West Sussex County Council

Inspection of local authority children's services

Inspection dates: 25 February to 8 March 2019

Lead inspector: Linda Steele
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Inadequate
Overall effectiveness	Inadequate

There are widespread and serious weaknesses in the provision of services to support, protect and care for children in West Sussex. Services have seriously declined since the last inspection, when all areas were judged to require improvement to be good. The quality of help and support that children receive is a lottery and depends on where they live. Children experience a negative impact from the considerable turnover of the social workers and managers and from the substantial variability in the quality of assessment and intervention.

Most social work practice is weak. Risks to children are seldom recognised, and social workers do not see children frequently enough. Children's views are not often included in assessments and plans, and their records are rarely up to date. Children in care wait too long for their permanence to be confirmed. Drift and delay are evident at every stage of the child's journey. This is particularly true for children living in neglectful circumstances. These critical weaknesses span across all social work teams. Consequently, some children remain without the protection and care that they need.

A service restructure in 2015 and subsequent changes in leadership at corporate and managerial levels have created considerable instability. Continual turnover in the workforce and high caseloads severely limit the local authority's ability to achieve a consistently acceptable standard of social work practice. Children do not always have a named social worker. This has a negative impact on how often they are seen and how well they are enabled to build relationships with professionals they know and trust. Insufficient rigour in challenging poor practice and weak management oversight have led to a deep-rooted culture of non-compliance with basic social work standards.

Many of the deficits highlighted through this inspection have been known to political and corporate leaders for some time. Political leaders have pledged further significant funds to support an increase in capacity and service developments. This has come too late to prevent substantial service decline. The corporate parenting panel has been largely ineffective in delivering much-needed improvements for children in care. Attempts to drive improvement under the direction of the quality and development board have not been sufficiently focused or effective. Partner agencies and the chair of the Local Safeguarding Children Board (LSCB) have not been included in this work. This has severely limited the extent to which the local authority has been able to effect the changes that are needed. In very recent months, the trajectory of improvement has accelerated, linked to recent action to establish an improvement board and appoint an independent chair. However, the quality of support that many children receive continues to fall significantly below an acceptable standard.

What needs to improve

- The infrastructure and services to support good-quality social work practice, reducing the number of transfer points for children. Clarity regarding the expectations of the workforce, including practice guidance and procedures and the quality of staff induction and training.
- The quality of social work practice, to assess, support and protect children who experience neglect.
- The effectiveness of assessment and planning for children in private fostering arrangements and 16- and 17-year-old homeless young people.
- The quality of plans, particularly in relation to the focus on critical issues for families, timescales for actions and the consideration of what will happen if improvements are not achieved or concerns increase.
- The quality of social work recording, including the inclusion of intelligence and an analysis of the critical issues for children in return home interview records.
- Permanence planning for children, including the availability and use of foster-to-adopt placements, timeliness of assessments and planning for unborn babies.
- The quality and timeliness of life-story work.

- The quality and regularity of supervision, management oversight, direction and challenge, at all levels.
- The effectiveness of quality assurance arrangements.
- Staff recruitment and retention so that children experience fewer social workers.
- The rigour and impact of corporate parenting arrangements.
- The active engagement of all relevant partners to tackle weaknesses in services and improve outcomes for children.

The experiences and progress of children who need help and protection is inadequate

1. There are long-standing, widespread and serious weaknesses in the provision of services to safeguard children in West Sussex. Risks are seldom recognised, and weak managerial oversight at all levels is a common feature in too many children's cases. Serious shortfalls in the response to neglect across the service, the steps that are taken to safeguard unborn babies and the quality of child protection planning mean that too many children are not effectively supported and protected.

2. Critical weaknesses in how social workers, managers and partner agencies identify and respond to neglect are evident across the service. Accumulating concerns about the neglect children have experienced are not always recognised or understood, resulting in a lack of assertive action and to some children experiencing profound and potentially long-term consequences. A neglect strategy, supported by a range of tools to identify and measure progress, was introduced by the LSCB in 2016. This has not led to an effective, coordinated response to neglect across the partnership.

