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Dear Colin Pettigrew,

Focused visit to Nottinghamshire County Council children's services

This letter summarises the findings of a focused visit to Nottinghamshire County Council children's services on 9 January 2019. The inspectors were Julie Knight, Her Majesty's Inspector, and Pauline Higham, Her Majesty's Inspector.

Inspectors looked at the local authority's arrangements for 'front door' responses to contacts and referrals of children potentially at risk or in need of support.

Inspectors looked at a range of evidence, including case discussions with social workers, multi-agency safeguarding hub (MASH) officers and meetings with managers. They observed operational frontline practice in the front door, including the daily domestic abuse meeting. Inspectors looked at local authority performance management and quality assurance information and children's case records.

Overview

The vast majority of children and their families receive quick and appropriate responses from the MASH when enquiries for early help and support and safeguarding concerns are received.

Staff morale is high in the MASH and assessment teams. Senior leaders have responded well to a previous increase in demand for services at the front door, implementing plans to ensure that social workers have manageable workloads and children's assessments are completed within appropriate timescales to meet their needs.

Thresholds are understood by partners and applied using a comprehensive pathway to provision. Children who need urgent protection receive an effective response, with prompt action taken to reduce risks. Children's assessments are mostly of good quality and include children's histories and views, which inform the analysis of risks.

However, planning processes for undertaking child protection enquiries are not always robust. Strategy discussions are not always timely, and this delays formal decisions on child protection investigations. The rationale for decisions is not sufficiently explained in children's records, and this includes giving reasons for why a strategy discussion has not been undertaken. Key partners, such as health agencies and schools, are not always included in strategy discussions. This means that not all information on potential risks to children is shared at these meetings and therefore not all partners will know about the child protection concerns. This reduces the effectiveness of information-sharing and reduces partners' responsibilities in the child protection process.

A multi-agency domestic abuse meeting, held daily in the MASH to consider incidents within the previous 24 hours, helps inform Operation Encompass so that schools can support children who have experienced domestic abuse. However, partners attending the meeting do not always have sufficient information on children and this reduces the effectiveness of the meeting in analysing risk.

Audits, undertaken by managers, overly focus on process and give little sense of children's experience, the quality of practice or learning from interventions. Senior leaders recognise this and have plans in place for changes to the current quality assurance framework.

Senior leaders have good oversight and understanding of operational practice at the front door. Prior to the focus visit, senior leaders implemented a work plan for improvements in the MASH following an internal learning review undertaken in November 2018, and this is already having a positive impact on services for children.

What needs to improve in this area of social work practice

- The quality of strategy discussions and meetings so that they are timely, involve all relevant partners and are well recorded.
- The quality and impact of audits so that they clearly evaluate the quality of social work practice.
- The quality of information-sharing, recording of decisions and child focus in the daily domestic abuse meeting.

Findings

- When children and families need early help and support, they are directed to services appropriate to their needs. The Early Help Unit (EHU) within the MASH is effective, collating information about children's needs and sharing this with MASH colleagues to inform decisions on thresholds. The EHU offers appropriate advice and guidance to MASH workers and other professionals regarding the availability of early help services. Families receive a letter advising them of when early help support will be available.
- The EHU is effective and efficient in managing the 'step-down' process from children's social care, which ensures that children are directed to services appropriate to their needs. The EHU gives appropriate support and advice to partners and lead professionals over the phone for completion of the early help assessment form (EHAF). This is helping to improve the quality of these assessments.
- When children need urgent protection and safeguarding, they are quickly allocated to a social worker and transferred to the appropriate assessment service. Team managers in the MASH have appropriate oversight of all MASH enquiries and record their decisions at each stage of the MASH process. This ensures that children receive a timely response and that there is management oversight of thresholds, so children receive the right service at the right time.
- The importance of seeking children and family consent to enquiries is well understood by workers in the MASH. Team managers record the rationale for overriding decisions on consent when it is appropriate. Staff make diligent attempts to speak to parents when some enquiries and referrals have not included consent to make MASH contact. Staff make good use of toolkits and the pathway to provision threshold document to help identify risks to children, including those children who may need an urgent visit but who do not meet the child protection threshold.
- Senior leaders responded quickly and appropriately to a recent period of instability in the MASH resulting from staff turnover and an increase in demand for services. Staff told inspectors that they are listened to by senior managers and feel supported. Investment in additional resource and workforce tools has been effective and workers now have manageable workloads. New staff are positive about their induction to the MASH and feel very supported in their new roles.
- Team managers are diligent in ensuring that new staff, including new managers, have time to understand the MASH process. Morale is good in the team and staff have easy access to informal peer and manager support as well as regular formal supervision. Team managers monitor workflows appropriately to reduce delays for children.

- Children are visited quickly by social workers when identified as being at immediate risk of harm. However, strategy discussions are not always considered when there are sufficient concerns to warrant multi-agency information-sharing to make decisions about child protection investigations. Recording does not always demonstrate the rationale for decisions when strategy discussions are not pursued, and often key partners are not included when strategy meetings are convened. This is a missed opportunity to analyse all potential risks and share information known about children in order to help inform decision-making on risks and appropriate actions.
- Children who have witnessed and experienced domestic abuse incidents at home receive additional oversight within the MASH through daily multi-agency domestic abuse meetings, where risks are discussed. These meetings support shared communication of incidents reported to the MASH within the previous 24 hours. Information shared between partners and verified at this early stage helps save time later when enquiries are progressed. All schools are notified following the meeting under Operation Encompass and, on most occasions, information is also shared with health partners for children under five.
- Social workers in the MASH do not always receive written police notifications of domestic abuse incidents, and when they are submitted, the quality of information on children's circumstances is not always sufficient. This means the MASH social workers have to spend more time locating the information. While the domestic abuse meeting supports information-sharing at an early stage in enquiry, it is not sufficiently focused on the impact of incidents on children or on recording specific and timely actions. Partners do not have all the available information they need on children's circumstances to fully assess levels of risk, reducing the effectiveness of the meeting. Local authority managers had not identified these shortfalls in the operation of these meetings.
- Children and their families benefit from an effective emergency duty system that responds appropriately to crises for children outside of office hours. Social workers are knowledgeable and can access and input children's records. This means that workers in the MASH can quickly access information and allocate children for assessments when ongoing needs are identified.
- Children's assessments are mostly comprehensive and of good quality. They include the views of children, including children who access the disabled children's service. Social workers demonstrate a clear understanding of what daily life is like for children. Social workers use a range of tools to help them identify risks and strengths in children's home environments. These include 'a day in my life' for children and 'parenting daily hassles' tools to assess parenting capacity. Social workers have a good understanding of risks to children and this is incorporated into assessment analysis. Wider risks to children are appropriately identified, including internet safety and teenagers at risk of neglect.

- Social workers make persistent efforts to engage with children and their parents when families are resistant to involvement with services. They show professional curiosity and take time to understand the needs of children and their families. Children's histories collated in the MASH are transferred to the assessment teams and are appropriately used in assessing risks. All assessments have management oversight and team managers provide appropriate challenge to assessment outcomes when necessary.

- Officers conducting internal audits and the audit tools they use overly focus on process and give little sense of children's experience. Information on the quality of practice or learning from interventions do not provide sufficient detail on what difference interventions have had for children and if their outcomes have improved. This hampers audit outcomes being used to drive improvement. Senior leaders recognise this and have plans in place for changes to the current quality assurance framework to help drive improvement.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit. This letter will be shared with the Department for Education and published on the Ofsted website.

Yours sincerely

Julie Knight
Her Majesty's Inspector