: there is careful consideration of special guardianship order applications when this is in the best long-term interests of children and their carers.
60. The recruitment of foster carers is recently improving in a highly competitive local environment. Social workers and managers in the fostering service are highly skilled, knowledgeable and experienced. Foster carers speak positively about the support, training and professional recognition they experience. Social workers undertake creative and child-focused direct work, including imaginative life-story work with carers and children. These measures promote placement stability, help build enduring attachments and assist children in understanding their passage into care, strengthening their self-esteem.
61. The timeliness and oversight of initial and review health assessments is a long-standing problem which continues to be a concern. Despite a recent concerted effort by the local authority and health partners to improve the timeliness of initial health assessments, not all children have their health assessed quickly enough when they enter care. Some children do not have regular enough dental checks or have their health needs reviewed on time. Timely health assessments are particularly important for children who have been living for too

long in harmful or neglectful circumstances. A further determined effort was made during the period of the inspection which showed encouraging improvements, but this should be embedded and sustained. (Recommendation)

62. The educational achievement of children looked after in Surrey is a mixed picture. The local authority does not monitor or analyse children's educational progress well. Virtual school staff do not ask for progress information beyond what is in the personal education plans (PEPs), which are not fit for purpose. Overall, school headteachers report that there is a lack of challenge, insufficient support and interest from the virtual school about progress when a child looked after is placed in their school.
63. PEPs are poor. In most, there is no assessment of prior attainment or analysis of needs. There is a lack of clear action plans to measurably inform improved attainment. Children's progress is frequently recorded as either 'expected', or 'less than expected'. When progress is described as 'less than expected', there is no analysis of why this is the case or what measures might improve progress. PEPs do detail better an understanding of children's emotional needs. The virtual school has been auditing PEPs for a year, but has not produced a summary of their quality or provided any feedback and advice to schools about how they can be improved. (Recommendation)
64. The local authority does not monitor the use and impact of the pupil premium funding given to schools for each child looked after. The attendance of children looked after in Surrey had been increasing and exclusion episodes have been reducing. Over the last year, however, these positive trends have reversed and absence rates are now above comparators. (Recommendation)
65. Emerging improvements are apparent. The virtual school has very recently increased the level of engagement with schools, and some headteachers report that virtual school staff are becoming more visible. Virtual school staff arrange a wide range of training for foster carers, school staff and other partners. The take up of this training is high, but the virtual school does not analyse the subsequent impact of it.

**The graded judgement for adoption performance is that it is good**

66. Children with a plan for adoption receive a good service. Adoption is considered for all children who cannot live with their birth family. This includes older children, children with complex or additional health needs, children from minority ethnic backgrounds and brothers and sisters.
67. Once a decision for adoption is made, effective planning enables children to live quickly with their adoptive parents. However, a lack of rigour in early planning before children become looked after means that, for a small minority of

children, the journey to their adoptive family is delayed. This means that these children experience changes of placements during care proceedings and do not always benefit from foster-to-adopt opportunities at the earliest stage. The number of foster-to-adopt arrangements is relatively low, and the local authority is actively seeking to strengthen its use of foster to adopt to promote permanence at the earliest opportunity for children. Early permanence planning for children also includes appropriate special guardianship and connected persons' arrangements; 55 children have secured permanence through special guardianship orders in the past 12 months. (Recommendation)

