Inspection of local authority arrangements for the protection of children

Sandwell

Inspection dates: **25 February – 6 March 2013**
Lead inspector **Ian Young HMI**

Age group: All

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The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Sandwell is judged to be **inadequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Sandwell the local authority and its partners should take the following action.

Immediately:

- ensure all Section 47 enquiries are compliant with child protection procedures and statutory guidance and that where joint investigations are required, these are effectively undertaken by the police and children's social care
- ensure that children and young people are enabled to contribute to their assessments and that their specific needs, including ethnicity, culture and language are considered in all assessment processes and plans
- ensure that all children who have been assessed as children in need have a written plan in place to enable professionals to coordinate their interventions and effectively manage risk.

Within three months:

- strengthen arrangements for information sharing between agencies at key points in the child's journey, including strategy meetings and initial child protection conferences to ensure that risks to children are appropriately assessed and effectively managed

- introduce a formal risk assessment process to improve management oversight of child protection work and ensure that decisions are based on robust written evaluations of risk, including those relating to decisions to close or transfer cases
- improve the quality and consistency of assessments so that full account is taken of risks, protective factors and historical information and that where appropriate, fathers are fully engaged in the process
- improve the quality and consistency of child protection plans to ensure that they have measurable outcomes and timescales for the completion of actions, so that progress can be monitored and risk effectively managed
- ensure that all children receive regular monitoring visits within statutory timescales, at which they are seen alone at appropriate intervals and their wishes and feelings well understood and recorded
- re-establish the effective functioning of Sandwell Safeguarding Children Board so that it operates to a regular pattern of meetings that ensures the effectiveness of multi-agency arrangements for the protection of children, in accordance with its statutory duties.

Within six months:

- ensure that thresholds for referral to children's social care are agreed, understood and embedded across the partnership
- ensure that all child protection conferences are chaired to an agreed standard and that all agencies provide written reports to conference, with parents having sight of the social work reports prior to the child protection conference
- develop quality assurance processes that are effective in monitoring the quality of services provided, address deficits identified on the management of individual cases file and contribute to a culture of continuous improvement
- establish a clear, jointly-owned early help offer that ensures seamless and effective support for those children who are not, or no longer, at risk of significant harm.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of four of Her Majesty's Inspectors (HMI) and one Associate Inspector.

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Sandwell is a metropolitan borough which comprises six towns; Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury and West Bromwich and is one of seven authorities that make up the West Midlands conurbation. It has an estimated population of 309,000 of whom 66,500 are aged 15 or under which is 21.5% of the population overall. In the 10 years between the 2001 and 2011 censuses, the White British population decreased from 78% to 65.8%. The White 'Other' category, (excluding Irish) increased by 78% to 10,463. Asian groups, including Indian, Pakistani, Bangladeshi, Chinese and Other Asian, account for 19.2% of the population.

10. The borough has high levels of deprivation, which is widespread yet fairly uniform. The worst areas of deprivation tend to follow the industrial belt, running from the northwest to southeast of the borough. The Indices of Multiple Deprivation (IMD) 2010 shows Sandwell as the 12th most deprived local authority in England, out of a total of 326. Previous IMD results for this measure show that its position has deteriorated relative to other districts in England.

11. The borough has a higher than average proportion of children and young people relative to the population overall. The last five years have seen a significant rise in the number of live births, to 4,977 in 2010-11. This represents a 21% growth in live births since 2004-5. The latest data on school pupils shows that the new generation of residents is ethnically more diverse than the population overall. In January 2011, 45% of children in Sandwell schools were from a minority ethnic group, whereas the percentage for England is estimated at just over 26%.

