Sandwell Metropolitan Borough Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 27 January 2015 – 19 February 2015

Report published: 5 June 2015

The overall judgement is that children's services are inadequate
There are widespread and serious failures that create or leave children being harmed or at risk of harm. Leaders and managers have not been able to demonstrate sufficient understanding of failures and have been ineffective in prioritising, challenging and making improvements. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Inadequate

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

[2] A full description of what the inspection judgements mean can be found at the end of this report.

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The local authority - Summary of findings

Children's services in Sandwell Metropolitan Borough Council are inadequate because:

Leadership, management and governance

- Strategic leaders have failed to ensure that vulnerable children at risk are protected. The application of thresholds is inconsistently, and at times, inappropriately, applied. Managers do not always recognise risk. This result in some children's needs not being assessed or supported at the appropriate level.
- Strategic leaders have failed to act with urgency to address audit findings, which identify that 20–25% of threshold decisions require a higher level of response.
- Strategic leaders and managers have failed to understand the potential impact on outcomes for children and the significance and reasons associated with a large drop in the number of children in need receiving services from November 2013.
- The arrangements for the management of children who are missing and at risk of child sexual exploitation are poor. This has resulted in children for whom there is known high risk of child sexual exploitation not receiving a social work assessment or service and not always being protected.
- The local authority and its partners do not fully understand the scale and prevalence of child sexual exploitation in Sandwell.

Quality of practice

- Management oversight of frontline practice is failing to ensure that children and families are receiving services at the right level based on need and risk and taking account of the requirements of 'Working together to safeguard children'.[3]
- The arrangements to escalate concerns about children from early help services to children's social care are not robust and result in some cases not receiving a social work intervention when they need one.
- There is significant drift in multi-agency core group meetings being held and this contributes to delay in progressing child protection plans.
- The authority is failing in its statutory duty to identify and effectively assess all aspects of private fostering arrangements.
- Sixteen- and 17-year-olds who present as homeless do not always benefit from an assessment of their needs, including their need for accommodation.

[3] *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children*, Department for Education, March 2013; www.gov.uk/government/publications/working-together-to-safeguard-children.

What does the local authority need to improve?

Priority and immediate action

Leadership, management and governance

1. Ensure that the application of thresholds results in children receiving services appropriate to their levels of need and risk and in line with Working Together requirements.

2. Undertake an immediate review of all child sexual exploitation cases and ensure that children and young people are appropriately assessed and receive services that meet their needs and risk.

3. Ensure that, when children go missing, the arrangements for independent return interviews result in children, including children looked after, being seen by an independent person within 72 hours.

4. Ensure that assessments inform planning where young people are either living in a private fostering arrangement or are 16- or 17-year-olds and homeless.

5. Ensure that case file auditing processes are robust and that action is taken to address audit findings in a timely manner.

Areas for improvement

Help and protection

6. Improve the management oversight of social work practice to ensure that assessments, plans and interventions are at the right level to address need and risk and that appropriate action is taken to safeguard children.

7. Improve the quality of plans, including child in need plans, to improve outcomes for children.

8. Ensure that multi-agency core group meetings are held within timescales and drive child protection plans forward.

9. Ensure that assessments include rigorous analysis of children's circumstances, are informed by chronologies, take account of issues of children's diversity and inform planning.

10. Ensure that information-sharing across the partnership in relation to children who are 'absent' and 'missing' inform risk assessments and support effective joint working.

Looked after children

11. Ensure that changes to children's plans are based on an assessment of need and are reviewed by an independent reviewing officer.

12. Ensure that permanence plans are in place for all children looked after by the second 'looked after children's statutory review' meeting.

13. Ensure that life story work is completed and that children and young people are meaningfully engaged so that they understand why they are in care.

14. Improve the health of looked after children and care leavers by ensuring that the quality and timeliness of health and dental assessments.

15. Improve access to Child and Adolescent Mental Health Services (CAMHS) for looked after children, care leavers and adopted children.

Adoption

16. Reduce the delay that children experience in achieving permanence.

Care leavers

17. Ensure that personal advisers use chronologies to understand young people's history and that all care leavers have a current pathway plan that is reviewed regularly.

18. Ensure effective and timely transition planning for children looked after and care leavers who will need support from adult services after the age of 18.

The local authority's strengths

19. The Children in Care Board is well established and representatives are enthusiastic about their role and have strong support from the participation officer. Members of the group sit on the Corporate Parenting Board and children's contributions influence the decisions that affect their lives.

20. There are effective arrangements in place to support young people to chair and lead their own looked after review meetings. This increases their participation in and contribution to the review process.

21. The local authority actively seeks adoption for children where this is in their best interest.

22. The Troubled Families initiative has successfully supported 764 families. The local authority has been invited to be an early implementer of the next troubled families phase.

23. Intensive family support workers and social workers in the Community Operating Groups (COGs) know their cases well and visit families frequently. There is evidence of success in some early help cases, such as improved school attendance.

Progress since the last inspection

24. The last Ofsted inspection of Sandwell's arrangements for the protection of children was undertaken in March 2013. The local authority was judged inadequate. The last Ofsted inspection of Sandwell's services for looked after children was in June 2013 and was judged inadequate.

25. A range of measures to drive improvement have been developed since the last inspection, such as the establishment of the multi-agency safeguarding hub (MASH), the early help offer, reduced reliance on agency staff and the appointment of senior officers. However, serious failings remain.

26. Thresholds for social work assessment and intervention are too high. This results in cases not being allocated for a social work assessment when appropriate and in cases remaining in early help when a social work intervention is required due to known and potential risk to children.

27. Strategic leaders and managers have failed to act on performance information that shows a significant drop in the number of children in need receiving services. The scale of the reduction in the number of children receiving services or its significance and potential impact on children's lives has not been recognised or understood. This is a serious failure.

28. Local authority audit findings in relation to decision-making at the point of contact highlighted that a significant number of decisions require a social work response. These findings have not been effectively acted on.

29. The quality of social work intervention across child protection cases remains poor. The local authority is aware of many of the weaknesses in practice. These include the quality of plans, core groups and child in need meetings. The local authority also recognises the need to strengthen the use of chronologies to inform assessment and planning and the need for greater availability of CAMHS provision.

30. The local authority has made progress in taking forward the recommendations from the last children looked after inspection. There is improvement in the effectiveness of the independent reviewing officer service. All children looked after now have care plans. The local authority has been proactive in reviewing the arrangements for children on care orders placed at home reduce drift

31. The Corporate Parenting Board has been strengthened and children's views now influence decision-making. Care leavers influenced the looked after children's and care leavers' pledge, which reflects issues that are important to them.

32. The Looked After Children Board is established and reports that strategic leaders listen to their views and take them seriously. Children have been actively involved in the work of the Board and presented the looked after children annual report to full council.

Summary for children and young people

- Some children who are at risk do not always get the right level of help and support they need to keep them safe.
- More needs to be done to make sure those children who are at risk of being sexually exploited get the right level of help and are protected.
- Too many children have had too many different social workers. This makes it hard for children to build a trusting relationship with them. It also makes it hard for social workers get to know the children and means that sometimes it takes too long to get important things done. This is a big problem for children looked after and for their foster carers.
- When children looked after go missing, they sometimes have to wait too long before someone comes to talk to them, to support them and help keep them safe in the future.
- There is a wide range of services to help children and their families, but the local authority needs to make sure that the right sort of help is provided to children and that it meets their needs.
- Social workers' assessments are getting better. Good assessments lead to children getting the help and support they need.
- When it is not safe for children to go back home to live with their parents, some children have to wait too long before a permanent home is found.
- Children looked after are supported to chair their reviews and this helps them to participate and contribute in decisions that affect their lives.
- Children and young people wait too long to get help from Child and Adolescent Mental Health Services (CAMHS) if they need it.
- Children's school attendance has got better and fewer children are being excluded from school. In 2014, children looked after in Sandwell did better at their GCSEs than children looked after living in other areas.
- Children told inspectors that senior managers listen to them and take their views seriously.
- The adoption team is doing well at finding adoptive families for children who need them.
- Services for care leavers have improved. Most care leavers are in employment, education or training and are living in suitable accommodation. Most young people are being helped to prepare for independence.