68. Family finding is rigorous and individual to each child's needs. This, coupled with a 'these children are our children' attitude, is to be commended. Family-finding progress meetings are comprehensive and ensure that tasks are progressed and closely tracked to minimise delay. Linking with potential adopters starts early. Family-finding profiles are regularly updated and provide a real sense of the positive characteristics of the child, but also of current and future difficulties they may face. Information about children and prospective adopters is shared promptly across the south-east partnership. This approach enables children with more complex needs to experience permanence through adoption. This includes foster carers adopting sibling groups and children with significant and complex health needs. The majority of the children currently waiting have links or matches to potential adopters.
69. The local authority is ambitious in seeking permanence through adoption for harder-to-place children. This is clearly good practice, but has had an adverse impact on the local authority's performance in meeting government scorecard targets in respect of the timeliness with which matching is achieved. In all children's cases seen, focused work was being undertaken, and any delays were appropriate in terms of achieving the right plan for those children. For a very small number of children, delays in care proceedings contributed to longer timescales.
70. Competent assessments are undertaken to inform decision-making and plans regarding brothers and sisters living together or apart. The local authority actively seeks adopters willing to offer a home to brothers and sisters. Creative use of media includes the publication of good news stories in order to reach a wider population.
71. Social workers and managers in the adoption service have a wealth and depth of experience and skills to draw on. They know the children, prospective adopters and adoptive parents they work with very well. Practice hubs promote the development of expertise in the service. Managers are strongly committed to developing practice and a wide range of professional development, and learning opportunities are available.
72. Training is responsive to the emerging needs of the service. Adopters who spoke with inspectors said that they felt that the information, support and training they received had prepared them well for the role. They felt supported

throughout the process and particularly valued the support they received from their social workers, 'trusting' them to 'make a match' for them rather than seeking to find a child for themselves.

73. Most stage two assessments are completed within the four-month timescale. Some stage one assessments take longer than the two-month target. This stage is largely adopter-led, and delays are mainly due to adhering to good practice principles, ensuring that preparation for adoption is well considered. However, there are some delays in adopters commencing disclosure and barring and health checks that impact on this timescale. Work is currently underway to strengthen these areas.
74. The adoption panel is chaired by an experienced practitioner. The support and advice from the panel and medical adviser are highly valued. Panel meetings are child-centred, well recorded and demonstrate effective preparation. Sensitive, probing and difficult conversations with proposed adopter approvals and matches to children are evident within panel minutes. Decision-making is transparent, objective and evidence-based. The panel rigorously scrutinises practice and provides a quality assurance function in respect of feedback on the quality child permanence reports and prospective adopter reports and plans. This feedback loop has contributed to improvements in reports, and the large majority of work is of a good standard. Most reports are child-centred, comprehensive, and sensitively written and evidence-based.
75. Timely and child-focused scrutiny of adoption plans by agency decision-makers ensures that children's best interests are promoted. However, for a small number of children, decisions are delayed due to requests for expert assessments or late connected person or special guardianship requests during court proceedings.
76. Many adopters are identified for children within Surrey, but where this is not possible, regional and national processes are promptly pursued. Matching is predominantly effective. Nevertheless, some matching reports could be strengthened by more explicit references to how the child fits within a specific family. Prospective adopters meet with the medical adviser prior to placement, and are given an opportunity to discuss the child's current and potential future physical and psychological needs. Adopters also welcomed the time taken with their social worker to consider children's permanence reports and 'read between the lines' to ensure that they properly understood what was being said.
77. Children adopted are provided with colourful life-story books, which are written in child-friendly language, with lots of photographs, helping to bring a child's history to life. They give a clear overview of the events leading to adoption, which will be of great help to children and their adopters as they seek to understand their life experiences. The quality of later-life letters is variable. Some are sensitively written, informative and child-focused letters, but others are rather impersonal and use too much professional language.

78. There have been two disruptions in the past year. Both of these were for older children. The local authority has a positive approach to learning from disruptions and has implemented a range of different approaches in response. Current work is being undertaken to strengthen the guidance, training and support when placing older children with their adoptive families. The local authority also plans to participate in a pilot to develop virtual reality training for adopters. The training will provide the opportunity for adopters to 'walk in the child's shoes', with the aim of developing greater understanding of the impact of parenting a traumatised child.
79. Post-adoption support is a real strength in Surrey. Children who are adopted and their adoptive families have access to a wide range of support, which is highly valued by adopters. Adoption support assessments and plans are comprehensive and evidence-based, and explore children's experiences, providing sound analyses of children's and adopters' support needs. Highly skilled and motivated social workers provide direct work and support adopted children and their families, as well as facilitating training and support groups.
80. Support includes access to a range of therapeutic specialists, individual work, targeted and universal support groups and family events. One hundred and seventeen children are currently accessing a range of therapeutic interventions through the Adoption Support Fund. Post-adoption support is available to all adopters living in Surrey. One adopter approved by another local authority described the support he had received as 'awesome'. The increasing reach and availability of adoption support has increased demand, and, consequently, a small number of adopters experience a short delay in their assessment being initiated. The service also provides helpful support to birth family members during and after care proceedings, and supports direct and indirect contact to adults who are adopted accessing birth records.

