Report of the Non-Executive Commissioner for Children's Services in Surrey

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1. Introduction

1.1. This is the report of the non-executive commissioner for Surrey County Council's children's services, who was appointed following the Ofsted inspection carried out under the Single Inspection Framework between 26 February and 22 March 2018. The Ofsted report was published on 16 May 2018[1]. Ofsted rated Surrey's children's services 'Inadequate'. Following consideration of the report, the Secretary of State concluded that the Council is failing to perform to an adequate standard for some or all of the functions to which Section 497a of the Education Act 1996 is applied by Section 50 of the Children Act 2004 (children's social care functions). I was appointed Commissioner for Children's services in Surrey on 25 June 2018. The Statutory Direction and Terms of Reference are published on gov.uk[2]. My primary focus as the Commissioner is the 'presumption test', that is "In cases of persistent or systemic failure, children's social care services will be removed from local authority control for a period of time in order to bring about sustainable improvement unless there are compelling reasons not to do so".

1.2. The aims of my review include:

- giving the Council the opportunity to provide evidence that it is taking decisive action since the Ofsted inspection and is no longer failing to perform to an adequate standard in the delivery of its children's social care functions;
- assessing the Council's capacity and capability to improve itself – within a reasonable timeframe – and to sustain improvement long-term; and
- advising the Minister on whether an alternative delivery and governance arrangement for children's social care, outside of the operational control of the Council, for a period of time, is required to bring about lasting improvement.

[1] Ofsted (May 2018) 'Surrey County Council: Reinspection of services for children in need of help and protection, children looked after and care leavers', https://files.api.ofsted.gov.uk/v1/file/50004443
[2] DfE (June 2018) 'Statutory Direction issued to Surrey County Council', https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719611/2018.06_Statutory_Direction_to_Surrey-Council.pdf

2. Executive summary and recommendations

2.1. The Ofsted inspection of Surrey County Council's children's social care services conducted in March 2018 identified serious failings in the overall effectiveness of its performance in helping and protecting children. The report also highlighted the failure of Surrey County Council over several years to establish and deliver an effective programme of improvement to rectify the shortfalls identified in successive inspections. There is evidence, then, that until recently the Council has not fully recognised the extent of its failure and the impact of this on the most vulnerable children and young people living in Surrey. There has been a persistent failure in the leadership of its children's social care services and a failure by the Council to appoint a leadership team with the capacity and capability to effectively improve its children's services.

2.2. However, there is clear evidence that the political leadership of the Council has now accepted the need for change. This is illustrated by the Council's success in attracting and appointing a Director of Children's Services (DCS) with a proven track record in bringing about significant improvements in children's services and a Chief Executive who fully recognises the challenge of the task ahead and the pre-requisite of full corporate support to eventual success. There is, of course, a danger of over-reliance on these two individuals, when the contribution of other system leaders is critical, although that is inevitable at this stage on the improvement journey.

2.3. There are aspects of practice that are still not yet compliant with Working Together to Safeguard Children[3] and the DCS recognises that the system is not yet safe. This requires urgent attention by his practice leaders. He has been concentrating on structure and strategy and building a leadership team that he can have confidence and trust in to make the right changes for children and families. There are several experienced individuals working in the new team. He is introducing best practice from around the country and there are several examples already of such innovation. However, there has not been time yet to establish a coherent model of social work. He recognises that more needs to be done to engage staff and partners in his vision and the process of change. The leadership team are aware of this and this needs to be the next step. The 'Ofsted Priority Action Board' has been established under the independent chairmanship of John Coughlan, an experienced Commissioner, with a particular aim of engaging partners in the improvement journey. There is also more work to be done to enable Members to hold the leadership team to account effectively for the performance of its children's services, including how to measure progress on the improvement journey.