Information about this local authority area[4]

Children living in this area

- Approximately 76,867 children and young people under the age of 18 years live in Sandwell. This is 25% of the total population in the area.
- Approximately 30% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22% (the national average is 17%)
  - in secondary schools is 22% (the national average is 15%).
- Children and young people from minority ethnic groups account for 41% of all children living in the area compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Indian and Pakistani.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 31% (the national average is 19%)
  - in secondary schools is 26% (the national average is 14%).
- Sandwell has experienced an increase in economic migrants, with the majority arriving from Poland. This group increased from 208 individuals in 2001 to 5,673 in 2011. In 2011, people born in EU accession countries accounted for 2.6% of the usual resident population of Sandwell. There have also been additions to the established communities, including the number of individuals born in India increasing by 4,556 to 15,190, in Pakistan increasing by 1,722 to 5,295 and in Bangladesh increasing by 1,120 to 2, 8483.

Child protection in this area

- As at 2 February 2015, 1,441 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,994 at 31 March 2014.
- As at 31 January 2015, 323 children and young people were the subject of a child protection plan. This is a reduction from 383 at 31 March 2014.
- As at 31 January 2015, three children lived in a privately arranged fostering placement. This is a reduction from six at 31 March 2014.
- Since the last inspection, two serious incident notifications have been submitted to Ofsted and one serious case review has been completed.

[4] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Children looked after in this area

- As at 31 January 2015, 538 children were being looked after by the local authority (a rate of 70 per 10,000 children). This is a reduction from 575 (75 per 10,000 children) at 31 March 2014. Of this number:
  - 294 (or 55%) live outside the local authority area
  - 31 live in residential children's homes, of whom 23 (74%) live out of the authority area
  - four live in residential special schools,[5] all of whom (100%) live out of the authority area
  - 412 live with foster families, of whom 213 (52%) live out of the authority area
  - 37 live with parents, of whom seven (19%) live out of the authority area
  - two children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 36 adoptions
  - 26 children became subjects of special guardianship orders
  - 210 children ceased to be looked after, of whom seven (4%) subsequently returned to be looked after
  - 34 children and young people ceased to be looked after and moved on to independent living
  - three children and young people ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of Sandwell's safeguarding arrangements for the protection of children took place between 25 February and 6 March 2013. The local authority was judged inadequate.
- The previous inspection of Sandwell's services for looked after children took place between 24 and 28 June 2013. The local authority was judged inadequate.
- The last adoption service inspection took place on 8 June 2010 and judged overall quality as satisfactory.
- The last fostering inspection took place on 27 July 2012 and was judged adequate.

[5] These are residential special schools that look after children for fewer than 295 days a year.

Other information about this area

- The Director of Children's Services has been in post since January 2013.
- The chair of the LSCB has been in post since August 2014.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Inadequate

Summary

The local authority has not ensured that cases of high risk or actual harm to children have a statutory assessment of need to enable children to be kept safe. The local authority has failed to apply effective thresholds or to respond appropriately to known or potential risk, which means that vulnerable children do not always receive services at the right time or at the appropriate level. This has left some children at risk. Those children who are identified as being at risk benefit from agencies working closely together within the MASH.

Too many child protection cases have had recent changes of social worker, causing drift and delay in progressing work. Multi-agency core group meetings are not held regularly enough and are not well recorded. This contributes to delay in the progression of plans.

Information about children who go missing and children at risk of child sexual exploitation is not brought together effectively to inform planning and intervention. Recording of return interviews is not entered on children's files, meaning that information is not being seen or acted on by social workers.

The identification, assessment and management oversight of private fostering arrangements is poor, resulting in children being left at potential risk.

Sixteen- and 17-year-olds who present as homeless do not benefit from an assessment of their needs.

Early help services, including children's centres are well resourced and parents who spoke to inspectors spoke positively of resources available and help received.

Exclusion rates from schools are reducing and attendance rates are improving. The numbers of children missing education shows a significant decrease.

33. Although there are well-established arrangements for multi-agency working in the MASH and a recently developed early help offer, not all children are adequately protected and some are left at serious risk of harm. Decision-making in the MASH sometimes results in children who need statutory intervention to ensure that they are fully protected being inappropriately referred for early help. At the initial point of contact, management decision-making within the MASH is not consistent. Inspectors found that, in a significant number of contacts that led to no further action, management decision-making demonstrated over-optimism and a lack of professional curiosity. Consequently, presenting information is not subject to adequate challenge or scrutiny. This resulted in children in need of services potentially not being recognised and left at risk.

34. In the three months prior to the inspection, 4,176 contacts resulted in 467 progressing to a referral. A significant number of these cases were repeat contacts. Between 31 March 2014 and 2 February 2015, there was a 43% reduction in the number of children in need receiving services. The local authority has failed to understand and act on the reasons for this.

35. Thresholds for access to social care services are not applied in accordance with the Sandwell LSCB multi-agency thresholds document, or in line with Working Together 2013. Although the local authority's early help strategy makes it clear that early help is for families who are below the threshold for social care intervention, inspectors identified cases where the risks identified required a statutory social work response. Failure to apply thresholds correctly reflects the local authority's own audits of activity within the MASH during 2014, which consistently identified 20–25% of decisions made as requiring a higher-level response. The local authority is yet to take action to address these shortfalls.

36. Inspectors found that understanding thresholds for statutory intervention, particularly in relation to some children considered to have targeted additional needs or be at risk of child sexual exploitation, has become blurred. This has resulted in some children at risk of sexual exploitation who required a high level of support being allocated to early help services without the necessary safeguards in place to ensure their protection. During the inspection, eight cases of serious concern were referred back to the local authority that met the criteria for child protection enquiries.

37. The local authority's approach to young people at risk of child sexual exploitation means that many child sexual exploitation cases are open to early help. Sampling of these cases identified 23% children at serious risk of harm. These cases were referred back to the local authority.

38. In a small number of cases referred back to the local authority by inspectors, social workers took urgent action to ensure children's safety. In each of these cases, there had been a failure to identify known risk and take appropriate protective action. In another case, inspectors identified the potential risk of sexual abuse to a child, leading to the local authority taking immediate action to rectify the situation.

39. The council has not been effective in ensuring that it understands the nature and level of child sexual exploitation, leaving some young people at potential risk. The implementation of the recently introduced child sexual exploitation screening tool and risk assessment is inconsistent, with some staff remaining untrained in its use. Although there has been some initial analysis of its use, its impact on the management of risk has yet to be evidenced.

40. When children return home following a missing episode, there is delay before they receive a visit from an independent person to explore the reasons for going missing. This leaves children vulnerable and without appropriate and timely support. Records of these interviews are not stored on children's files. This means that social workers do not consider this information when assessing risks and planning interventions.

41. The local authority does not sufficiently evaluate the links between children missing education and child sexual exploitation to identify themes and patterns to inform planning. Police record 'absence episodes' manually. This does not support robust joint working or timely intervention.

42. Children who are identified and recognised as needing protection benefit from the joint intervention of partners co-located in the MASH. Child protection strategy meetings take place promptly where children are at potential or immediate risk of harm. Outcomes from these meetings are consistent with the information discussed and the level of risk identified, and this supports timely interventions. However, the recording does not always make clear which agencies attended.

43. The absence of chronologies from case files means that social workers do not always take into account historical information to inform assessments. Assessments of children's needs are often detailed and consideration is given to children's wishes and feelings, which reflect their understanding of situations and what they want to happen. Assessments result in the provision of a wide range of support services. This includes services from Sandwell women's aid and interventions through 'safer activities for everyone' (SAFE), a scheme run by the NSPCC. There was evidence that families and children benefited from the help provided by these services.