12. Early help is provided from 22 children's centres, all of which have now been recommissioned. Family support is provided through the family support team and family intervention project. A contact centre takes all calls coming in to the local authority, within which a small team of qualified social workers, including a team manager, screen calls relating to children and families and direct them to appropriate services. The team is supported by a group of experienced business administrators and a common assessment framework (CAF) coordinator, and determines whether referrals meet the threshold for children's social care services. Referrals, initial assessments and enquiries under Section 47 of the Children Act 1989 are dealt with by the referral and assessment service; which has four teams, providing a duty service on a weekly rotational basis. Cases proceeding to an initial child protection conference are the subject of a Section 47 core assessment and remain allocated with the referral and assessment team until the first core group of professionals after children become subject to a child protection plan, at which stage they move to one of six care management teams. These teams also hold cases of children in need under Section 17 of the Children Act 1989.

13. In November 2009, Sandwell underwent an announced safeguarding and looked after children inspection which concluded that overall effectiveness of safeguarding arrangements was inadequate. The inspection report was followed by an Improvement Notice from the Minister of State for Children, Young People and Families, in March 2010. From this point, an improvement plan was developed and an Improvement Board formed, to address the findings of the inspection report and the requirements of the Improvement Notice. In January 2012, Ofsted reassessed safeguarding services for children as adequate. In August 2012, the council recognised that it had failed to deliver improvements consistently and sustainably over time, across the service and decided to enter into a strategic partnership with a private provider for service improvement.

Overall effectiveness

14. The overall effectiveness of arrangements to protect children is inadequate. Significant, systemic failures in arrangements for the protection of children mean that the council and its partners cannot be assured that all children and young people in Sandwell are being appropriately protected from harm. The council is aware of the poor quality of its services, and in January 2013 entered into a strategic partnership with a private provider to secure sustainable long term improvement in the performance of child protection and early help services. However, a significant challenge remains in ensuring the current safety of children and young people while long term plans take effect.

15. The current early help offer is not coherent and until very recently has lacked a suitable governance structure. This results in the provision of early help and intervention services that are neither consistently available across the area, nor well integrated, either with each other, or with statutory services. Whilst some examples were seen by inspectors of effective early help being offered to individual families, too many cases were seen by inspectors where intervention was repeatedly transferring between family support and social work services without a satisfactory assessment being undertaken and a consistent plan for improvement being put in place. This means that in too many cases children in the family did not have an assessment of their risk of harm, including children in families where domestic abuse is known to have occurred.

16. Where children and young people are assessed as children in need, the quality of assessment and management decision making is often poor. It is unclear on many case files seen, why more immediate action is not being taken to protect children, including those in highly vulnerable groups such as young people who are persistently missing and at risk of sexual exploitation. Some children spend an inappropriately brief period on child protection plans prior to work being discontinued without the council and its partners being assured that they are any safer. Most cases being dealt with as children in need do not have a current plan on file, and it is therefore unclear what social work intervention with families is aiming to achieve and by when.

17. Systems for the referral, assessment and protection of children at risk of significant harm are very weak. Thresholds for social work intervention are not well understood by partners and the multi-agency referral form introduced by Sandwell Safeguarding Children Board (SSCB) is rarely used. The work of the Access Centre in screening cases is mostly appropriate and results in cases being transferred to the referral and assessment teams in a timely manner in the vast majority of cases. However, some cases which should have been passed on to the referral and assessment teams for assessment had been inappropriately dealt with as contacts and this does not meet statutory guidance.

18. Where children are considered at risk of immediate harm, arrangements for an inter-agency strategy discussion to coordinate the response are insufficiently robust. Strategy discussions do not always take place when they are appropriate, rarely involve agencies other than the police and children's social care, and when they do take place they are not clearly recorded.

19. Child protection enquiries are not always clearly recorded and it was therefore not possible to be assured that children were safe. Children, young people and parents are not routinely involved in assessments of their family's circumstances. A significant number of cases seen by inspectors were without an assessment of risk, leaving children and young people in potentially unsafe situations without an appropriate plan being put in place to secure their safety. While some examples of good assessment were seen by inspectors, assessment practice was poor overall and contributing significantly to the systemic failure to ensure that children and young people are safe.

20. Child protection conference arrangements are too variable. Not all child protection conferences observed by inspectors were fit for purpose. Some were poorly attended by partner agencies and decisions and plans were made about children's safety on too little information. Child protection plans do not always consist of specific and measurable actions to ensure that children are safe. Core groups for the coordination of inter-agency action to support the child protection plan are not well recorded. Visits to children and young people subject to child protection plans are infrequent and not always sufficient to ensure their safety.