**The graded judgement about the experience and progress of care leavers is that it requires improvement to be good**

81. Despite high workloads for personal advisers (PAs), leaders have improved some parts of the service for care leavers since the previous inspection. However, they acknowledge that the rate of improvement since the previous inspection has been too slow. PA workloads are too high and this has adversely affected several parts of the service for care leavers. Leaders have very recently established an additional leaving care team, but this had not reduced workloads at the point of the inspection. (Recommendation)
82. PAs work well with care leavers, focusing particularly effectively on helping them to stay safe. Risk assessments are clear and specific to individual young people. One young person told an inspector, 'My PA nags me more than my

mum about my safety.' The local authority is in touch with nearly all of its large number of care leavers.

83. Leaders and managers have been effective in improving pathway plans for care leavers aged over 18. Young people are fully involved in developing their plans. They are detailed, yet achievable, clear and specific. Rigorous and regular management oversight of pathway planning ensures that all are reviewed, with helpful comments directly addressed to young people by supervisors, demonstrating a young person-centred approach. However, pathway plans for young people aged 16 and 17 that are carried out by social workers in other parts of the service are less effective. They do not capture the young person's issues and needs with the same detail, depth and specificity.  
(Recommendation)
84. Most young people's health needs are assessed, and important needs are addressed promptly. More routine matters, such as ensuring registration with a GP or dentist, have been adversely affected by high PA workloads and too many young people are not registered. Some young people have not had a recent health assessment. Young people's mental health and emotional support needs are met well. The care leaving service has three mental health workers, who provide continuing care over the crucial transition period to adult services and beyond. These workers also help young people with more serious mental health difficulties to access adult mental health services.
85. Care leavers are not provided with details of their health histories. Managers acknowledge that the current document is neither comprehensive nor young person friendly. A much better 'health passport' has been devised with young people and is planned to be rolled out in April 2018. Managers acknowledge that it has taken far too long to reach this point. (Recommendation)
86. Foster carers, PAs and accommodation support staff all work well to help care leavers develop confident independent living skills. Contracts with accommodation providers address this vital area of skills training comprehensively. PAs closely monitor how well providers develop the young person's skills. In a recent local authority audit, the large majority of young people reported favourably on the support provided in this area. Accommodation providers submit regular progress reports, which are detailed and comprehensive about the skills development of each young person. The care leavers' service is currently developing the use of a well-known and evidence-based outcomes framework to better track young people's progress in important fields.
87. Transition planning for young people looked after aged 16 and 17 years is weak. The local authority does not routinely allocate a PA to a young person until they are approaching their 18th birthdays, and in some cases shortly afterwards. Care leavers report that one impact of this is that PAs do not always have enough time to help them prepare and move to new accommodation. At the time of the inspection, 68 care leavers were in 'staying

put' arrangements with their former foster carers and the local authority is working purposefully to increase the use of 'staying put' further.  
(Recommendation)