44. Assessments seen included details of ethnic origin, but most assessments and plans do not pay sufficient attention to the impact and context of cultural background. This results in poor consideration of children's full needs and does not inform the planning process.

45. In sampled cases of homeless 16–17-year-olds, there was no assessment to establish their eligibility for support under Section 17 or Section 20 of the Children Act 1989. One young person had been referred to the MASH but had been stepped down to early help. In another case, the young person repeatedly presented as homeless and, while good support was provided from the early help service, no assessment of need was undertaken. Failure to provide appropriate levels of assessment and support means that young people who present as homeless are potentially vulnerable.

46. There are three children known to be privately fostered. Inspectors identified two further cases. One young person was recognised as being fostered privately but appropriate action was not taken. In the other, the local authority did not actively consider the appropriateness of the arrangement. In these cases, young people had been left in situations of unassessed risk. This is a serious weakness.

47. In a number of cases, there was a failure to assess need and risk. This includes children in need cases of chronic neglect in households with very young children. In seven of nine tracked cases, there was evidence of poor management oversight and of multiple changes of social workers, which contributed to some drift and delay.

48. Visits to children who have a child protection plan are not always undertaken within agreed timescales and, while there is evidence that children are seen during visits, they are not always seen alone. Records of these visits are not always purposeful and do not demonstrate what actions have been undertaken to drive forward the child protection plan.

49. Child protection conferences and reviews of child protection plans are timely and are attended by an appropriate range of agencies. Social work reports presented at the conferences identify risk factors and make recommendations that are supported by evidence. However, conferences do not always receive reports from social workers and reflects variable performance. In January 2015, the rate of reports provided for conference was 70%, which is poor.

50. While commissioned services for advocacy are available, the participation of young people 12 years and over in child protection conferences is low, averaging at 15% over 2014–15. This means that children and young people's contribution to the arrangements to protect them is potentially limited.

51. Child protection plans were of variable quality and actions from conferences do not always make clear what needs to change for the better. Timescales are not always specified. There is insufficient challenge from conference chairs when there are delays in progressing plans and actions. The use of written agreements with families is well utilised and focuses on identified actions to reduce immediate risk, particularly in domestic violence cases.

52. In the majority of cases seen, core group meetings did not take place in accordance with the agreed timescales set out in the child protection plan. Some of these delays were significant. When meetings were held, minutes were often not added to the child's case file. This means that core group meetings are not used as an effective way of ensuring and tracking the progress of child protection plans and the engagement of the family and partners. This is a significant weakness.

53. In a number of cases seen, children had frequent changes of social workers. This means that children do not benefit from relationships with professionals who they get to know. Frequent changes in social workers also led to drift in the planning for some children.

54. When risks increase and children may need to become looked after by the local authority, social workers have a good understanding of the public law outline (PLO) process. Inspectors saw appropriate use and consideration of the PLO. Legal services monitor progress in PLO cases to ensure that cases do not drift.

55. Management oversight and case supervision is not consistent. In seven out of nine cases tracked in care management teams there were evidence of poor management oversight and multiple changes of social worker. These contributed to drift and delay.

56. The MASH screens domestic abuse referrals and this ensures multi-agency oversight of these concerns. An assessment tool effectively supports decision-making and provides a good range and depth of information. However, police notifications to children's social care do not consistently include information about whether children were present during domestic abuse incidents. The local authority is taking steps to address this, but it is too early to identify any impact.

57. Multi-agency risk assessment conferences (MARACs) take place fortnightly and are chaired by the police. They appropriately review cases deemed high risk. These include breaches of Domestic Violence Protection Orders and 'Claire's Law' applications. However, there was little evidence seen on children's case files of minutes of these meetings.

58. When allegations are made about adults who work with children, the local authority designated officer (LADO) provides timely and effective intervention, although the systems for recording activity are cumbersome. The LADO reports that the service is under-resourced and this has limited the effectiveness of the role. Work with faith groups to ensure that they have a full understanding of their safeguarding responsibilities and when to refer concerns to the LADO is under-developed.

59. Police powers are used appropriately in the protection of children identified at risk. The out of hours service provides timely support to families who need help. Clear recording passed from the out of hours service to daytime staff supports the MASH to make informed interventions.

60. Resources for early help provision incorporate a wide range of support services. The local authority's early help services has limited remaining capacity, with 1,858 children receiving services in February 2015.This situation is compounded by the number of complex and inappropriate cases being passed to early help that require statutory intervention within children's social care services.

61. Team around the family meetings (TAFs) do not sufficiently focus on outcomes for families. Required actions do not explain what families need to do to ensure that children and young people make progress and thrive. Multi-agency partners' attendance at TAFs is poor. However, plans seen show that families' wishes are taken in to account.

62. Intensive family support workers and social workers in the community operating groups (COGs) know their cases well. They visit families frequently and there is evidence of success, such as improved school attendance. Early help assessments seen by inspectors are detailed. However, timescales for improvement are often not clear enough and the actions contained within plans do not sufficiently consider how outcomes for children will be improved.

63. All but one of the local authority's 21 children's centres inspected by Ofsted were rated as good or outstanding at their last inspection. Families had received help promptly and support was coordinated effectively. Parents who spoke to inspectors were positive about the range of early help services available, such as support for victims of domestic abuse, parenting courses and access to counselling.

64. The Troubled Families initiative has successfully supported 764 families out of a cohort of 1,115 and has been invited to be an early implementer of the next Troubled Families phase involving a further 3,910 families in 2015–20.

65. The early help desk provides advice and guidance to school staff regarding safeguarding concerns. Education partners report significant improvements in this initiative, particularly over the past few months, and they find access to early help services more straightforward than in the past. Where schools have a referral to social work services accepted, they receive prompt feedback. However, some staff stated that they are concerned when high-risk cases are stepped down too quickly to early help.

66. The overall school absence rates of all children are close to the national average. Exclusions are reducing and attendance is improving. Almost all secondary schools and the majority of primary schools have improved their attendance rates this year. A comprehensive database records children and young people missing from schools and shows that numbers of children not on a school roll are reducing. This academic year, 40 new referrals were received and, of those, half have now been closed successfully. Currently, 55 children and young people are on the register of children missing education; none is on a child protection plan, two are on a child in need plan and three receive early help support.

67. At the time of the inspection, 54 pupils were attending bespoke programmes with alternative providers. Quality assurance of this provision is undertaken by the local authority and through Ofsted inspection. A further 61 children attend the hospital school. Schools are provided with clear guidance on the actions to take following withdrawal of a child from the school roll. A child missing education officer is linked to each COG, thus ensuring better tracking in each of the seven localities.

68. The work to engage with all education providers to identify risks with more accuracy requires consolidation. This includes independent schools and providers of alternative education.

69. The local authority maintains a list of children and young people who are electively home educated. Currently, 141 young people are registered as home educated. Of these, eight families were judged to provide an unsuitable programme to their children. Almost all are now either re-integrated into school or provided with learning with an accredited alternative provider. Two have moved out of the area. No child educated at home is on a child protection plan, one is on a child in need plan and 10 receive early help support.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Children do not always become looked after at the right time and some suffer drift and delay in their needs being appropriately met.

Outcomes for looked after children are not yet good because care planning does not always support improving the experiences and progress of looked after children. Inspectors found some instances where children were returned home without a full assessment and this potentially left some children vulnerable.

When children are on the edge of requiring care from the local authority, the use of the public law outline (PLO) is improving and families benefit from a range of support services to enable them to remain at home safely.

Some children had frequent changes of social worker and this contributed to delays in progressing care plans and securing legal orders.

When children looked after go missing, they do not routinely receive timely independent return interviews to identify where they have been, whether they have been harmed or whether they need any additional support.

Life story work for children who are in care is not always completed. This means that some children do not understand their early life experiences.

Some children experience delay in achieving permanence.