21. Leadership and governance arrangements for the protection of children are currently inadequate. Senior leaders interviewed by inspectors accept that they have been insufficiently rigorous in their oversight of child protection arrangements. The SSCB is currently failing to meet its statutory duty to ensure appropriate oversight of inter-agency arrangements for the protection of children. The council's own framework for monitoring the quality of services is inadequate and unreliable. However, inspectors did see recent evidence of senior leaders engaging more robustly with child protection issues, most particularly in the formation of the strategic partnership, and putting firm plans in place to re-establish the SSCB.

The effectiveness of the help and protection provided to children, young people, families and carers

Inadequate

22. There are significant failures in the effectiveness of the help and protection provided by the council and its partners and, as a result, children and young people receive ineffective early help and are inadequately protected.

23. Early help services have been re-structured and are undergoing whole system change, but are currently neither well-integrated nor coherent. Families often do not receive the support they need at an early enough stage to prevent deterioration in their circumstances. Planning in the family support service (FSS) is recognised by the council as an area for development, as too often plans comprise a long list of tasks and lack clear and measurable outcomes. Whilst inspectors saw examples of effective intervention that prevented children's circumstances getting worse, and spoke to families who valued the support offered, in too many cases services are not responding quickly enough to prevent family circumstances deteriorating and statutory intervention being required.

24. Generic and specialist family support, such as for parents with learning disabilities, is delivered by an appropriate range of commissioned providers, working in partnership with children's services. Contracts with providers are monitored in terms of the number of families receiving services, although evaluation is not sufficiently developed to demonstrate how services are making a difference to children and families' lives. However, individual cases seen by inspectors do show some instances of effective support. The introduction of the Troubled Families initiative is at an early stage, with no evidence as yet of positive impact.

25. Too many families are being passed repeatedly and inappropriately between early intervention services and children's social care. Demand on the FSS is increasing due to a rapidly growing number of cases being de-escalated by children's social care to be supported through Team around the Family (TAF) multi-agency packages. Transfers are immediate, and made regardless of capacity within the FSS or prior discussion with the family. This means that the TAF model is often unsuccessfully implemented and families are potentially left without suitable levels of support. The FSS is appropriately prioritising these families, but this results in delays to existing work, meaning reviews of families' needs are not always timely. Many families' cases are inappropriately de-escalated by social workers then rapidly re-escalated. For example, the council's own figures show that of the 168 families that were de-escalated to family support from children's social care between October and December 2012, three were immediately identified as above the threshold for support at

this level and referred straight back to children's social care, and a further 34 families were re-escalated within three months.

26. Children's centres are in a period of transition and some centres do not have agreed delivery plans. This means that the delivery of, and access to, family support through children's centres is currently inconsistent across the area and this is impacting negatively on the availability of support to families. For example, in some localities, family support cannot currently be included within TAF plans as none is available locally. Centres are of a suitable quality; of the 20, 12 have previously been inspected by Ofsted, six of which were judged outstanding; five good and one satisfactory. Although centres are now routinely informed of children living in their locality that are subject to child protection plans, this is not yet the case for children deemed to be in need. Centres formerly received live birth data, but this is no longer the case and this means that they are not easily able to identify and engage at an early stage with all families whose circumstances may make them vulnerable.

27. Some specialist early help services are not available or easily accessed by children and families. Child and adolescent mental health services (CAMHS) to support children's emotional well-being at an early stage are a deficit identified by the council and its partners, with long waiting times currently for counselling services. Although a variety of evidenced-based parenting programmes are delivered within different service areas, including schools, children's centres and CAMHS, these are not well coordinated and parents of troubled teenagers report that they are insufficient to meet their needs.