3. The assessment and management of risk to unborn babies are poor. The practice of not allocating the cases of all unborn babies to social workers when they are first referred leads to significant drift and delay in pre-birth assessment and planning. Thus, babies are born without robust plans in place to safeguard their welfare, leading to unnecessary emergency action or unplanned parent and child placements. The practice of requiring all care leavers' unborn children to be referred for assessment, regardless of whether there are concerns about their capacity to parent, further illustrates the need for significant improvement in this area.

4. The integrated prevention and earliest help (IPEH) service delivers early help to families across the county. Some children experience delays accessing early help due to duplication in screening and triaging. Delays vary in length from initial contact to allocation and first visit. Early help assessments and plans undertaken by the local authority and partners are variable in quality. Some are

comprehensive, analytical and provide a good sense of the child, but too many do not focus on the needs or voice of the child and sometimes adult issues dominate. The local authority uses a range of approaches, including feedback from children and families, to evaluate the impact of the service. This is making a positive difference to some children's lives but is yet to have a demonstrable impact on reducing the number of referrals to children's social care.

5. Under the direction of the strategic multi-agency safeguarding hub (MASH) board, partners have worked purposefully to strengthen the response that children receive when they are first referred for help, support or protection. The co-location of police, health and other agencies supports effective joint working and information-sharing. The integration of early help screening staff ensures that consideration is given to meeting children's needs at the earliest point. Daily screening by the police, social care and a domestic abuse service provider ensures a joined-up response to police notifications, particularly in respect to concerns about domestic abuse.

6. When children are first referred to the MASH, the response is mostly timely and effective. Consent to share information is routinely sought from parents. Careful consideration is given to children's histories, and, along with timely and thorough agency checks, this supports mostly effective decision-making regarding next steps. Not all decisions are timely, with some delays seen in progressing contacts. These delays are seen when the decisions are of a less serious nature. Managers oversee all referrals and decision-making. In most cases, threshold decisions are appropriate. Nevertheless, the MASH continues to receive a high number of contacts which result in no further action or are closed with advice and guidance because partner agencies are not clear enough about thresholds.

7. Strategy meetings are not always convened in response to potential concerns regarding significant harm. Strategy meetings that do take place vary in quality. Those that are carried out by the MASH are comprehensive, include key agencies in decision-making and result in the right outcome. Strategy discussions carried out by area teams are less comprehensive, but mostly lead to appropriate decisions. Child protection enquiries vary in quality, although the majority lead to the right outcome and ensure that children are safeguarded.

8. Child and family assessments are not always completed within timescales that meet individual needs of children. They do not consistently include historical family information or needs arising from culture or religion and lack coherent analysis to inform decision-making. Insufficient social work capacity means that some children are not visited regularly enough, or they are visited by different duty workers. This impacts negatively on social workers' ability to gain a proper understanding of children's changing needs. Direct work with children is evident, but it is not always used to gather children's views or to get an understanding of what life is like for children.

9. Child protection plans are rarely written with a clear focus on reducing risks to children and promoting their welfare. Although children have plans, they are complex documents that include a large amount of information, and far too many actions. They also lack timescales. The impact of this is that it is difficult to understand the critical concerns and for families and agencies to know what to focus on. Most child protection conferences and reviews are well attended by parents and professionals, who are supported to share their views. Parents and children benefit from the regular presence of advocates in conferences.

10. When concerns about children do not reduce, legal planning meetings provide a forum for deciding whether further action is needed. These meetings consider whether the threshold is met for pre-proceedings under the Public Law Outline (PLO). However, pre-proceedings are not consistently considered for all children who would benefit from this approach, for example unborn babies, or in response to accumulating concerns, such as chronic neglect. Consequently, risks escalate, or concerns increase without compensatory action, leading to further harm for some children. The judiciary is highly critical of the quality of social work practice, due to continued examples of staff turnover and changes in social work allocation to families. Subsequently, this leads to a lack of timely assessment and action and results in drift and delay in progressing some children's plans.

11. Risks to children, including exploitation, are, for the majority, well identified and responded to. A multi-agency framework supports professionals to identify and respond to exploitation in all its forms. Risks to children are monitored via the missing and exploitation operational group. Concerted effort has been made across the partnership to improve outcomes for a cohort of high-risk adolescents with complex needs in the local authority. This work has delivered effective results in reducing risk, missing episodes and offending for some young people.