All children looked after have care plans that are regularly reviewed and children and young people are supported to chair and lead their own review meetings.

Education outcomes for children looked after have improved over time and gaps between all pupils and those in care are closing. The 2014 GCSE results are above the national results for pupils looked after.

Some improvements have been made in the quality and timeliness of health assessments, although children and young people wait too long for services from Child and Adolescent Mental Health Services (CAMHS).

Adoption is considered for all children looked after, but some children still wait too long between entering care and going to live with adoptive families.

Services for care leavers have improved over the past 12 months. Most care leavers are in employment, education or training and live in suitable accommodation.

70. A range of responsive services is available to support children, parents and carers to prevent family breakdown. During 2014, the Family Solutions Team (FST) worked with 141 families with children on the edge of care and, at the end of the year, 94% of these children were living at home. The use of family group conferences (FGC) is increasing and there are some positive examples of plans made by families to support children remaining at home. Inspectors saw no cases where children had become looked after unnecessarily. When children need to be looked after, in a small number of cases inspectors saw drift and delay in children becoming looked after at an early enough stage.

71. A number of panels track and monitor looked after children's plans and placements. The weekly placement panel, chaired by a senior manager, considers whether children should enter care and any plans for them to return home.

72. A legacy of insufficient use of PLO processes and poor quality social work assessments led to delays in instigating legal proceedings. This has resulted in a lack of confidence in the local authority by the judiciary and the Children and Family Court Advisory and Support Service (Cafcass). This is particularly evident in cases of chronic neglect.

73. Assessments and care plans do not routinely demonstrate good analysis of children's needs and social workers do not always update assessments and plans with significant events in children's lives. Issues of equality and diversity such as ethnicity, sexual orientation or faith, are not always fully considered within assessments and care plans. Historical information is not always fully utilised and chronologies are often of poor quality or absent from the file. However, in the vast majority of assessment and plans, the wishes and feelings of children are well recorded.

74. Social workers are increasingly using 'viability' and 'together or apart' assessments to contribute to planning for looked after children. This ensures that the possibility of children living with relatives, or with brothers and sisters are appropriately considered.

75. The quality of looked after children's reviews are not yet consistently good enough. Inspectors saw some good examples of independent reviewing officers (IROs) challenging care plans. In other cases, actions had drifted and were deferred to the next review without being effectively dealt with. Permanency planning meetings routinely consider the best way of achieving permanence for every child although plans are not always in place by the second looked after statutory review. For some children, this has caused delay in planning for their future.

76. Children attend their reviews and are seen and consulted with by their IROs. Effective arrangements are in place to encourage young people to chair and lead their own review meetings. This has increased month on month, from 13% in May 2014 to 37% in January 2015.

77. Relevant professionals attend reviews and persistent efforts are made to involve parents. In a review meeting observed during the inspection, the IRO ensured that the meeting was child-focused and that the young person was fully involved throughout.

78. At the time of the inspection, all children looked after had an allocated social worker. However, between September 2014 and February 2015, five children looked after have had periods without an allocated social worker. This is not consistent with supporting children well.

79. Thirty-seven children looked after live with a parent under placement with parents' regulations. In most cases seen by inspectors, these arrangements were appropriate to meet the needs of the children and young people.

80. Contact between children looked after and their families is supervised by family support workers where necessary, who provide comprehensive reports to social workers. Some creative and persistent direct work by social workers has resulted in children looked after enjoying contact arrangements where relationships had previously broken down.

81. In December 2014, the number of children experiencing three or more placement moves over a 12-month period had reduced from 13% to 10.3%. A small cohort of children had experienced a high number of placement moves. The percentage of children living with their carers for more than two years is positive, at 69.5%.

82. The local authority is currently updating the Placement Sufficiency Strategy dated 2013 to inform future planning and commissioning of placements.

83. When the plan for permanence is for children not to return home, life story work is not routinely undertaken. This means that some children have significant gaps in their knowledge and understanding about their past.

84. The family finding service has been restructured to ensure a sharper focus on permanency and support. This has improved the competence and resilience of foster carers through good quality supervision and training. The annual foster carer review process has been strengthened with action taken to address the backlog of 60 annual reviews. Managers recognise that there is a pressing need to improve communication and re-engage foster carers.

85. Foster carers who had recently completed 'KEEP' training spoke very positively, of their experience. The training is helping carers to better understand the needs of children looked after and reduce the number of placements that result in an unplanned ending.

86. The majority of foster carers spoken to expressed concern about frequent changes of social workers and the impact that the lack of continuity has on the children and young people in their care.

87. The local authority has worked hard to secure permanency for a cohort of children living in foster care through special guardianship orders (SGOs). Although they have been successful in many cases, foster carers expressed concern about levels of ongoing support and were therefore reluctant to progress this route to permanence. This resulted in some children in foster care not achieving permanence through a SGO as planned. Work is being done with the Family Justice Board to develop a more consistent approach to the use of SGOs and connected persons' assessments.

88. Of the 65 children and young people looked after placed outside of Sandwell, 9% are placed more than 20 miles from their home. The local authority gives careful consideration to placing young people out of area and does this based on an assessment of the children or young people's needs. In the majority of cases, arrangements are monitored closely and access to education and health services is timely. Inspectors found that young people placed out of area were making good progress.

89. Where looked after children require support from adult services after their 18th birthday, they often experience delay in being assessed. This creates anxiety for parents and carers and uncertainty for the young people, who do not know what their future holds.

90. All looked after children aged between 10 and 17 have been screened by their social worker for risks relating to child sexual exploitation. At the time of the inspection, 10 young people looked after were assessed as high risk or vulnerable to child sexual exploitation. From July to December 2014, there were 35 missing from care episodes involving 20 children. Information is not readily available to identify patterns and trends of absences or missing episodes to inform decision-making and risk assessments. Children placed out of area do not consistently receive return interviews following missing episodes.

91. Children and young people know the local authority's complaints procedure. The resolution of some complaints has not been timely. Children and young people have access to advocacy and independent visitors but take-up is low. Only six young people have received effective support from an independent visitor; 35 received support from advocacy services.

92. The majority of children and young people have an assessment of their health needs. The named nurse liaises with health visitors, school nurses, general practitioners and CAMHS to obtain a health summary of each child. The timeliness of health assessments has improved but is still poor, at 73%. Dental checks are extremely low at 69%.

93. Children looked after experience delay when accessing bespoke therapeutic work, which is limited in availability. Social workers spoke of high thresholds and lengthy waiting lists for access to CAMHS. 'My Shield' provides a range of interventions, including intensive support through the B-Well programme and one-to-one counselling services to young people (aged five to 19) in Sandwell.

94. The Children in Care board is well established; participants are enthusiastic about their role and have strong support from a participation officer. Members of the group sit on the corporate parenting board and this is improving the influence that children looked after have on decision-making.

95. Education outcomes for children looked after in primary schools match those of children looked after nationally and their results are improving. The most recent validated results (2014) for a small cohort of 31 pupils show that 75% of children looked after in primary schools made the expected progress in reading, 59% in writing and 66% in mathematics. These results compare favourably with the national results for children looked after. However, they are still well below the results of all primary-aged pupils in Sandwell. In 2014, over 90% of all pupils in the borough made the expected progress in these subjects.

96. Key Stage 4 results fluctuate year on year due to the small cohort size. In 2014, the proportion of children looked after achieving five good GCSEs including English and mathematics (18%) was above the national average for looked after children (12%). Progress between Key Stages 2 and 4 is also comparable. The proportion of pupils making the expected progress in English (42%) and in mathematics (28%) match the national figures for children looked after of 39% in English and 29% in mathematics. Although closing, there is still a huge attainment gap at GCSE between pupils who are looked after and all pupils in Sandwell. Most of the Year 11 pupils (76%) who left school in July 2014 continued their education or training post-16. The use of post-16 personal education plans is a good development, aiming to increase the number of students obtaining A-level qualifications and entering higher education.