28. The response of the council and its partners to domestic abuse cases is seriously inadequate. Reviews into four domestic homicides have been undertaken locally in the past year, together with an independent management review following the death of a child in a neighbouring authority. Each identified that improvements are needed by partner agencies in their response to domestic abuse, but this was not in evidence during the inspection. Many of the domestic abuse cases notified to children's social care do not meet the locally agreed criteria for involvement, including details being sent on some cases where there were apparently no children and young people in the household. Multi-agency screening is carried out using a nationally recognised tool, but relevant agencies do not always attend screening meetings and this seriously reduces the effectiveness of preventative work. Not all high risk cases are being robustly assessed. For instance, according to the partnership's own figures, there were 4840 notifications in 2011/2012, but only 307 (6%) progressed to an assessment of which only 25 (8%) were further actioned. Therefore, only 0.5% of domestic abuse cases notified to children's services resulted in a coordinated package of support to prevent further incidents and ensure that children are safe.

29. Too many cases seen by inspectors lacked the appropriate level of involvement of children, young people and their parents and carers, and in some cases this left children and young people at risk of significant harm. A significant number of the cases referred by partner agencies to children's social care had not been discussed first with parents and in some cases seen by inspectors, agencies had refused to do this, evidencing a lack of joint ownership of child care issues by the wider partnership. Where enquiries are undertaken into children's safety, inspectors observed an over-reliance on parental views of the situation, and a lack of appropriate challenge to them. Children and young people are not always seen alone when their needs are being assessed, and when they are, their views are not always fully considered. Feedback from children, young people and parents interviewed by inspectors was generally positive, with good reports on the work of some social workers. In particular, young people reported a good range of support to assist them with behavioural issues. However, variable performance was seen in visiting children and young people as part of their child protection plan. In some cases this is appropriate, but in others, children and young people, including very young children, are only being visited four to six weekly and this frequency is not commensurate to the level of assessed risk and therefore insufficient to ensure their safety. The turnover rates of staff often means that it is not possible for a child to build an effective relationship with a social worker before they move on.

30. Most children in need cases seen by inspectors are not being suitably dealt with, leaving vulnerable children and their families insufficiently supported. Child in need plans are not routinely completed in a large majority of these cases, and plans that were seen were mostly of a poor quality, with actions and objectives set that are often too vague. The child's individual experience and needs are too often not well represented in these plans and poor planning overall means that arrangements to monitor the safety of children in need are insufficiently clear, leaving them at potential risk.

31. The electronic recording system used by the council is poor and difficult to access and as a result, the quality of case recording is too often inadequate. Documents critical to children and young people's safety, such as the decisions and recommendations, and the minutes of child protection conferences, are not always completed and placed on the electronic system in a timely manner. This does not meet statutory guidance.

32. Support for young people at risk of sexual exploitation or missing is coordinated through a multi-agency meeting, which is chaired well by a senior police officer. However, inter-agency sharing of information and actions undertaken between these meetings is too variable and in most cases inadequate. For instance, at one meeting observed by inspectors, 27 cases were due to be discussed, but updates were received from children's social care on only two of those cases, seriously limiting the

ability of the meeting to effectively assess risk to this highly vulnerable group of young people. Inspectors also identified through tracking, cases that met the criteria, but had not been dealt with through this process. Inspectors found that risk was not assessed with sufficient rigour in these cases and young people did not have a suitable offer of help provided to them and their families that was effectively coordinated by either a child in need or child protection plan.

33. Suitable arrangements are in place within the local authority to ensure that their responsibilities to safeguard the welfare of children and young people in private fostering arrangements are appropriately discharged. There are currently a small number of children being supported through these arrangements and appropriate systems are in place to monitor notifications and ensure compliance with the procedures. However, this service is offered to a low number given the size and makeup of the local population.

34. An appropriate child protection service is provided to children with a disability through a dedicated team, although none are currently the subject of a child protection plan. Inspectors visiting this team saw a timely and appropriate response to referrals and the completion of good quality initial and core assessments, although the quality of children in need plans is variable. As a result of the support provided, evidence was seen by inspectors of improved outcomes for this group of children and young people.