12. The local authority has strengthened its response to missing children, bringing this service in-house after discontinuing its contract with an externally commissioned provider. Most missing children are identified effectively and are offered return home interviews. Return home interviews are not always recorded or recorded well enough, leading to considerable gaps in the use of intelligence to support the ongoing assessment and management of risk for children.

13. Not all children living in private fostering arrangements are supported effectively. Critical safeguarding checks and assessments are not always undertaken in accordance with procedures and not all visits to children are timely.

14. The local authority recognises that it has further work to do to strengthen the response to 16- and 17-year-olds who present as homeless. Young people's needs are assessed, but assessments do not sufficiently consider their

accommodation needs, or their entitlement to become looked after. Young people are not fully informed of their rights and entitlements. Some young people who should have been offered accommodation under section 20 of the Children Act 1989 have not been afforded this.

15. An increasing number of children in West Sussex are electively home educated. The local authority has processes in place for identifying and tracking children and it maintains records. The local authority liaises proportionately with families to ensure that children are safe, and to check plans for their education. The local authority keeps a record of any children not attending school full-time and works effectively to integrate children back into mainstream placements. In some instances, it takes longer than is desirable to place children in appropriate provision, especially where their needs are complex.

16. The system for managing allegations or concerns about adults who work with children is generally effective. Nevertheless, there is more work to do to ensure that the process for tracking and overseeing allegations is accurate and measures the time taken for investigations to be completed. There is variability in social workers' understanding of the designated officer's role and a lack of progression of important actions arising from strategy meetings.

17. Awareness of, and the response to, children at risk of radicalisation are established and effective, but further work is needed to ensure that the workforce is trained in how to respond to these risks.

The experiences and progress of children in care and care leavers is inadequate

18. Services for children in care have declined since the single inspection in 2016. Serious shortfalls in practice mean that children in care receive an inadequate service. Too few children in care have an up-to-date, good-quality care plan, and children wait too long for assessments of their health needs and for permanent homes. Issues in how social workers, managers and partner agencies respond to neglect lead to children coming into care too late, and when their needs have become complex and challenging. The effect of all these shortfalls is that there is drift and delay in progressing children's plans, which results in missed opportunities to improve children's lives and to achieve permanence in families when it is right for children.

19. Assessments and care plans vary considerably in their timeliness and quality. Senior managers' actions to tackle weaknesses in the quality of care plans have had limited impact. Some care plans meet required standards, but most do not clearly set out accountabilities, or effectively represent the child's voice. A quarter of children in care do not have an up-to-date care plan. A new care plan format has only recently been implemented, and training on what a good care plan looks like is yet to take place. Assessments to inform decision-making

on whether to place brothers and sisters together are of better quality and provide a rich understanding of children's attachments. Unaccompanied minors' needs are well assessed, and these children are well supported when they arrive in the country.

20. The quality of health provision for children in care is poor, despite this being an area of focus since the last inspection. Serious shortfalls remain in the timeliness in which children's health needs are assessed when they first come into care. For example, of the children who started to be looked after during December 2018, only 13% had an initial health assessment completed on time. This means that children's health needs are not properly understood at the early stages of care planning. Strengths and difficulties questionnaires are now completed for children in care, but they are not routinely used to inform care planning. The child and adolescent mental health service for children in care is currently being recommissioned to deliver more timely mental health support for children, who currently have to wait several months for treatment.

21. Independent reviewing officers (IROs) are largely ineffective in challenging poor practice or addressing drift and delay. This is despite an increase in the number of IROs and some improvement in their oversight. Most children's circumstances are regularly considered through statutory reviews, but not all of these are timely or effective in ensuring that children's plans are progressed at the necessary pace. Shortfalls in practice identified by IROs through the dispute resolution process can go many months without being addressed. This is because managers at all levels are not rigorously overseeing social work practice to ensure that outstanding actions are swiftly completed.

22. Plans to reunify children with their families are seldom based on coherent assessments of risk and need. Placement-with-parents regulations are not properly understood by social workers and managers, and important parts of the process, such as critical checks, are not reliably completed. When children do return home to live with their families, they are not always offered the support they need to help them to make good progress and remain there.

23. Most social workers visit children regularly according to their needs. This includes those children placed out of the West Sussex area. Children's views are sought and captured through a range of activities, but this is often not well reflected in children's case records. Although some children are supported to understand their experiences through a range of direct work, others wait too long for important life-story work to take place to help them to make sense of their life histories.