97. The large majority (75%) of children looked after, including those placed out of borough, attend a good or outstanding school. The Looked After Children Education (LACE) team contributes to decisions about the placement of children and the choice of schools is given due consideration. Additional scrutiny is given to arrangements for pupils looked after who attend schools where weaknesses have been identified. Pupils are not moved unnecessarily.

98. The virtual school holds clear records of pupils receiving alternative education. A bespoke timetable is provided for two children looked after who are not in full-time education. Students in the pupil referral unit follow a specific curriculum to improve their attendance and re-engage them in learning.

99. School attendance is good overall and compares well with that of all pupils. Over the past few years, success in ensuring no permanent exclusions has been maintained and, although still above average, the number of fixed-term exclusions is reducing. The LACE team are strengthening their alert system so that support is provided as soon as young people's behaviour patterns change and risks of exclusion are reduced.

100. A range of social and additional education opportunities are available to children looked after. The Easter Club offers support for GCSE revision. Eleven young people attended an intensive mathematics week. Personal tutors are funded to help students prepare for their GCSEs and post 16-education provision. Take-up for these opportunities is low. Academic and personal achievements are celebrated in high-profile events.

101. The recently appointed part-time headteacher of the virtual school has drawn up a clear strategic plan for further improvement. He is very aware of the strengths and areas that require further improvement. These include raising expectations of carers and school staff, improving the effectiveness of personal education plans, reducing fixed-term exclusions and monitoring more tightly the impact of pupil premium funding. The personal education plans completed (70%) usually provide a good overview of pupils' attendance, welfare and emotional well-being, including the risk of bullying. However, targets for progress and attainment are often too broad and the impact of pupil premium funding on raising the achievement of children looked after is not clearly demonstrated. The local authority provides access to a wide range of leisure activities to support children and young people.

The graded judgement for adoption performance is that it requires improvement

102. Adoption performance is not yet good. Although adoption is considered for all children looked after, variability in the quality and timeliness of work in some cases has led to delay and decisions having to be deferred. The local authority is taking action to address performance problems and raise practice standards. It recognises that there is further to go, including improvements to the support provided to adoptive families.

103. On average, care proceedings in Sandwell conclude in 44 weeks (quarter 3, 2014/15). The local authority's own unvalidated figures indicate that 66% of care proceedings conclude within 29 weeks. This means that 34% of children have to wait longer than they should for their legal position to be secured and the local authority's performance does not meet the national requirement of 26 weeks.

104. Performance measured against the adoption scorecard shows that some children still wait too long between entering care and going to live with adoptive families. While the three-year average of 594 days continues to fall and is now below the national average of 628 days, it is it still 47 days over the national threshold set out in the adoption scorecard.

105. Once the court has agreed that a child may be adopted, the local authority agrees on a match by 147 days on average. This is better than the three-year national average for England and meets the scorecard threshold. Over the last three years, 50% of children (85) have entered care and moved in with their adoptive family within 18 months.

106. The local authority's own data show that 29 children were matched with an adoptive family in 2014. Of these, 19 were not matched within the timeframe required by the adoption scorecard. This means that too many children wait too long to be matched with their permanent family.

107. Sixteen of the 19 children who are currently the subject of a placement order but have not yet gone to live with their adoptive family are either matched with prospective adopters or linked with foster carers.

108. The agency decision-maker considers recommendations made by the adoption panel, has been effective in driving up practice standards and exerts appropriate influence and control. Inspectors saw examples of effective oversight by the adoption panel and agency decision-maker in the adoption process that led to positive outcomes.

109. A rigorous and robust two-stage quality assurance process means that the quality of child permanence reports (CPRs) is improving. A concerted effort is being made to improve the quality of CPRs in order to minimise delays for children and young people for whom the permanence plan is adoption. The adoption panel adviser and court officer work closely together and hold CPR surgeries with individual social workers so that they can rigorously track progress.

110. The adoption team is effective in recruiting, training, preparing and assessing adoptive families and then matching them with children in a timely way. Some adopters are matched with children from other authorities through local consortia arrangements.

111. Membership of the Adoption in the Black Country (ABC) consortium has enhanced the local authority's ability to reach out to individuals and couples who are interested in adopting. High quality marketing materials and a rolling programme of information events and family finding activities provide a steady flow of prospective adopters. Of the numbers of potential adopters attending information events, 25% go on to be assessed at stage 1 of the adoption assessment process.

112. Adopters and prospective adopters are positive about the quality of the training provided and the thoroughness of the assessment. As part of the matching process, good use is made of child appreciation days to help adopters develop a much fuller picture of the lives of the children with whom they are matched and begin to make an emotional connection with them. Sixteen of the 19 children who are currently the subject of a placement order but have not yet gone to live with their adoptive family are either matched with prospective adopters or are linked with foster carers.

113. The adoption panel, which is chaired well, reflects the diversity of the local community and provides effective scrutiny and critical challenge. A pre-condition for panel approval is that prospective adopters are in a position to make informed choices about fostering to adopt. In the event that prospective adopters are not approved, they are given information about the independent review mechanism (IRM). Approximately half of all adoptions made by the local authority involve inter-agency placements.

114. In 2013–14, 17% of children who ceased to be looked after were adopted. Although lower than the previous year's figure of 23%, this is in line with the national average. Between 2011 and 2014, 11% of children who left care as a result of being adopted were from an ethnic minority background. This was higher than the proportion in England – 8% – over the same period. In 2013–14, six sibling groups made up of 13 children were placed together for adoption. Currently, there are three sibling groups waiting for an adoptive family. In the financial year to date, 33 children have been adopted.

115. The local authority offers a range of post-adoption support services, including means-tested adoption allowances. The looked after children education service (LACES) provides support to adoptive families. However, the local authority acknowledges weaknesses in resources, training and capacity. The adoption team manager has identified access to CAMHS as a key issue. Seven of the 14 respondents to the adoption survey disagreed with the statement, 'My child has effective adoption support if and when he or she needs it'. Four of them disagreed strongly.

116. The adoption passport provides clear and comprehensive information about rights and entitlements and the range of support services available. Service level agreements with Adoption UK and After Adoption mean, for example, that: there is a buddy system for those adopters who want to use it; adopted teenagers can access 'Talk about adoption groups'; and there is support for birth parents. In 2013–14, five out of six assessments for post-adoption support resulted in support being provided. Currently, there are 11 adoptive families receiving post-adoption support packages funded by the local authority.

The graded judgement about the experience and progress of care leavers is that it requires improvement

117. Too many care leavers do not have an up-to-date pathway plan and a significant number of plans are not completed to a good enough standard. While all care leavers have an up-to-date review of their plan, inspectors found that there were significant gaps between the review periods. This does not support effective planning. Too many young people are not involved in reviewing their plans. Assessments are not updated once young people transfer to the 18 Plus team. This is a missed opportunity to record key events, changes and concerns and to celebrate important progress and achievements in young people's lives.

118. Personal advisers have regular face-to-face contact with young people. They are in tune with care leavers' wishes and speak warmly of them and know their personalities. They demonstrate a rich knowledge of young people's needs and goals and any risks within their lives. However, despite the good relationships, personal advisers do not have records of young people's histories, so they cannot help them to understand and make sense of what has happened in their earlier lives.

119. The co-location of the 18 Plus team with targeted services such as the substance misuse team, Connexions and the youth offending service means that this help and advice is readily available to young people. However, services for older care leavers are limited and CAMHS support is not available to young people over the age of 18. This is not identified within the local authority's looked after children strategic priorities. There are limited facilities within the 18 Plus building for young people to use a computer with their personal adviser.

120. The local authority has been slow to ensure that care leavers have access to their health history when they leave care. The existing information provided to care leavers about their health histories is also too limited. The designated nurse for care leavers is based within the 18 Plus team but there is no drop-in service for young people to access advice about their health when they need it.