The quality of practice

Inadequate

35. Significant weaknesses within the child protection system are resulting in children and young people being left at risk of significant harm. A substantial number of cases were seen during the inspection where child protection procedures were not complied with and, as a result, risks were not fully assessed. Examples were seen of some effective practice by social workers and partner agencies and these are leading to effective outcomes for some children. However, inspectors identified a significant number of cases where poor information sharing between agencies, inadequate assessment and insufficiently robust management decision making is leaving too many children inadequately protected.

36. Thresholds for referral to children's social care are not well embedded and understood across the partnership. Whilst most contacts and referrals receive an adequate and timely response, in too many other cases a lack of understanding of thresholds to children's social care results in a high number of contacts being closed without any further action taken. Some complex cases are having too detailed a screening, including phone contact with children, families and other agencies, and this is in effect a partial assessment, without the important visit to the family home where

all of the children are seen. This practice does not meet statutory guidance and is potentially unsafe. Partner agencies are not routinely using the multi-agency referral form for referrals into children's social care and as a result, social workers in the referral and assessment teams do not always have all the necessary relevant information to enable them to commence child protection enquiries. Social worker's time is therefore spent gathering information and, in some cases, this is impacting on the timeliness of their commencing child protection investigations, potentially leaving children at risk.

37. Commitment to, and engagement with, the family support model is varied between agencies across the partnership, although when used well it is seen as effective by the partners involved. The quality of assessment conducted in accordance with the common assessment framework (CAF) is too variable, ranging from good to inadequate. Too many CAFs seen by inspectors were descriptive rather than analytical, and sometimes the desired outcomes and reason for undertaking the assessment were not clear. Some partners are strongly resistant to taking responsibility for being lead professional for CAFs and Team around the Family (TAF) multi-agency work. This function is therefore undertaken by the TAF coordinators based within the FSS, and their work is valued by the professionals who spoke to inspectors. However, increasing demand means that TAF coordinators are chairing too many TAF meetings and the result is that sometimes key issues are insufficiently addressed.

38. In most cases seen by inspectors, there was a timely transfer of referrals from the access centre to the referral and assessment team, with good management oversight at the point of transfer, effective prioritisation and timely allocation of work. However, significant weaknesses in information sharing between agencies results in some decisions being made on partial information, leaving children in situations of unassessed risk.

39. Insufficiently robust systems are in place for the conduct and recording of strategy discussions or meetings when children are considered to be at risk of harm. Appropriate agency checks are undertaken in most cases, but very few discussions involved partner agencies other than the police and children's social care. Strategy discussions are recorded, but the quality of recording is too variable, with action to be taken and responsibility for taking it not clearly defined. The police do not attend all initial child protection conferences, including those where they have direct involvement. This is affecting the ability of these multi-agency forums to consider all relevant information and make informed decisions, potentially leaving some children at risk of significant harm.

40. The majority of child protection enquiries are conducted well and result in a clear offer of help or protection to children. However a significant minority of child protection enquiries are not compliant with child protection procedures and statutory guidance. The emergency duty

service reported to inspectors that unqualified workers are carrying out visits to assess children's safety and this is in breach of statutory guidance. This was raised with the council during the inspection and they have taken immediate steps to end this practice. The outcome of child protection enquiries is not always clear from the records and management oversight is inconsistent. This has resulted in some cases being seen by inspectors where children's needs were not fully risk assessed. The use of written agreements following child protection enquiries is therefore not always based on a full assessment of risk, and too much responsibility is given to parents to monitor their own behaviour. In addition, in some of these cases, the lack of a record of management decision making means that it is unclear on what basis the decision has been made that use of a written agreement will keep these children safe.

41. The rigour of management oversight by first and second line managers is too variable. Decision making within children's social care is undertaken by suitably qualified managers and in a number of cases seen by inspectors, accountability for decision making is clear and the rationale for decisions is clearly evidenced and recorded. However, this practice is not consistent, with significant numbers of cases where the rationale for decision making is unclear. It is therefore difficult sometimes to determine the reasons for decisions, or even whether managers have been engaged in decision making at all. A high turnover of staff within children's social care means that when cases are transferred to a new worker, the lack of clarity and accountability for decision making on case files has the potential to cause confusion and drift.

