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Dear Ms Smith

Focused visit to North Somerset local authority children's services

This letter summarises the findings of a focused visit to North Somerset local authority children's services on 19 March 2019. The inspectors were Nicola Bennett, HMI, and Diane Partridge, HMI.

Inspectors looked at the local authority's arrangements at the first point of contact for children who need help and protection in accordance with the Inspection of Local Authority Children's Services framework (ILACS). Specifically, they considered contacts, referrals, assessments and plans for children in need of help and protection.

Inspectors considered a range of evidence, including case discussions with social workers and managers and other staff working in the referral and assessment team and locality teams. They also reviewed the local authority's performance management arrangements, quality assurance information and children's case records.

Overview

North Somerset children's services were last inspected by Ofsted in 2017, when the overall effectiveness of services was judged to require improvement to be good. Since then, senior leaders have focused on improving services for vulnerable children. However, not all areas identified for improvement have been fully addressed. The range of performance information available to senior leaders is not comprehensive enough, and they do not have sufficient oversight of the quality of

frontline practice and the timeliness of interventions to safeguard children in this part of the service.

When risks of harm are obvious at the point of contact with the local authority, concerns are responded to promptly. However, when further information is required to inform next steps, there are often delays in completing multi-agency checks. Inspectors identified over 50 contacts where information gathering was not timely, leading to delays of up to two weeks in decision-making. Children for whom there are safety concerns are not always visited as a matter of urgency, and some are not seen before enquiries are completed. Senior leaders were not aware of this poor practice until it was raised by inspectors.

Good partnership working in the 'one front door' service, which responds to domestic abuse notifications, results in effective decisions that safeguard children. Thresholds are applied appropriately by partners. Once children are seen, the interventions of referral and assessment and locality teams to meet their needs are proportionate.

Too many children do not have an allocated social worker. This includes children subject to child protection planning and in care. At the time of this visit, there were more than 60 children managed on a duty basis, including a small number whose cases had remained unallocated for five months.

Areas for priority action

The local authority needs to take swift and decisive action to improve the following areas of practice:

- all children requiring an assessment or service, in particular children subject to child protection planning or in care, should be allocated to a social worker without delay
- the timeliness, effectiveness and management oversight of decision-making when children first come to the attention of the local authority.

What needs to improve in this area of social work practice

- the timeliness of visits to children subject to child protection enquiries, commensurate with their circumstances
- the timeliness of assessments and the quality of planning
- the quality and range of performance management information available and used by senior leaders to understand and monitor children's experiences and the quality of practice.

Findings

- Thresholds are understood and applied by partner agencies and lead to timely referrals to children's social care. Parental consent for the local authority to gather and share further information is gained in the majority of cases, and when decisions are made to override consent they are appropriate. Social workers and managers do not always make the necessary multi-agency checks to inform decision-making. As a result, a small number of children do not receive the right level of intervention and support to address their needs at the earliest opportunity.

- When risks to children at the point of contact with children's services are clear, timely decisions are made. When children's needs are less obvious, too often there are delays in decision-making while further information is gathered, leaving children for too long in circumstances of unassessed risk or without the help and support that they need to improve their circumstances. Capacity issues within the referral and assessment team are leading to cumulative delay in decision-making for children, and management oversight and grip are weak due to an absence of effective tracking systems.

- Where there are concerns for the safety of children, strategy discussions are timely. Since the last inspection, the local authority has worked with partners to improve the attendance of key agencies at strategy discussions held in the referral and assessment team. While these efforts have led to improvements in police attendance, health professionals are not routinely present, and this is not compliant with statutory guidance. As a result, opportunities to share information to inform assessment of risk and actions are missed.

- Action planning arising from strategy discussions is not consistently rigorous or timebound, leading to delays in completing child protection enquiries. Children are not always seen or they are not seen with sufficient urgency as part of these enquiries to ascertain their welfare, leaving them for too long in situations of unassessed risk.

- Too many children remain unallocated to a social worker for long periods of time. Managers regularly review these children, and duty workers undertake necessary tasks. This does not support children and parents to develop trusting relationships with workers in order to effect positive change. Not all children subject to child in need plans are being seen on a regular basis, or are having their needs assessed or their plans actively progressed in order to improve their circumstances within reasonable timescales.

- Within the 'one front door', agencies work well together and provide an effective, coordinated response to children and families where domestic abuse is a feature. Police notifications to this service are not consistently timely,

leading to unnecessary delays in children being seen, and the assessment of risk and provision of services by agencies.

- Young people who present as homeless are informed about their rights and entitlements, with clear explanations provided to help them make informed decisions. A good range of housing options are available, and children live in suitable accommodation.

- The out-of-hours service is effective. The service provides an appropriate and timely response to ascertain and respond to children's circumstances. There is timely notification and handover to the referral and assessment team. Arrangements for considering and responding to allegations made against adults who work or volunteer with children are timely and effective.

- The majority of assessments are up to date and of good quality and include clear analysis of risk and needs. Children's voices and experiences are clearly articulated in most assessments. While the timeliness of assessments is improving, not all assessments are completed within timescales that reflect children's circumstances. Assessments do not always contribute to effective planning.

- Initial child protection conferences are mostly timely and well attended by agency partners. There is clear analysis of risk and needs. However, plans for children are too variable in their quality. Better plans are leading to timely improvements in children's circumstances. Many plans do not include clear, timebound actions, and are not specific enough about what needs to change to improve children's circumstances. This makes it difficult to hold workers, agencies and sometimes parents to account. There is an absence of contingency planning in the vast majority of children's plans.

- Social workers in the locality teams know their children well and are committed to improving their lives. They undertake regular, purposeful visiting and direct work to help children and to inform planning. For some children, changes of social workers mean that they do not have the opportunity to develop trusting relationships or to be heard.

- Senior leaders have worked hard to create a working environment that supports good practice. Social workers have manageable caseloads and are supported to develop their knowledge and skills through a comprehensive learning and development offer. Both these strategic initiatives contribute to high morale across the service, as well as improving the quality of social work practice and interventions. A consequence of managing social work caseloads is that too many children remain unallocated for too long. This is an issue that senior leaders have failed to address.

- Supervision takes place on a regular basis and increasingly provides opportunities for reflection and risk-based analysis of children's' circumstances. When actions for workers to complete are identified, they are not consistently timebound or revisited.

- Managers are increasingly using available team performance information, supported by a bespoke development programme, to inform and improve practice within their teams. For example, the timeliness of single assessments has improved, although senior leaders recognise that there is more to be done to ensure that assessments are completed within a timescale that is right for individual children.

- While regular auditing of practice is taking place, the current programme does not always assist leaders in identifying and prioritising areas for improvement. Individual case audits are too variable in their quality and do not consistently include SMART actions. Currently, there are no mechanisms for senior leaders to be assured that actions identified in audits are progressed and to evaluate the difference that this is making to improving children's circumstances. Learning from case file audits is not currently collated to identify themes or trends, identify practice deficits and inform service improvements. As a result, auditing of casework does not effectively contribute to practice improvement.

- The quality and range of performance management information used by senior leaders to understand and monitor children's experiences is not sufficiently comprehensive. It does not provide a clear view of frontline performance and the quality of practice, particularly the timeliness of decision-making, undertaking child protection enquiries and seeing children. While aware of the deficits, senior leaders have not developed alternative means of obtaining this information. As a result, their oversight of practice in this part of the service is insufficient.

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

Yours sincerely

Nicola Bennett
Her Majesty's Inspector