88. Leaders and managers focus effectively on helping young people find education, training or employment. As a result, the proportion of care leavers aged 17 to 19 who are not in education, employment or training (NEET) is comparatively low. Approximately a third of 19- to 21-year-olds are NEET, which although lower than typically reported elsewhere, indicates that efforts to increase participation should continue. The local authority has worked diligently to increase the number of young people who are on apprenticeships, both with local employers and the local authority. Currently, there are 36 such apprentices, but only seven of them are care leavers. Careful communication with local employers has helped to identify high-quality training opportunities, including with a national construction company. PAs work well to support young people to engage in further and higher education, and 37 were attending higher education courses at the time of the inspection.
89. Many young people are positive about themselves. However, some reported that senior leaders and managers do not show sufficient pride in their achievements, however small and incremental these might be. The local authority has previously provided celebratory events, but some of these have been cancelled due to resource constraints. Positively, one event highly valued by young people has just been reinstated.
90. The local authority provides a wide range of suitable accommodation to meet the differing needs of care leavers. The proportion of young people living in appropriate settings is high and above the national average. Contract monitoring is rigorous and regular, ensuring that good standards are maintained. Living arrangements are safe, providing young people with the right level of support for their individual needs, and developing their independent living skills. An example was seen of prompt and effective action being taken when standards slipped with one provider. Accommodation provision is regularly reviewed to add further improvements. A bespoke hostel provision, which effectively assesses and supports newly arrived unaccompanied asylum seekers, has been fully occupied since its inception in 2017. The local authority is in the advanced stages of plans to further improve accommodation through introducing a 'dynamic purchasing system' to offer a greater variety of providers and range of support offers.
91. The local authority provides information for young people on a range of entitlements and services. However, care leavers report that sometimes their PAs are too busy to discuss and advise on their entitlements. Consequently, young people are not sufficiently aware of all their entitlements. A small number of young people who spoke to inspectors were not aware of the allowance they are entitled to, to help buy essential items when they move to independent living. (Recommendation)

<b>Leadership, management and governance</b>	<b>Inadequate</b>
<p><b>Summary</b></p> <p>The overall pace of change following an inadequate judgement inspection has been too slow. The learning from monitoring visits, external reviews and internal audits has not led to sufficient progress in a number of critical practice areas. This has been compounded by a largely ineffective improvement board, which has not had sufficient impact across the partnership to deliver practice improvements in a timely way. This means that children do not always receive a safe and effective service, leading to some worrying examples of drift and delay in the face of escalating risk for the most vulnerable children</p> <p>More focused partnership working is evident in the last few months, following a recent change of leadership in children’s services, and including the appointment of a new interim DCS in October 2017 and a newly appointed LSCB chair. While these are encouraging developments, the standard of social work practice and management oversight remains inconsistent.</p> <p>There is evidence of a positive change in culture since the appointment of a new interim DCS in October 2017. Current leadership is more visible and approachable. Senior managers are more informed about frontline practice, and there is an honest acceptance of practice deficits. However, this has not yet led to sustained and effective change on the scale that is required.</p> <p>The foundations for a more supportive learning environment have been recently introduced through the roll-out of a recognised model of social work practice. This is in the early stages of helping social workers frame their thinking about risk in a strength-based way. It has not yet led to consistent improvements in child-centred practice, which is still too variable across the service. This results in crisis-driven plans, delayed assessments and an inconsistent response to risks faced by children. There remains an uncertain understanding and application of thresholds, resulting in the MASH being overwhelmed by inappropriate referrals. A recently revised early help offer is not yet fully embedded.</p> <p>Staff turnover in some parts of the service is relatively high, and although extra social workers have been provided in response to increasing demand at the front door and assessment teams, children still experience too many changes of social worker. Social workers have told their managers that they do not always feel well equipped to deal with complex risk. In some teams, their caseloads are too high and supervision is sometimes a ‘tick-box’ exercise.</p> <p>The strategic approach to child sexual exploitation has improved, with some evidence of better partnership working at district borough level. Performance on</p>	

return home conversations has been poor, and there is only very recent evidence of improvement following recently introduced revised arrangements.

