Aviation House
125 Kingsway
London WC2B 6SE

T 0300 123 1231
enquiries@ofsted.gov.uk
www.ofsted.gov.uk

4 September 2017

Ms Julie Fisher
Deputy Chief Executive and Director of Children's Services
Surrey County Council
Penrhyn Road
Kingston upon Thames
Surrey
KT1 2DJ

Dear Ms Fisher

Monitoring visit of Surrey children's services

This letter summarises the findings of the monitoring visit to Surrey children's services on 2 and 3 August 2017. The visit was the eighth monitoring visit since the local authority was inspected in 2014 and the fourth under the new arrangements. The inspectors were Stephanie Murray, Senior HMI, and Natalie Trentham, HMI.

Senior managers have identified and begun to address serious weaknesses within the multi-agency safeguarding hub (MASH), which was launched in October 2016. Inspectors noted recent improvements, particularly in the few weeks prior to the visit. However, some changes have taken too long to achieve. Children continue to receive an inconsistent response to their needs and, for some, potential risks are not explored quickly enough.

Areas covered by the visit

During the course of the visit, inspectors reviewed the progress made in the areas of:

- the effectiveness of the MASH in responding to concerns about children, including those who live in families in which there is domestic abuse and those who go missing from home
- the response to children who are, or who might be, at risk of significant harm
- the timeliness of initial visits to children and their families following referral, taking into account their individual circumstances.

The visit considered a range of evidence, including children's electronic case records, key strategic and operational documents, and the observation of social workers and managers within the MASH. In addition, inspectors spoke to a number of social workers, senior social workers, leaders, managers and professionals from partner agencies.

Overview

The local authority and its partners launched a large-scale MASH in October 2016. Although this was an appropriate development, there were challenges in implementation. Early in 2017, before the scheduled six-month review had taken place, it became clear to senior managers that the MASH was not working as effectively as it should be. As a result, leaders increased their financial investment in the service to meet increased demand and undertook a comprehensive review of practice. Over 600 cases were reviewed in February 2017, and all staff were afforded the opportunity to provide feedback. This review highlighted a number of concerns, including the impact of a backlog within early help and the poor prioritisation of cases. All of the actions resulting from the review of the MASH have been completed or are on track. However, further work is needed to ensure that children receive the response that they need. Inspectors found that some children whose circumstances warrant a social work assessment are stepped down to early help. Others are passed to the area teams for assessment when, in fact, the risk of significant harm should prompt a strategy meeting. This leaves these children in situations in which they are not assessed, helped or protected quickly enough.

A backlog of referrals that had previously been screened, reviewed by a manager and held on a separate list within the MASH gave inspectors cause for concern. In a number of these cases, children's needs had remained unassessed for too long. The MASH enquiry process, in which agencies are asked to provide information about families, is cumbersome and results in delays for some children. A substantial increase in contacts from the police in June 2017 created considerable pressure both within the MASH and within area teams, and this has contributed to high caseloads.

Inspectors found that the very recently established processes for prioritising work within the MASH are now working well for most newly referred children. In the majority of cases, referrals of children with high-level needs or who are considered to be at risk of significant harm are quickly progressed, and most strategy meetings include the appropriate agencies to enable social workers and managers to make informed decisions about risk. However, when children are transferred to area teams for assessment, delays in visiting them are often evident.

In most of the recent casework seen by inspectors, management oversight is timely, and there is evidence of appropriate review and challenge of initial screening decisions. The backlog of work within early help, which has been a challenge for a number of months, is gradually reducing, enabling more children to be stepped down to these services.

Processes to respond to children who go missing are clear, but they are not always adhered to, and too many children are not spoken to quickly enough after they return home.

Social workers within the MASH are enjoying working in the newly created hubs and they told inspectors that they feel that their suggestions and concerns are heard and

acted on by senior managers. This approach to learning and improvement was evidenced by the response of senior managers to the case concerns highlighted by inspectors during the visit.

Findings and evaluation of progress

Based on the evidence gathered during the visit, inspectors identified strengths, areas where improvement has very recently been accelerated and some areas where action is required to address weaknesses.

- Prior to mid-July 2017, the screening and prioritisation of new contacts was not efficient or robust enough. Although, at the time of the visit, senior managers had recently introduced a more effective system, 194 children's cases, relating to 140 families, remained in the previous work tray awaiting action. Sampling highlighted a number of children for whom no steps had been taken to understand potential risk or need since the date of the referral, which in most cases was a period of three weeks. Based on what is already known about these children's circumstances, they have waited too long. Senior managers agreed to review urgently each of these cases to ensure that children receive the help that they need.