42. Overall the timeliness of initial and core assessments seen is good, with the local authority's performance demonstrating sustained improvement. However, the current system of duplicating core assessments in the referral and assessment and care management teams is not compliant with statutory guidance. This practice is resulting in families being made the subject of three assessments, with the result in some cases of delays for families in receiving the services they need.

43. The quality of initial and core assessments is extremely variable, ranging from inadequate to good. A significant number of initial and core assessments seen by inspectors are descriptive with very little analysis and inadequate consideration of all risk factors. Historical information is not routinely considered in all assessments and there is a lack of rigour in ensuring that fathers are involved. Poor assessment represents a significant and systemic weakness in social work practice that is resulting in the failure to routinely identify all potential risk factors, and in some cases children and young people are left at risk of significant harm. Inspectors also saw some other examples of assessments which comprehensively address children's physical, social, emotional and educational needs and historical information is used with good effect to inform the analysis of risk. In a number of assessments seen, good

consideration is given to children's needs in relation to ethnicity, culture and language, although this is not consistent across the service.

44. Child protection plans are insufficiently specific and do not set appropriate timescales. While most plans clearly identify actions and outcomes, some plans are very general which makes monitoring progress against them difficult. Children and young people who are the subject of child protection plans are not always seen alone in cases where this would be appropriate. Inspectors found limited evidence of children and young people's views impacting on individual planning. Most case records fail to demonstrate that children and young people's voices are heard and that their experiences are being fully taken into account and acted upon.

45. Inspectors saw considerable variation in the management of child protection conferences; whilst some were well managed, others were poor. Inspectors observed instances where practice was weak and resulted in poor information sharing between agencies, insufficient consideration and analysis of all risk factors, and an over reliance on parents' reporting of events. In some cases seen, decision making was based on partial information and was therefore inadequate. These deficits were raised with the council and the conference was reconvened. Other conferences observed were very well chaired, with good attendance and participation by families, young people and professionals. Within these conferences, the quality of assessments was adequate, with risk clearly identified and responded to, and appropriate measures put in place to ensure children's safety. Advocacy services were available for parents, children and young people attending conferences. Decision making was appropriate and parents reported that they had been effectively helped.

46. Conference reports are not always shared with parents prior to conference to enable them to consider the content and make a fully informed and effective contribution. The quality of social work reports to conference is too variable. Some are very detailed with good consideration of historical information, risks and protective factors and an analysis that results in clear and appropriate recommendations. However, too many reports are purely factual with little evidence of analysis. Key issues of risk are therefore not always addressed and the reports' recommendations are not always clear. Social workers' reports to review conferences do not always contain details of core group meetings, and it is therefore not always possible for child protection chairs to monitor the frequency of these meetings.

47. The quality of recording of core group meetings is too variable and it is not always sufficiently clear that all key aspects of the child protection plan have been reviewed. This is impacting on the timely review of the progress of some child protection plans. Significant gaps were seen by inspectors in the frequency of core group meetings in some cases. In others, regular core groups were well attended by partner agencies, but

this practice is insufficiently consistent. Most parents, children and young people seen understood the purpose of plans, the responsibilities of agencies and what was expected of them. Some parents expressed frustration at the frequent change of social worker, and child protection chairs interviewed by inspectors commented that frequent changes in social worker can sometimes impact on the progress of child protection plans. Use of chronologies is not well embedded, except in those cases subject to Public Law Outline and this limits the ability of social workers and partner agencies to undertake comprehensive assessments and implement plans that include a full consideration of historical information.

Leadership and governance
Inadequate

48. As a result of previous failures to provide consistent leadership, the current quality of social work practice is very poor and this has, until very recently, gone unchecked by senior leaders. From January 2013 the council has made a significant investment in children's services and entered into a strategic partnership with a private provider for service improvement. However, the partnership is in its early stages and is yet to demonstrate impact. The council face a significant challenge in assuring itself of children's current safety while its long term plans take effect. All strategic leaders interviewed, including elected members and partners, were able to fully describe the purpose of strategic partnership, the expected outcomes and the succession plan. All are involved to a greater or lesser extent in making the partnership work and are evidently fully committed to it. However, this strategic direction is relatively recent and has yet to replace previous, seriously underdeveloped strategies, such as the current disjointed, inconsistent and fragmented early help offer.

