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Ms Annie MacIver
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Dear Annie

Focused visit to West Sussex children's services

This letter summarises the findings of a focused visit to West Sussex children's services on 20 and 21 March 2018. The inspectors were Donna Marriott, HMI, and Linda Steele, HMI.

Inspectors reviewed the local authority's arrangements for contacts and referrals in the multi-agency safeguarding hub (MASH) and thresholds for early help, children in need and those in need of protection. Inspectors reviewed a range of evidence, including children's case records, case discussions with social workers and managers, performance management and quality assurance information and supervision files.

Overview

Since the last inspection of children's services in 2015, there has been significant work across the partnership to develop the multi-agency safeguarding hub. Partners benefit from being co-located, with greater opportunity for joint working, though not all information sharing is effective yet. The integrated prevention and earliest help service is an integral part of the MASH and provides an accessible point of contact for children, families and professionals. This means that many children get support before their needs escalate. The MASH provides a timely and child-focused response to children at risk of harm. Strategy meetings held in the MASH ensure a joined-up response to concerns regarding children's welfare. However, the MASH is not yet

providing an efficient service for all children. Systems are over-complex, with too much duplication and too many decision-making points.

The local authority and the strategic MASH board have taken action to tackle identified weaknesses in the service through the implementation of the MASH improvement plan. Partners have responded effectively, committing additional resource and offering solutions to support improvements. Work has been undertaken to update the threshold guidance that has led to more appropriate referrals. However, partners also send a high volume of unrelated information, which needs action by different parts of the service. This means that MASH staff spend a great deal of time processing information and undertaking administrative tasks. Police notifications of low-risk incidents, which do not involve children, exacerbate the pressures. The impact of this is that requests for support are not always progressed quickly enough after initial screening and means that some children in need wait too long to get help. This has been more evident in recent weeks, when the service has experienced additional pressures.

What needs to improve in this area of social work practice

- the rationale for managers' decisions need to be consistently recorded and informed by careful consideration of family history
- systems and processes in the MASH need to be simplified to ensure fewer hand-offs and more timely progression of work
- contact information needs to be entered onto the children's information system as soon as it is received into the MASH.

Findings

- A good range of partners, including early help, housing, domestic abuse services, police, health and the designated officer, are co-located in the MASH. This supports information sharing, but there is more to do to ensure that referrals are of consistent good quality and include parental consent.
- Health partners have had less of a presence in the MASH, but have recently taken action to address this by agreeing to increase capacity. The additional staff are not yet in place.
- Following the relaunch of the threshold guidance, most partners understand and apply thresholds appropriately. However, the MASH also receives a high volume of unrelated information from partners, much of which requires a response from different parts of the service. This means that MASH staff spend a great deal of their time undertaking administrative tasks for the partnership. The police practice of sending notifications in respect of low-risk incidents that do not involve children adds significant additional pressure. This has been a longstanding

issue, but the police have recently put forward a plan to implement an internal triage process to reduce the unnecessary burden.

- The impact of these various pressures results in the MASH experiencing significant demand. Managers struggle to ensure that all referrals are progressed in a sufficiently timely manner after initial screening. These pressures have been even more evident over recent weeks, when a range of factors have resulted in a backlog of work.

- Threshold decisions in response to initial enquiries are mostly timely and appropriate. When children are at risk of harm, decisions are timely and decisive action is taken to protect them.

- The practice of not adding initial contacts to the system in a timely way, combined with too many decision-making points, leads to duplication and inefficiencies. Consequently, not all cases where children are in need of support are progressed with the pace needed. This is evident in respect of children in need of statutory services, as well as those who require early help. This means that a small number of children in need wait too long for the support that they need.

- The local authority's social work model provides a framework with which to consider strengths and risks, but is not yet embedded. Case recording does not consistently provide clarity about what life is like for individual children.

- Strategy meetings have considerably improved since the last inspection. The vast majority provide a sound overview of agency information and rationale for decisions. They are well attended by key partners and result in the right outcome. However, health professionals do not consistently attend strategy meetings. Although health professionals provide information to support decision-making, their non-attendance is a missed opportunity for shared decision-making. This has been addressed and two safeguarding nurses are currently in the process of being recruited. Strategy minutes are typed up during the meeting, thereby ensuring timely information sharing. The attendance at these meetings of receiving social work teams is good practice. This ensures effective transfer of information to those responsible for carrying out the section 47 enquiry.

- There is extensive support offered to children and families experiencing domestic abuse. The domestic abuse initial triage process is effective, though this part of the system is also under pressure. Notifications and risk assessments from the police are not consistently of a good enough quality to support decision-making. The police have taken action to respond to this and are in the process of raising awareness with frontline officers.

- Managers' decisions are mostly appropriate, but the rationale for them is not always recorded and historical information is not always considered. Therefore, it is not always possible to understand whether decisions are proportionate and

justified. Dates and times of decisions are not consistently recorded, which makes it difficult to evidence rigour in the decision-making process. It also undermines the quality of performance reporting.

- Staff spoken to by inspectors are positive about working for West Sussex. They feel well supported by managers and have access to training and development opportunities. However, supervision is not sufficiently regular or in line with the local authority's own supervision procedures. This is a concern given the considerable pressures in the service. The senior leadership team had already identified this shortfall through its quality assurance process and had taken action to increase managerial capacity.

- There has been an extensive audit programme in place across the local authority, including a range of themed audits. The local authority identified and has already taken action to respond to weaknesses in the quality of audits undertaken and has introduced a new approach, but it is too early to demonstrate impact.

- There has been wider work across children's service to improve performance information. A newly developed MASH performance scorecard is about to be produced. Nevertheless, managers do not have a reliable way of ensuring effective oversight of all work in the MASH to prevent drift and delay. This is a weakness given the large volumes of work within the MASH.

- The DCS has worked resolutely to ensure that the local authority has a rigorous understanding of the strengths and weaknesses of the MASH. There is a learning culture in which good use is made of external reviews and other diagnostic work. As a result, the newly formed senior leadership team is clear about the work needed to secure improvement. This has resulted in an accurate self-evaluation and focused MASH improvement plan.

- After a period of instability, a permanent management team with an experienced service lead is now in place in the MASH to implement improvements.

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

Yours sincerely

Donna Marriott

Her Majesty's Inspector