2.4. It is too early to make a secure judgement about whether the steps that have and are being taken will bring about sustainable improvement in the effectiveness of

[3] DfE (July 2018) 'Working Together to Safeguard Children', https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

children's social care services in Surrey. The Council now recognises and accepts the depth and complex nature of the issues it faces in children's social care. It has appointed a sector leader as the DCS and a Chief Executive who understands the challenge and how to support her DCS and what to look for. However, it is too early to expect the improvements required to rectify the deep and long-standing problems identified by Ofsted and confirmed by my review. Given the clear intention of the Council and significant resources allocated to the task, at this early stage I do not believe that taking the Service out of the control of the Council will accelerate progress, rather that it could serve as a distraction to the considerable efforts of the DCS to make the necessary improvements. It is for these reasons, I recommend that the Minister allow the Council a further 12 months to demonstrate that the action plan it has put in place is working. It is particularly important that there is continuity in an ongoing dialogue to monitor improvement in addition to the monitoring visits by Ofsted. I would, therefore, also recommend that Commissioner oversight should continue with further reviews and assessment of progress against the findings of this first review in around 6 and 12 months. In my view, this would strike a proper balance between concern arising from the previous 'false starts' and an acknowledgement of the recent but palpable change in the attitude and approach by the Council to bring about sustainable improvement.

3. Methodology

3.1. My approach, agreed with Surrey County Council and the Department for Education (DfE) at the set up meeting on 12 July 2018, has been to use experienced leaders and managers and practitioners from Cornwall Council to assist me in a deep analysis of the current quality and impact of practice in helping and protecting children, the impact of the changes made so far, and what needs to happen. I interviewed senior Members of the Council and senior officers of the Council and partner organisations. I also spoke to John Coughlan, the independent Chair of Surrey's 'Ofsted Priority Action Board'.

3.2. I was assisted in my review by on-site visits undertaken by six senior social work managers, three other senior managers (psychology, commissioning and business support), six middle managers and two practitioners. The team included the Principal Child and Family Social Worker and specialists in the operation of the front door, early help, children in need, court work, children in care, care leavers, workforce development, partnership working, commissioning and business support (systems and reporting).

3.3. The review was undertaken through six two-day visits (Woking, Leatherhead and Redhill) and discussions with over 170 staff both individually and in groups from the four "quadrants" that form the Surrey operational delivery model. The team met over 60 representatives and practitioners from partner agencies including schools, voluntary organisations, the police and health agencies. Some young people and parent/carers were seen. Referrals and contacts were tracked. Over 50 recent cases were audited, including supervision records. Written documentation including performance data was studied.

3.4. The review team was led by Jack Cordery, Service Director for Children and Family Services, who contributed to the work of the Social Work Reform Group and the Munro Review of Child Protection. He was a member of the Children and Family Faculty of the College of Social Work and a senior sector representative on the development of the Ofsted Single Inspection Framework.

3.5. I provided initial feedback to the Lead Member for Children and Families, the DCS, his leadership team and the representative of the DfE on 5 September 2018. The discussion was open, appropriately challenging and constructive. The DCS and his leadership team that were present accepted the findings, which reflected their own analysis.

3.6. My team and I were made very welcome by officers and every assistance was given to enable the review team to gain a good understanding of the issues facing the Council and how the changes put in place are bringing about improvements. It was particularly helpful that the DCS actively encouraged staff and partners to be as open as possible in discussions with the review team. This has been crucial in forming an accurate appraisal as the basis of my recommendation.

4. Context

4.1. The serious underperformance in children's social care services in Surrey are widespread and long-standing. There was a variety of views among senior managers, partners and members but all agreed that the issues have not been properly resolved or effectively addressed for at least 10 years and quite possibly for many years prior to that. There have been several 'false dawns'. This has been coupled with an unwillingness or inability by the Council to accept the findings of inspections, understand its own performance data and acknowledge the risks to children of failing to provide effective services in line with raised standards. This denial was seen as the main barrier to change and improvement.

4.2. The Corporate Leadership Team until recently have not recognised or delivered the kind of specialist leadership that is required at the DCS level. Previous improvement initiatives, though well intentioned, appear to have lacked the necessary expertise and insight to prioritise the things that deliver improved services to children and young people and their families in Surrey. A telling quote from a long-serving member of staff is, "We've restructured so often and changed so little". This member of staff succinctly sums up the previous attempts to improve the effectiveness of Surrey's children's services. However, another telling quote from another long-serving member of staff is, "This time it feels different."

4.3. The Chief Executive was appointed on 5 March 2018 and the DCS was appointed on 30 April 2018 following the latest Ofsted inspection. These senior appointments are of fundamental importance to my recommendation because they demonstrate two significant differences in the response of Surrey County Council to previous failures in Ofsted inspections. Firstly, I have found consistent acceptance from both senior members and senior managers of the fundamental change they need to bring about in children's services in order to raise them from a rating of Inadequate. Secondly, a specialist DCS with a proven track record in delivering improvement and a positive reputation in the sector has been recruited to lead the improvement journey.