## Inspection findings

92. The local authority accepts that the pace of change has been too slow and the quality of practice inconsistent, as evidenced in its children's improvement plan. This is partly due to a pattern of denial following the last inspection, including a lack of both effective partnership work and urgency to introduce whole system improvement. There has also been insufficient rigorous challenge and scrutiny from the LSCB and elected members. Governance arrangements between the LSCB and the Improvement Board have been recently and helpfully strengthened and clarified. The Health and Well-Being Board has been too adult-focused and, until recently, was not focused enough on the experiences of the most vulnerable children. (Recommendation)
93. There have been some improvements in recent months, and this has led to a more focused vision and leadership approach. The interim DCS and newly appointed LSCB chair have firm plans in place to review the levels of need threshold document, the effectiveness of the MASH and the partnership response to early help. These are important initiatives, as the inconsistent application of thresholds and the low take-up of the lead professional role across the partnership have been longstanding concerns, and this has resulted in too much drift and delay for children. Senior leaders and managers have much more to do to ensure that serious weaknesses are fully addressed with pace and determination. (Recommendation)
94. Commissioning priorities are linked to a detailed understanding of the needs of local communities, based on a joint strategic needs assessment. These are aligned with sufficiency statements and financial priorities. In response to increased demand and a growing child population, the 10 commissioning priorities include an appropriate focus on the transformation of early help, a reduction in out-of-county placements for children in care and an increased level of support to improve the emotional health and well-being of children, particularly of those in care. This has led to an improved child and adolescent mental health (CAMHS) offer, jointly commissioned with six clinical commissioning groups across Surrey. These include a range of therapeutic services to children on the edge of care, such as the Hope and Extended Hope outreach services, out-of-hours 'Havens' and dedicated mental health support in schools. However, support is not always timely, responsive or effective for the most vulnerable children.
95. There are too many children looked after placed far away from home rather than close to their own local communities. Surrey is part of a regional commissioning framework and has a number of block contracts for challenging teenagers, with plans to tender for more. However, this has not yet led to sustained improvements in sufficiency planning. While there is evidence of tighter contract management regarding poor performance on return home

conversations for missing children, new arrangements are yet to deliver demonstrable improvements, and data is not yet routinely collected.  
(Recommendation)

96. Current senior leaders have recently made welcome efforts to listen to staff more regularly through a series of practice conversation workshops. Staff have advised leaders that they are worried about the inconsistent application of thresholds, the variability of management oversight and high caseloads in some teams. New practice expectations for social workers, managers and leaders have been developed in response, but are not yet embedded to ensure a more consistent approach across the service. There are also missed opportunities to ensure that social workers have the right basic tools for their work. This includes the lack of early provision of training to use the electronic recording system, and unwieldy and time-consuming efforts expended accessing information across three separate databases. (Recommendation)
97. Partnership working is not always effective or sufficiently focused on children's needs. This has limited the ability to drive sustained improvement in relation to weaker areas of performance. For example, the ambition to reduce the number of inappropriate police referrals into the MASH has not been realised, despite repeated efforts, and this has continued to adversely impact on the timeliness and quality of decision-making at the front door. Partnership arrangements have been ineffective in addressing the poor timeliness of initial health assessments and some initial child protection case conferences. This means that some of the most vulnerable children, who have experienced abuse and neglect, wait too long to receive appropriate help and support.  
(Recommendation)
98. A more committed, strategic response to child sexual exploitation has led to additional strategic partnership posts, increased awareness raising and a new risk management process to replace an earlier model that was not wholly effective in assessing and reviewing risk. There is a more joined up, centralised approach to 'Prevent', improved partly in response to a very recent learning review involving an unaccompanied asylum seeker in foster care. However, the roll out of 'Prevent' awareness training across the partnership needs to be much more clearly evidenced, to ensure that all foster carers and other frontline professionals have timely access to the right level of support to keep children safe.
99. The corporate parenting board has had a mixed impact on improving services and outcomes for children in care. The board has a wide membership and has listened carefully to children about their concerns in relation to frequent changes of social worker. 'Total Respect' training has been rolled out widely across the partnership and has raised more awareness of the needs of children looked after. However, the board has not ensured an equitable and consistent approach to some fundamental entitlements, including access to laptops and leisure facilities in different parts of the county. The timeliness of initial health assessments is poor and the quality of PEPs is concerning. The impact of early

delays on securing permanence for children who become looked after is not sufficiently understood by the board. (Recommendation)