- Inspectors observed senior social workers screening new contacts and found this response to be timely and proportionate, with the vast majority passed to the relevant hub for action within four hours. Screening social workers carefully check children's details and consider any previous social care information before making their initial recommendation. The early help client database has only recently been made available to all MASH staff. This is helpful to them, but has taken too long to achieve.

- Once transferred to one of the three MASH hubs according to the initial level of need, most newly referred cases now receive a timely initial response. However, for some children who were referred some weeks before the visit, delays were evident. Social workers seek consent and gather information from partner agencies to inform next steps. Decisions are routinely recorded by managers, although these records are often not clear enough about how quickly children should be seen and assessed. Inspectors found that, in most cases, insufficient steps had been taken to find out about the daily lives of children and to hear about their views, for example through direct discussions with children and young people or with adults who know them well.

- In too many cases, an insufficient analysis of family history or an over-optimism about parents' capacity for change has led to families initially being offered early help when a social care assessment is needed, or being allocated for assessment when a strategy discussion is required. These children do not initially receive the right help or protection and, in some cases, their situations deteriorate while they wait to receive the support that they need.

- Social workers told inspectors that the hub model is enabling them to work more efficiently and to identify gaps or areas where practice needs to improve. The active participation of staff in the development of the MASH is evident, and social workers told inspectors that the new processes are clearer and safer than those that were in place previously. Some had been worried about children's needs not being addressed. One social worker said, 'It's so much better now that we know what we are doing.'

- Key partners have committed staff resources to the MASH, and helpful communication between operational staff to support decision-making was seen in a number of cases. However, the MASH enquiry process, in which partner agencies are asked to provide information in writing to help social workers to make decisions about the support that children need, has been under-utilised. The number of children considered through this process increased from 32 in February 2017 to 110 in June 2017. However, inspectors found that in some cases the enquiries take too long. This leads to delays in children receiving the help that they need.

- Clear processes for children who go missing are in place, but they are not robustly applied. In some cases seen by inspectors, police reports were not on the child's record and, in others, the consideration of risk following the return home interview was not sufficient to inform plans to keep children safer. Attempts to engage with children who go missing are often not assertive enough, and there are long gaps between attempts to contact some children. Brothers and sisters are not always considered when assessing the circumstances of children who go missing. Senior managers have recognised that the response to these children needs to be improved, and have introduced closer monitoring and oversight. The impact of this is yet to be demonstrated.

- In some cases seen, police referrals had not been sent to the MASH quickly enough following a domestic abuse incident to enable the timely consideration of children's circumstances. The backlog of police notifications that are awaiting referral to the MASH had reduced considerably in the weeks prior to the visit. However, approximately 1,000 additional police contacts were received by the MASH in June of this year. This created considerable additional pressure, both within the MASH and within area teams. Police lead managers are taking appropriate steps to reduce the variability in the quality of police referrals, through opportunities for training and observation, and some good examples were seen. Police domestic abuse, stalking and honour-based violence (DASH) risk assessments were rarely evident in cases seen, reducing the information available to social workers when these referrals are received.

- Inspectors reviewed a number of cases that had been allocated to a social worker to undertake a child and family assessment. In too many of these cases, children have experienced unacceptable delay in being seen and assessed. Once a decision is made that a child protection strategy meeting is needed, cases are

transferred to area teams. Overall, these meetings and discussions are timely and, in most cases, partners are well engaged. The majority of the records of meetings seen by inspectors evidenced detailed consideration of history and helpful information sharing, aided by conference-call facilities.

- An increasingly detailed approach to the quality and usefulness of management information is assisting operational and senior managers to improve their monitoring of the performance of the service, such as timeliness of initial management decisions following referral. However, greater rigour is needed in the routine oversight of practice in the areas considered in this visit. Leaders have made a firm commitment to the roll out of 'Safer Surrey', a model of assessment and practice that supports the analysis of risk, need and strength. This is well underway. The use of the model was evident in case files, including in management oversight, supervision and strategy meetings.

I am copying this letter to the Department for Education. It will also be published on the Ofsted website.

Yours sincerely

Stephanie Murray
Senior Her Majesty's Inspector