121. Care leavers and personal advisers report a much-improved service over the past year and in particular since additional staff resource was added to the team in November 2014. Personal advisers receive regular supervision and they report good access to their managers. The quality of supervision notes is inconsistent and they contain limited analysis of young people's previous experiences. This has been identified within the local authority's own audits.

122. The proportion of Sandwell care leavers who are in education, employment or training, at 48%, is slightly better than the national average of 45% (2013–14 figures). Five care leavers are currently engaged in apprenticeship schemes. There is appropriate support in place for young people who wish to enter higher education and there are currently 15 care leavers aged 18 to 21 attending university. Those who are not in education, training or employment are tracked and personal advisers seek to re-engage them as far as possible, but efforts to re-engage young people age 16–18 who are not in education, employment or training have drifted in some cases.

123. Young people looked after are encouraged to live with their carers for as long as they wish. In 2013–14, the proportion of children looked after aged 16 who remained looked after when they reached 18 years of age was 76%, which is 9% higher than the national average. In the same year, almost half of the 20 young people who turned 18 remained with their foster carers under a 'staying put' arrangement. This is close to the national average of 52% and is significantly higher than the previous year in Sandwell when just 12% remained with their carers beyond their 18th birthday.

124. There have been no care leavers living in bed and breakfast accommodation for the past 12 months and the local authority does not consider this suitable accommodation for young people of any age. A large majority (91%) of care leavers live in appropriate accommodation, which is an improvement from 75% in March 2013 and is slightly higher than the national average. A range of suitable housing options are available to care leavers including foster care, supported lodgings, training flats, semi-supported and independent accommodation. Young people are effectively helped to prepare for their own tenancy through the intensive and practical support of an apprentice who is employed by the local authority and based within the 18 Plus team. The eight care leavers who live in training flats are progressing well towards independence. A local foundation provides helpful support to care leavers though the provision of courses in DIY, cooking and healthy eating.

125. There is no mention of care leavers in the annual complaints report, which is a weakness, but care leavers spoken to say that they receive a swift and proactive response when they are unhappy about something. They feel confident about contacting managers directly and are pleased with the warm and helpful response they receive. Personal advisers are knowledgeable about young people's entitlements and advocate on their behalf to ensure that they receive the help and financial support they need. An up-to-date financial entitlements policy underpins this aspect of supporting care leavers. These entitlements are outlined clearly in the Sandwell leaving care website. Care leavers value the role of the welfare rights officer.

126. There are 15 unaccompanied asylum-seeking children and young people in Sandwell. Thirteen of these are aged between 18 and 21. The 18 Plus team benefits from the expertise of a specialist new arrivals manager. This means that the team remains up to date in their knowledge and that personal advisers are able to provide targeted help to this group of young people. Inspectors saw examples of unaccompanied asylum seeking young people sensitively prepared for the future.

127. Of 174 care leavers, 21 are parents. There is a comprehensive support package available to young parents and inspectors saw some good examples of support and intervention.

128. Care leavers have been instrumental in developing the combined looked after children and care leavers' pledge and are happy that it includes all the key assurances they need from their corporate parents. The care leavers' forum, an enthusiastic group of young people, is working hard to improve the experiences of all care leavers in Sandwell. Children told inspectors that senior managers and leaders within the council take issues that are important to them seriously. Care leavers valued the involvement of senior leaders at the successful care leavers' event in October 2014, which was attended by 50 young people.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

Leaders and managers have failed to recognise situations where children have been at risk of harm and as such have not ensured appropriate thresholds and the right balance between when children should receive early help services and when their needs require a statutory social work response. This has left children at potential risk of harm.

Leaders have failed to understand and act on the marked reduction in child in need work identified through performance management information.

Local authority audit activity has not provided senior managers with an accurate picture of frontline practice. Managers have failed to follow up recommendations from audit activity.

The local authority and its partners do not have a current clear assessment of the broad range of needs of children and their families in Sandwell or a clear plan to deliver services and assess what difference they make.

Work by the local authority and partners to understand the links between child sexual exploitation and children missing from home or education has not taken place quickly enough. The local authority has not ensured that all children assessed as at high risk of child sexual exploitation are receiving services appropriate to their level of need and risk.

The establishment of the MASH has strengthened joint working between partners. Early help is well resourced and beginning to make a positive difference for some children.

Senior managers have failed to act on previous recommendations about implementing an effective electronic record system. This lack of action is a barrier to delivering good social work practice and does not support management oversight and decision-making.

Strategic leaders and members are committed corporate parents and encourage the participation of children and young people from the Children in Care Board in the work of the Corporate Parenting Board

Newly qualified social workers are well supported and there has been a significant reduction in the use of agency workers.

129. Sandwell has a history of poor performance. Against this background, following the last inspection, strategic leaders undertook a major reorganisation to drive improvement. Although strategic and political leaders have resourced the improvement agenda at a time of severe financial pressure, too many children in Sandwell continue to be failed. Strategic managers have failed to understand and effectively act on performance information and audit intelligence that has consistently identified that a significant number of cases require a higher level of response. Too many children who require social work statutory intervention in line with Working Together fail to receive it and are provided with lower levels of support that fail to meet their needs for protection.

130. Strategic managers have not ensured that services to children and young people meet their needs including their need for protection. While the MASH process provides for a timely response to contacts, the council's performance management information shows that multiple contacts often occur before cases progress to a referral. Inspectors identified a number of occasions where children were left at risk and where opportunities to intervene in an appropriate and timely manner were missed, resulting in cases being inappropriately dealt with. This included children who were either homeless or living in a private fostering arrangement. Strategic leaders took immediate action in response to issues raised in relation to cases referred back during this inspection. In addition, the local authority took immediate action to strengthen decision-making processes within the MASH in response to findings during this inspection.

131. While the local authority undertakes extensive case audit activity, the use of audits in understanding and improving practice has been poor. The audits have not resulted in senior managers having a clear and accurate picture of service performance or a 'clear line of sight' on the quality of frontline practice. Consequently, audit activity has not resulted in appropriate action being taken to ensure that thresholds and practice are delivered at an appropriate level to meet children's needs.

132. Audits of work within the MASH carried out between January 2014 and January 2015 identified some key learning points, including inappropriate threshold decision-making in 20–25% of cases. Action plans have not been progressed in relation to eight out of 10 local authority audits. While the local authority has been aware of this failing since September 2014, actions have only recently been collated into one plan. However, actions from audits do not demonstrate impact on improving services in 78% of cases and learning and action from audit findings is not demonstrated.

133. Findings from local authority audits are overly positive and therefore senior managers cannot rely on such audits to give them an accurate understanding of the appropriateness, quality and impact of practice. This is despite the oversight and scrutiny of the Performance Accountability Board, as directed by the Secretary of State, and the local authority's use of external consultancy to add capacity and direction to improvement planning.

134. Of 20 case files audits carried out by the authority for this inspection, inspectors disagreed with the local authority's rating in nine cases. In these cases, the local authority assessment of the quality of work was more positive than the findings of the inspection team. In four cases, inspectors evaluated practice as inadequate. In three of these, the local authority had evaluated them more positively. This mirrors the findings of the recent Local Government Association (LGA)-led peer review, which rated 10 of 21 case audits less positively than the local authority.

135. Management oversight of child protection and child in need work remains variable and in some cases poor, with too few children benefiting from a robust plan that ensures that known risks are rigorously monitored and result in improved outcomes. In one social work case audited by the local authority for this inspection, there were known serious risks of potential abuse where children were not protected. In a significant number of other cases referred back to the local authority, risk was not appropriately identified or acted on. Managers failed to appropriately identify and act on these issues of known risk. When this was brought to the local authority's attention during the inspection, they took immediate appropriate action.

136. Following the child protection and looked after children inspections in 2013, strategic leaders and partners implemented the MASH, a combination of co-located key partners that includes early help. The early help model and strategy, delivered across the borough through the local Community Operating Groups (COGs), is in the early stages of implementation and seeks to support families before statutory intervention is necessary.