100. Very recent progress during the course of the inspection on improved take-up of timely initial health assessments clearly demonstrates that more determined, collaborative leadership results in rapid improvements. However, a range of strategic partnerships boards have been aware of this, and other issues, for some considerable time, and have failed to resolve them quickly enough for children. Many children in care have waited months for an initial health assessment from their corporate parent, which is unacceptable. (Recommendation)
101. The care council is an active and vocal group which does not always feel it is listened to in a meaningful way. This has led to a perception from some members that the views of children in care are sometimes sought by senior leaders and managers in a tokenistic manner. (Recommendation)
102. The rationale for continued weak areas of performance is unclear, and the scrutiny of performance has not led to sufficient progress or clear action plans to improve a number of important practice indicators. As demand has increased at the front door, there has been a deterioration in the timeliness of assessments, initial child protection case conferences and initial health assessments. A comprehensive monthly performance compendium is now produced through use of a more effective data collection tool. Data integrity issues that had adversely affected the reliability and quality of analysis have recently been resolved. (Recommendation)
103. Management oversight of practice is too variable in quality, and a source of concern for some social workers. Senior managers have made progress in achieving more regular recording of frontline management decisions, but this does not always guide and support social workers' learning and engagement with difficult issues in their work with children and their families. Mandatory management supervision training has been undertaken in recent months, and it is hoped that this will lead to a more consistently effective approach to supervision in the future. (Recommendation)
104. The uncoordinated response to children in pre-proceedings is a further example of ineffectual management that has adversely impacted on some of the most vulnerable children living in neglectful and abusive circumstances. The local authority is aware of this shortcoming and has plans in place to recruit dedicated staff to monitor and track performance. However, this is a further example of a very late response, given the longstanding concerns about drift and delay in both pre-proceedings and subsequent care proceedings, and should have been in place much sooner. (Recommendation)
105. A range of improved initiatives illustrate a more systematic approach to quality assurance with better engagement of frontline staff and managers. Quality assurance activity has highlighted ongoing considerable uncertainty about the

quality of decision-making, and the continuing prevalence of widespread practice deficits across the service. Themed audits are undertaken by the practice, quality and learning team. The findings from audits and performance data inform the content of seven practice challenge hubs held across the service. DCS assurance meetings are held with the chief executive fortnightly to review progress. An external independent audit of 327 cases of concern was undertaken following the last monitoring visit. A mapping exercise of 270 children on a child protection plan for a second or subsequent time has been completed. Threshold meetings are held, reviewing approximately 200 cancelled assessments each month. (Recommendation)

106. Quality assurance measures do not yet challenge effectively or quickly improve persistent practice deficits or a lack of appropriate response to risk. Significant delays in completing serious incident notifications is a further indicator of this trend. The new approach to quality assurance is a positive measure, but it is not yet sufficiently rigorous or mature to accelerate consistent improvements for the most vulnerable children. (Recommendation)
107. Complaints are largely addressed at an early stage, avoiding recourse to formal investigations. Helpful and well-established formal and informal routes for resolving issues quickly, including restorative approaches, are in place. The number of children making a formal complaint has increased on the previous year, and half of these complaints have been partially or wholly upheld. Recurring themes concern the quality of service, communication, decision-making and the responsiveness of staff.
108. Relationships with the children and family court advisory and support service (CAFCASS), the family courts and the local family justice board have improved following an increased focus by current senior managers. Delays in care proceedings are not yet fully resolved, however, which has resulted in a recent decline in performance against the 26-week timescale. This is attributable to a history of poor compliance with court scheduling timescales and an earlier lack of oversight for children in pre-proceedings. There is also a perception in the judiciary that the quality of legal advice is not always assured and confident in the most complex cases.
109. The turnover of staff has increased in recent months in some parts of the service. There is a significant reliance on locum social workers, and temporary social workers comprise half of the establishment in the MASH. Additional capacity is provided by a peripatetic team of locum social workers. Recruitment is underway to establish a second team, to address staff shortfalls across the service, particularly in assessment teams. Although retention is reported to be a key priority, there is much more to do to reduce a continual turnover of staff and high caseloads in some teams, in order to build a more stable, permanent workforce.
110. Staff training has been prioritised around child sexual exploitation, 'Total Respect' and the implementation of a recognised strength-based model of

social work practice, which has recently replaced the 'Safer Surrey' approach. The existence of two practice frameworks was felt to be too confusing. A highly regarded assessed and supported year in employment academy model supports newly qualified social workers well in their first year, encouraging many to remain in Surrey.

## **Information about this inspection**

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven Her Majesty's Inspectors (HMI) from Ofsted.

### **The inspection team**

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