24. Most children live with carers who meet their needs, support their aspirations and act as a champion for them. Although matching processes identify suitable placements for children, a shortfall in availability of carers means that choice is limited, resulting in unnecessary moves for some children. Opportunities to utilise foster-to-adopt placements are not considered for babies at the earliest

stages. Senior managers recognise that fostering-to-adopt practice is under-developed. Very recent work has been done to raise awareness and increase the number of children who can benefit from this route to permanence.

25. The virtual school is working to improve the number of personal education plans that are completed. While there has been some improvement in the completion rate, too many are still not produced within the expected timescales or to a sufficiently high standard. Consequently, the virtual school's knowledge about and impact on the academic outcomes of children in care are limited.

26. The number of children in care who are persistently absent from school remains high. Exclusions have risen over time. The local authority is tackling this issue strategically, working with schools and governors to develop their work around pupil exclusion as part of the promotion of a broader approach to safeguarding. This is supporting an emerging culture of inclusion.

27. Foster carers receive effective assessment and training. Carers value the support that they receive from supervising social workers. However, too many foster carers express concern and frustration about the impact on children of the high turnover and poor practice of some children's social workers. Allegations against foster carers and concerns about standards of care are not always rigorously investigated and understood. The local authority has begun to take action to respond to this, but it is too early to demonstrate impact.

28. The importance of permanence planning for children is not understood across the service and is not effective enough for too many children. Senior managers have started to improve the focus on early permanence across the service, but they recognise that there is much more work to do. Permanence decisions are made for most children before their second review. However, managers' tracking and oversight of the permanence process are not robust enough. The current local authority policy for children to remain in placement for 12 months before being eligible for a match with permanent carers prevents children from living in situations in which they feel confident they will stay for the remainder of their childhood.

29. A range of options, including special guardianship and adoption, enable children to experience permanence. Children are well matched with adopters who are able to meet their needs. Nevertheless, there has been a decline in the timeliness of matching and placing children with their adoptive families. Children's permanence reports are variable in quality, with some gaps and inconsistencies in important information. Some adopters are positive about their experiences, but others describe failures by children's social workers to visit in accordance with requirements, or to complete important tasks. This causes delays in achieving permanence for children and distress to adopters. Letters for later life vary in quality and are not always completed soon enough.

30. The local authority has made some progress in the support it provides to care leavers since the last inspection. A dedicated care leavers' service now ensures that young people are visited regularly and supported by personal advisers who know them well. This includes young people who are in custody and those who live out of the area. Many young people remain with their foster carers after their eighteenth birthday under staying put arrangements. Young people who spoke to inspectors were all happy with their accommodation and the support they receive. Additional support is available to care leavers from some district councils, but a consistent offer is not available across the county.

31. Young people are involved in their pathway planning. The quality of these plans varies, and some are more detailed than others. Plans are regularly updated, but actions arising from them are not always clear and timebound. Consideration is given to young people's day-to-day health needs. Although the local authority asserts that young people are provided with information about their health histories, this information is not held by the local authority. Should young people require access to this information in the future, it would not be easily available to them.

32. The local authority has taken action to raise young people's awareness of post-16 opportunities, such as apprenticeships, colleges and universities, using well-established local networks. As a result, the proportion of care leavers who are in education, employment or training has improved and is now broadly in line with national averages.

The impact of leaders on social work practice with children and families is inadequate

33. Leaders and managers have not prevented service decline, resulting in widespread and serious failures in the experiences of children in West Sussex who need help, protection and care. Oversight, scrutiny and challenge from corporate leaders, including the children's select committee and the corporate parenting panel, have not been sufficiently rigorous. Consequently, chronic instability at all levels of the organisation, poor practice and a culture of non-compliance is evident. This leaves children at continued risk of significant harm and with their needs unmet.

34. Senior leaders have an accurate and realistic understanding of the quality of services. The actions that have been taken to tackle some of the deficits, such as the launch of the quality and development board, have not been focused or effective enough in addressing the widespread concerns. Many actions in the improvement plan have not been progressed despite continued attention. Partner agencies and the chair of the Local Safeguarding Children Board (LSCB) have not been included in this work. This has severely limited the extent to which the local authority has been able to effect the changes that are needed.