137. The creation of the MASH has been an important step forward for services for children in Sandwell. The restructuring of teams that followed the creation of the MASH has created a clearer structure with fewer transfer points for children receiving services and a stable senior management structure that has been in place for a year.

138. The model of the MASH and COGs has clear purpose and function. However, the thresholds for intervention within the model result in the local authority failing to fulfil its statutory duties. Too many contacts are being diverted into early help without the benefit of an appropriate social work assessment, where potential risk of harm requires further examination before the appropriate level of support can be identified. Inspectors identified a number of cases where there were missed opportunities at the point of initial contact that required an assessment or child protection enquiry. These cases were wrongly categorised at a much lower level of need. In some cases seen, action was only taken after further incidents had occurred. This is a serious failure in management decision-making and oversight.

139. Senior manager oversight of the interface between the early help offer and statutory intervention is weak. Senior leaders do not have a full understanding of the strengths and weaknesses of frontline practice. When children and families are receiving an offer of early help and risks escalate, responses from statutory social care services have not been effective. Some cases are not accepted as meeting the threshold for statutory intervention, while others are not sufficiently scrutinised. This has resulted in children and young people remaining at known potential risk of significant harm.

140. The local authority has an insufficient understanding of the context and circumstances of children and young people at risk of child sexual exploitation and those who go missing from home, care or education. This information has not been brought together to create an informed overview of trends and themes, nor is such information aggregated or cross-referenced with information about child sexual exploitation to identify themes to inform strategic planning. This limits the ability of the local authority and its partner agencies to effectively protect children who may be at risk of child sexual exploitation or who are at risk as a result of going missing.

141. The local authority is aware of these weaknesses and is working with partners through the LSCB to improve how this is done in the future. An updated multi-agency child sexual exploitation strategy is due to be finalised by March 2015 and a new multi-agency child sexual exploitation team is almost fully staffed. It is too early to assess the impact of the new child sexual exploitation team. Although there have been some recent positive examples of action to disrupt potential CSE activity, including work with taxi companies, hotels and fast-food outlets, the impact is yet to be evaluated.

142. Management overview of practice in relation to child sexual exploitation has been poor. An audit of the cases of five children at risk of child sexual exploitation completed by the LSCB on 4 October 2014 raised serious concerns, including unaddressed risk of harm for all five young people. A series of recommendations was made to address these. Although action has been taken to address risk, senior managers had not followed up on four of the five cases to ensure that recommendations had been followed and children were safe. This had not been reported back to the LSCB by the time of this inspection some four months later. This is a serious failing. At the request of inspectors, an updated report was produced early and is planned to be presented to the LCSB in February 2015.

143. Strategic leaders and partners have not been effective in ensuring that they understand the nature and level of child sexual exploitation cases open to early help services, leaving some young people at potential risk. A number of these cases were referred back to the local authority because the assessed level of risk was such that the threshold for a statutory social work response was met. This mirrors the findings of the LSCB audit, which found significant and repeated concerns about the local authority's threshold decision-making in four of the five cases.

144. Senior leaders and managers have failed to ensure that when children go missing the arrangements for independent return interviews result in children, including children looked after, being seen by an independent person within 72 hours.

145. The Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing strategy lack a focus on children in need, child protection or child sexual exploitation. The local authority has clear priorities and an improvement plan. However, there has not been a strategic multi-agency plan that effectively supports multi-agency planning and commissioning since the 2013–14 Children and Young People's Plan.

146. While the local authority has a placement report dated 2013, this is not supported by an implementation plan to deliver a sufficiency strategy and does not support the effective commissioning of placements for children looked after. Although the local authority has been successful in recruiting foster carers, it has been less positive in matching the range of carers recruited with the profile of children's needs. This means that children are not always matched with placement provision that meets their assessed needs.

147. The local authority has an established performance and reporting arrangements. This is regularly considered at strategic and operational levels, including the improvement board and monthly manager surgeries. Notwithstanding this, the monitoring of data is not rigorous. Managers had failed to identify the weaknesses that we identified in this inspection, including understanding the implications for children in the reduction in child in need cases. A new quality assurance framework provides a structure to help the local authority improve how it uses audits and employs learning from feedback and complaints, but is still too new to have had a significant impact. Information from complaints and other feedback from children and families is under-utilised and their voices do not inform the local authority's understanding of the quality and impact of the services provided.

148. Strategic leaders and members are committed corporate parents and promote the engagement of children and young people from the Children in Care Board in the work of the Corporate Parenting Board. This has been supported through the appointment of an effective participation officer. Young people have been active in shaping the 'Sandwell Pledge' and in providing training for foster carers.

149. There are regular meetings between the Chief Executive, Independent Chair of the Local Safeguarding Children Board (LSCB) and Director of Children's Services. Work plans align across strategic boards, including Scrutiny Committee and the LSCB. The Leader of the Council and elected members take an active interest in frontline practice and regularly visit services such as MASH, Multi-agency Enquiry Team (MAET), Care Management and Community Operating Groups (COGs). They ensure that children's services are financially prioritised by the council.

150. The electronic social care record system remains a key challenge for the local authority and, in spite of an upgrade since the last inspection, the system remains unfit for purpose. The local authority is looking to replace the current system later this year. Senior leaders are aware that the current system does not support good social work practice.

151. Supervision records seen were of variable quality, with some lacking detail and evidence of reflective discussion. Not all social workers have had regular supervision and in some cases, there was limited evidence of annual appraisals.

152. The development of social work practice is not supported by a clear learning and development model or by the consistent leadership of a principal social worker (PSW) to challenge and improve practice. The recent appointment of a new learning and development strategic lead, the planned rollout of models such as signs of safety and the planned future appointment of a principal social worker should support social workers in developing their practice and understanding what good practice looks like, but these arrangements are not yet in place.

153. The council has taken a determined approach to addressing staffing concerns that existed at the time of the last inspection, when there was a heavy reliance on temporary agency staff and the variable quality of the staff group had a negative impact on services for children. The establishment of a more permanent workforce is a notable achievement. The council now has very few agency staff and workers benefit from manageable caseloads. However, in some services, children continue to experience multiple changes of social worker and this affects children's ability to form effective relationships with workers. Newly qualified social workers are well supported with protected caseloads, mentoring and individual and group supervision. They say that they feel well supported by these arrangements.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate

Summary of findings

The LSCB is inadequate because

Scrutiny and challenge

- Since the last inspection, the pace of improvement has been too slow and resulted in the LSCB not fully discharging its statutory responsibilities. This includes failing to assess the effectiveness of the help being provided to children and families, including early help, and assessing whether LSCB partners are fulfilling their statutory obligations.
- Recent changes made since the appointment of the new independent chair in August 2014 are having a positive impact on the effectiveness of the LSCB.

Performance and quality

- The LSCB has not regularly scrutinised performance information from across agencies.
- The LSCB has not effectively used audits to improve multi-agency practice.

Engagement

- The LSCB has not fully engaged lay members, faith groups or young people in the work of the board.
- The LSCB has not worked with the local Family Justice Board to ensure it scrutinises outcomes for children within the court system.

Learning

- Learning from the LSCB child sexual exploitation (CSE) audit in October 2014 has not been acted upon effectively.
- The LSCB has not consistently ensured that learning from local serious case reviews has been implemented across all partner agencies to help improve practice.
- The quality and impact of training has not been adequately evaluated by the LSCB, despite this concern being noted within the 2013–14 annual report.

What does the LSCB need to improve?

Priority and immediate action

Scrutiny and challenge

154. Ensure that partners, both as individual agencies and within statutory partnerships are scrutinised and held to account for the quality and impact of their practice with children and families.

155. Ensure that a S11 audit takes place so that the LSCB can assure itself partners are fulfilling their statutory safeguarding duties.

156. Scrutinise the understanding and application by partner agencies of the LSCB threshold document in order that all children and young are receiving services appropriate to their needs.