5. People and Leadership

5.1. The DCS recognises the depth of the challenge and has taken significant immediate action. This includes introducing a new quality and audit system overseen by external auditors; the 'no wrong door' approach pioneered by North Yorkshire; the 'family safeguarding' model introduced by Hertfordshire; a fundamental review of early help; and an analysis of the front-door by Essex. These are appropriate initiatives and have, of necessity, been coupled with an extensive change in the senior leadership team, the engagement of interim managers, the implementation of a new structure, and recruitment to the structure. The new and emerging senior management team is negotiating the difficult balance required between taking immediate action to 'fix' unsafe elements of the system and embedding longer-term cultural change. The DCS is fully aware of the risk of bringing in too many new ideas at once through engaging external help. However, given that Surrey has been reluctant in the past to look outside the authority for assistance, the learning culture he is seeking to develop is an appropriate and important approach. It will be important to follow on from this positive start quickly, with change processes that engage staff and make them the most important part of the improvement journey. Staff and partners told the review team that they do not yet feel involved in the analysis and solutions and are not yet clear about the way ahead and what is expected of them. This is a priority for the leadership team and an important success measure. Measures for progress are being developed but not yet understood by staff at this early stage in the improvement journey.

5.2. Despite the significant resource issues facing children's services nationally, the Council appears determined to fully resource the improvement journey. This will require continued commitment from members and the corporate leadership team. The findings of the Ofsted report in 2018 are widely accepted. Staff and partners showed enthusiasm in wanting to contribute to improvement. The service has many committed and skilled staff and the review team found some evidence of good practice and innovation. Staff morale appears strong and staff generally said they feel optimistic about the future. Much of this optimism is because of confidence in the reputations of the new DCS and Chief Executive. The changes at the senior level in children's services are accompanied by changes in senior management across the Council and this is welcomed by staff. There is an openness and willingness to learn from best practice elsewhere.

6. Service Effectiveness

Front-Door – the 'MASH' (Multi-Agency Safeguarding Hub)

6.1. The front-door is not fit-for-purpose or compliant with Working Together to Safeguard Children. The review team studied the May 2018 performance compendium data and a concern is the volume of contacts that do not go onto intervention for children and families. This is an area that warrants further exploration. The MASH is based in a police station. The head of the MASH is a retired police officer and 60% of all contacts received in the MASH are from the Police. There is an undue reliance on child protection strategy discussions, which are not always undertaken in a timely way, involving the right people. The assessment teams have rooms booked Mondays, Wednesdays and Fridays each week to hold strategy meetings – but the conversion from s47 enquiries to initial child protection conferences is less than 40%. Observations confirmed that the current practice is police-led, risk averse and disproportionate to the nature of referrals. This risks a lack of prioritisation and overwhelms the social work teams.

6.2. The service manager in the MASH is a social worker, but there is a disconnect between the strategic lead and the operational development that I feel causes the social workers to feel overwhelmed, not confident, valued or listened to. There is no consistency in decisions on thresholds as they are decided by too many managers. The service manager has a clear understanding of the areas for improvement in the MASH but until recently has been unable to make changes due to a disconnection with senior management and the fact that partner agencies are not fully sharing the responsibility to safeguard children beyond the MASH. This problem is amplified by a poor understanding of thresholds.

6.3. There is no whole-system approach or unified model of social work though this is now in development and recognised as a priority. A high re-referral rate (28%) indicates that the system is not working and is still unsafe. Contacts and referrals being made, including those at a universal level, leave the MASH overwhelmed and unable to prioritise the focus on safeguarding and making decisions within timescale to be compliant with Working Together to Safeguard Children. The culture observed by the review team was one of being risk averse, assessments being completed in a transactional way, limited purposeful work being undertaken with families and then cases being closed resulting in high re-referrals.

Early Help

6.4. There has until recently been no clear strategic vision for early help. The services are fragmented and operate in silos across the two-tier Council model. Partners are confused about the early help offer and early help does not have the necessary high profile across the system. Staff and partners reported a lack of communication and inconsistencies. There is a significant early help budget to support many staff, buildings

and managers but there are too many panels, boards and meetings without an overarching strategy and direction. There is little evidence of impact.