35. A quality assurance framework is in place and provides some scrutiny and oversight of practice. However, too few audits are undertaken and non-compliance by managers in conducting audits, combined with a lack of understanding of what good practice looks like, means that they are limited in their impact. Until very recently – January 2019 – there was no system in place to ensure that specific tasks arising from audits were consistently followed through, and this resulted in drift and delay for children. For example, the identification of poor practice through audits in October 2018 has yet to result in a clear action plan to drive improvement in the quality of service that children receive.

36. A deep-rooted culture of non-compliance with basic social work standards is a serious issue across the service. Recording is poor, with some important documents blank or missing. This is largely due to social workers and managers not updating records on the electronic recording system. Consequently, leaders cannot rely on performance information. Performance information in relation to return home interviews appears to demonstrate an improving picture. However, too often forms generated on the children's recording system contain only key dates and critical information is absent. The impact of this is that leaders cannot be confident about the quality of practice or the reliability of the performance information.

37. A clear, targeted sufficiency strategy provides a coherent analysis, effectively forecasting future placement need. The high number of children placed in the West Sussex area by other local authorities adversely impacts on the sufficiency of local placements, particularly for high-risk adolescents. Leaders have responded to this by monitoring the local market and seeking to engage more proactively with existing and emerging providers, but challenges in demand remain.

38. The corporate parenting panel is not sufficiently aspirational and has had limited impact on making a demonstrable difference to services or outcomes for children in care. The lead member attends, but the panel has limited membership, with no partner agencies, such as housing services, and no representation by foster carers or young people. Members of the panel have been aware of the significant concerns across the service, particularly longstanding weaknesses regarding the very poor timeliness of initial health assessments, but they have not been effective in making changes to this.

39. The local authority's reporting and governance arrangements do not provide a helpful framework to support the delivery of the largescale improvements that are needed across the service. The DCS does not directly report to the chief executive or attend the executive director board meetings. At the time of the inspection the DCS and the senior leadership team considered that this arrangement reduced the visibility of children's services within the corporate agenda. Changes in leadership at corporate and managerial levels, combined with service restructure in 2015, have resulted in significant staff turnover and

a workforce having to cover a broad range of work, without the skills and expertise that are needed. The creation of children looked after social work teams with responsibility for court work led to this work being prioritised above other casework, and resulted in a poor service for children in care.

40. A significant challenge facing the local authority is the instability in the children's care workforce. Senior managers have worked to improve the stability of the workforce, strengthening the recruitment and retention offer through a recent workforce strategy. Political leaders have provided significant financial investment to support an increase in capacity and service developments, but this has come too late to prevent turnover and instability and has negatively affected children's experiences.

41. Too many children have experienced too many changes of social worker, resulting in disruption and delayed intervention for many of them. Some children in foster care have lost confidence in social workers following these frequent changes, as well as when social workers leave, sometimes without saying goodbye. One child described the impact of such changes when they spoke about their frustration about 'having to say the same thing over and over again'.

42. Some children's cases are allocated in managers' names rather than to social workers due to increasing workloads and capacity issues. In these circumstances, a series of duty workers, who do not know or fully understand the children's histories or experiences, undertake statutory visits. This leads to delays in meeting the assessed needs of children and adversely impacts on the progress of their plans.

43. The constant turnover of social workers and managers, combined with a lack of clear, up-to-date procedures and practice standards has led to poor and inconsistent practice. Drift and delay are evident at every stage of the child's journey. This is particularly evident for children living in neglectful circumstances. For a very small minority of children, the prolonged experience of living in such conditions has had an adverse effect on their long-term health and well-being.

44. Management oversight at every level, including by IROs and child protection chairs, lacks rigour and does not tackle weaknesses or drive practice improvement. The variability in the skills and knowledge of first- and second-line managers undermines the much-needed improvements through inconsistent and often poor management oversight. Considerable gaps are evident in staff and case supervision. When it does take place, it is rarely detailed, focused or analytical enough.

45. The local authority has an established Children in Care Council that is supported by participation officers. The council champions the views of all children in care and care leavers. Children in care are listened to through this

forum and their voice has influenced the development of services, for example through the campaign 'treat us the same' where children expressed their concerns about being taken out of classes for statutory reviews and meetings.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W:www.gov.uk/ofsted