157. Oversee the gathering of intelligence of CSE to inform training and planning so that agencies fully understand their roles in identifying concerns for children who are at risk of CSE.

Learning and development

158. Ensure that learning from case file audits, local serious case reviews, learning reviews and key national serious case reviews is routinely disseminated across partner agencies, that it is used to inform the development of policies and procedures and that learning and recommendations from action plans have been implemented.

Areas for improvement

Performance and quality

159. Implement the new multi-agency data set and quality assurance framework to ensure that the LSCB has a clear understanding of the performance of agencies and the findings from audit. Scrutinise partners' use of audits in driving improvement.

Engagement

160. Ensure that children and young people are able to influence the work of the LSCB and that the wider community is involved through ensuring that the Board has active lay members and engages with faith groups.

Learning

161. Use the new learning and improvement framework to ensure that the quality and impact of training is assessed and that training available clearly reflects priorities identified by the LSCB.

Inspection judgement about the LSCB

162. The LSCB has not demonstrated that it is effectively discharging its statutory functions. Progress by the LSCB has been too slow since the time of the last Ofsted inspection when an area for development was to improve the functioning of the LSCB. Although progress since the appointment of a new independent chair has been rapid, it is too recent and at too early a stage to have had a significant impact on the Board's ability to fulfil its statutory functions.

163. The new chair's review of the functioning of the LSCB presented to the performance accountability board (PAB) in October 2014, concluded that at that point in time the LSCB was not discharging its statutory responsibilities. The review highlighted similar concerns to those raised by the chair of the PAB and by the DfE during 2014. These concerns included not assessing whether partners are discharging their statutory functions; not prioritising key safeguarding issues or incorporating them into a delivery plan; and limited auditing that does not identify where improvement is needed. It also identified an underdeveloped learning and improvement framework, partners not holding one another to account, not assessing or challenging the effectiveness of local services and not using its scrutiny role effectively to challenge statutory partnerships such as the Health and Wellbeing Board (H&WB). Governance arrangements are now in place and the Chief Executive holds the chair to account through regular meetings and through reporting to the PAB.

164. LSCB board members from partner agencies, state that until recently the board was drifting and had no clear direction. The new chair has brought leadership and purpose to the work of the board, although impact has yet to be demonstrated.

165. The LSCB arrangements for scrutinising the performance of agencies in a structured manner with the use of a broad data set of performance information have been ineffective. This important function has largely been left to the PAB and has limited the LSCB's ability to assess the effectiveness of help being provided to children and their families. Although the LSCB is planning to carry out a Section 11 Audit during 2015-16 to assess whether agencies are fulfilling their statutory obligations as set out in chapter two of Working Together 2013, it has not carried out such an audit in 2014-15. This compounds its failure to monitor, scrutinise and provide leadership to agencies who provide services to safeguard children. Although the Board's new performance framework and dataset are too new to have had an impact yet, they are important documents that, alongside an improving culture of challenge, mean that the LSCB is now much better placed to take on this monitoring and scrutiny function in the near future.

166. The role of case file audits to help the board scrutinise, understand and drive up the quality of practice with children their families is underdeveloped. For example, although the July 2014, Section 31 threshold audit identified delay within three of five cases looked at, it is not possible to see how this learning has been applied to practice and impact assessed by the LSCB. None of the five actions on a 'voice of the child' audit action plan from April 2014 has been concluded.

167. The influence and involvement of children and young people with the work of the LSCB is underdeveloped as is engagement with the faith community, an important consideration in an area of cultural, ethnic and religious diversity. The board has not benefited from regular attendance by lay members; this also limits its ability to engage with the wider community and act as an influential advocate for children's safeguarding.

168. The LSCB's 'threshold document' is supported by a full package of training. However, in relation to how thresholds are applied in practice the LSCB has not assured itself that the learning from audits, is being used to ensure that they are consistently and correctly applied and that children are receiving the services they need. This is a serious gap in the LSCB's scrutiny of front-line practice.

169. The LSCB has not assured itself that children at risk of CSE in Sandwell are identified by agencies or that they are receiving appropriate services. It has not provided sufficiently timely or strong leadership despite having a longstanding link to the Young People at risk of Sexual Exploitation and Missing group (YPSEM). The LSCB is in the process of revising and updating its CSE strategy, but this work is not yet complete.

170. An audit of five cases of children and young people at risk of CSE presented to the Board in October 2014, resulted in the roll out of a CSE screening tool by the local authority and provided impetus to plans for the new CSE team. However, four months on from these audits the LSCB has not been assured that recommendations have been carried out so that young people are effectively safeguarded.

171. The Serious Case Review sub-group has undertaken learning and serious case reviews but has not ensured that learning from these or from key national serious case reviews is routinely disseminated to staff across agencies, or that it informs the training programme or the development of policies and procedures. Although recently collated into an over-arching action plan, recommendations from these reviews have not been tracked for completion and to assess impact on practice. Learning has been disseminated to professionals and managers directly involved in cases reviewed. There has also been training of some specific staff groups such as housing officers and health visitors, but learning has not been cascaded across agencies in a co-ordinated way. Two planned events to share learning more widely were cancelled recently due to a lack of capacity to deliver them.

172. The LSCB provides a range of core training which was well attended during 2013-14. However, evaluation of the quality and impact of this training has been limited. This is noted within the LSCB 2013-14 annual report. Until the recent publication of a new Learning and Improvement Framework, there has been no clear mechanism for addressing this area for development in a structured manner.

173. The LSCB annual report dated November 2014 was prepared in parallel with the new chair's strategic review report. The annual report identifies, but does not fully explore, some deficits in both the running of the board and in agency practice. This includes the failure of the policy and procedures sub-group to meet for 18 months and a failure to identify what the board is doing to scrutinise private fostering practice. It does however provide detailed information on the work of some subgroups, such as the Child Death Overview Panel (CDOP). This group, although without a co-ordinator for some months last year, is an established and active group that has developed a range of public health campaigns from through its work, including safer sleeping and suicide prevention.

174. A broad range of partners attend LSCB board meetings from relevant agencies and, following the recent review of the board's functioning, the LSCB has a new structure including a number of appropriate sub-groups. Board members report that the chairs group, made up of the chairs of the sub-groups, now acts in a co-ordinating role and drives the work of the Board.

175. Engagement with schools has been strengthened through a new clearer structure to engage representatives of schools (primary, secondary, colleges and special) and a strengthened approach to S.175 audits providing greater challenge to schools.

176. There has also been challenge to agencies in relation to their willingness to carry out the 'lead professional role' within Team Around the Family meetings (TAFSs) and challenge to West Midlands police at the December Board in relation to their practice with missing children following a recent inspection by Her Majesty's Inspectorate of Constabulary (HMIC).

177. From a low base, the work of the LSCB is now going through a necessary and rapid period of development. This is based on a new 2014-15, 10 point business plan presented to the Board in October 2014. This stemmed from the strategic review and is aimed at moving the Board to a position where it is able to fully discharge its statutory functions within six months. A workshop event for Board members on 15 January 2015 considered how to make this vision a reality. This provides a clear route map for progress but it remains too soon for a significant impact to be seen.

178. The LSCB chair attends the Health and Wellbeing Board (H&WB) and a new document shaped by the chair lays out the roles of LSCB, the local safeguarding adults' board, the H&WB and the Safer Sandwell Partnership. This will support the LSCB in the exercise of scrutiny of other statutory partnerships in the future and will assist the LSCB in taking the lead role in providing inter-agency monitoring challenge and leadership.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professionals work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Mary Candlin HMI

Deputy lead inspector Dominic Stevens HMI

Team inspectors: Peter McEntee HMI, Linda Steele HMI, Nigel Parkes HMI, Stephanie Murray HMI, Marianick Ellender-Gele HMI

Quality assurance manager: John Gregg, Senior Her Majesty's Inspector

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