Help and Protection

6.5. The lack of coherence and consistency in the delivery of early help is reflected in help and protection. Repeat referrals, assessments and interventions are commonplace with a lack of purposeful intervention and focus on impacts and outcomes. Social work was seen to be skewed by the police agenda and decision-making was too disbursed and variable. In too many cases, decisions were being made without sufficient information or contributions by partners. The system required too numerous changes in worker.

Children in Care

6.6. The Council has 50% of its children in care and care leavers placed out of county. As these children are not living in local communities, the experience of the child in care or care leaver is often “rootless”. Providing good support to children in these placements and improving children’s outcomes is a complicated process. The placements are costly. Fundamental practice like undertaking initial health assessments and personal education plans are significant problems. The health assessment of children looked after has been an unresolved practice issue for several years, showing that the challenges faced by the Council are systemic, involving the wider partnership and not just the Council’s services.

6.7. The Council is aware of its long-standing difficulties in delivering good enough corporate parenting and acknowledges it is not getting good enough outcomes for the children in its care. Children are being seen and plans undertaken but this appears to be a primary focus and seen as an end in itself rather than being purposeful in developing a positive relationship and focussed on improving outcomes. Workers at many levels are aware of the problems and it will take some time to progress to a good level. There is recognition that the approach taken in the past needs to change and that staff and partners must work together with the new senior management team on the basis of a clear methodology and approach to supporting children in care, such as recovery plans.

Quality Assurance and Performance Management

6.8. For many years and until recently, there has been a lack of clear and consistent leadership and direction, compounded by a fragmented silo-based structure. In these circumstances, a quality and performance management system cannot function effectively and this has been the case in Surrey. There are some enthusiastic and motivated individuals within the data team, who were able to identify issues and challenge but felt that under previous management and leadership they had not been able to bring about the changes required. A performance management data set has been implemented and made available but there are significant issues with compliance, understanding, and data quality. System management is fragmented and governance in

terms of system change has not worked well. There has not been best use of functionality within the system nor until recently a full review of the system since its implementation in 2010. An area of concern is that the system based records for social care and early help are in different modules of the Liquid Logic system and it does not appear to be possible to see all information about a child necessary to make safe decisions, without accessing both models separately. The DCS and new leadership team are fully aware of the fundamental importance of these issues and a new 'Design Authority' has been recently introduced. It is too early to comment on its effectiveness in improving the quality of data and its use to monitor progress on Surrey's improvement journey.

7. Summary

7.1. An effective children's social care system that can deliver positive outcomes for children requires an underlying theoretical model supported by evidence-based practice. This needs to be underpinned by practice quality standards and an operating model that supports those standards. Social workers and other staff need this as the basis of understanding what good looks like and to know what is expected of them. They need to participate in setting the standards. Only when these are in place can a quality assurance and performance management system be effective. The nationally accepted work of Eileen Munro and Moria Gibb in raising the status and expertise of social workers through rigorous professional development and reflective supervision are the reference points to why this is essential to bringing about sustainable improvements in children's social care.

7.2. For many years, there has been no coherent children's social care approach or model in Surrey to support best practice. Until this fundamental issue has been fully addressed, the inevitable consequences will continue. These include some caseloads being too high; social work teams feeling overwhelmed; a high turnover of staff, vacancies; and over reliance on agency staff. The new DCS and senior team are fully aware of these critical issues and the unifying model is under development but in the early stages of implementation and therefore, has yet to be understood by frontline practitioners. My review has come too soon in the process to comment on the way these changes are being implemented or their effectiveness. My review has led me to conclude, however, that there is now a DCS and team in place who know what needs to be done and have embarked on that improvement journey.

8. Recommendations

To the Minister

1. No alternative delivery model at this early stage
2. Maintain ongoing dialogue and oversight of progress by a Commissioner
3. Further Commissioner reviews at 6 and 12 months

To Surrey County Council

1. Engage staff and partners in the vision and ensure they actively participate in the improvement of the overall children's system in Surrey
2. Encourage the involvement of children and young people in the design and delivery of services
3. Prioritise reform of the MASH
4. Urgently address compliance issues and shortfalls in safe practice
5. Review and configure the early help offer
6. Bring home children in care and care leavers placed outside Surrey
7. Consider a single improvement partner
8. Embed a unified theoretical model for children's social care
9. Continue urgent action around reducing agency staff and improving social worker employment and retention
10. Establish widely understood milestones for the improvement journey with full commitment from Surrey County Council, partner organisations and the wider system

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Commissioner for Surrey's Children's Services

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