49. The Sandwell Safeguarding Children Board (SSCB) is seriously underdeveloped and members spoken to by inspectors acknowledge the need to in effect re-establish the Board, which is failing to meet its statutory duties. A period of hiatus, in which the Board did not have a Business Manager or a permanent independent Chair, has led to the lack of a pattern of regular, well-attended meetings operating to a consistent business agenda that drives forward the business plan. For instance, although the Board has a data compendium, the information reported is out of date and is not successfully used to routinely monitor the quality of inter-agency arrangements for the protection of children. Although some parts of Board activity are functional, such as the training and serious case review (SCR) sub-groups, there is little evidence of their work feeding into a main SCB which has a clear overview and ownership of the local multi-agency child protection agenda. One example of the negative impact of this serious situation is the failure of the SSCB to successfully develop, implement and launch an effective multi-agency referral form. A permanent independent Chair has recently been appointed, and following this appointment, the Board are prioritising and implementing a range of

measures to get the Board re-energised and functioning effectively. However, this activity is very recent and at the time of the inspection it was too early for it to demonstrate positive impact.

50. Senior leaders interviewed acknowledge that serious practice deficits have developed during their tenure and accept they should have previously been more challenging in identifying and dealing with them. However, a clear sense of ownership of and accountability for child protection services is now evident across the senior leadership. The Chief Executive's awareness of deficits in the delivery of children's social care services was acquired during a recent period as acting Director of Children's Services (DCS). He appropriately identified these shortfalls as a historical failure of consistent senior leadership and was instrumental in the development of the strategic partnership. A highly experienced DCS has now been recruited by the strategic partners, and he has a clear vision for the sustainable development of children's services and his role in it.

51. A hiatus in management arrangements prior to the current strategic partnership has led to some drift and delay in implementing the council's improvement plan. The current improvement plan suitably meets the requirements of the existing Improvement Notice and was appropriately kept in place following a reinspection and further recommendations from Ofsted in 2012. The Improvement Board is functional and well led by a knowledgeable and highly experienced independent Chair. The appropriate decision by the Improvement Board to prioritise child protection due to the organisational risks it was presenting is one of several recent indicators of the senior leadership engaging more strongly and realistically with the improvement agenda.

52. The system of quality assurance operated by children's social care services is inadequate. As a key part of the quality assurance framework, a routine audit process is in place to which there is a high level of awareness and commitment amongst staff as an activity. However, consideration of overview reports by inspectors indicates that, as a process, auditing is over-optimistic and lacks rigour, so that it neither acts as an effective failsafe to individual examples of poor practice, nor promotes a culture of continuous improvement. A far greater level of poor practice was identified by inspectors tracking cases during the inspection than by managers participating in routine case audits. Individual thematic audits are undertaken, and the brief but acceptable reports produced, provided evidence of an attempt to understand the issues identified from audits. However, these are undertaken as a series of separate events; they are not joined up and they do not feed into an overview of practice standards. Audit reports do not conclude with SMART action plans to support sustained practice improvement. For example, a thematic audit was undertaken in August 2012 on child protection plans that had lasted three months or less and recommendations were made to reduce this unacceptable practice. However, when inspectors sampled similar cases as

part of the inspection process, they identified the fact that more cases were now subject to this practice than before the audit had been conducted.

53. There is little strategic consultation with children and young people to improve safeguarding services. The elected Lead Member is a strong supporter of participation and when interviewed, was able to offer examples of the active involvement of young people, such as at the Children's Strategic Partnership. However, no systematic attempt to capture and build the experience of service users into strategic planning was seen by inspectors during the inspection.

54. Limited evidence was available to inspectors of a learning culture. The SSCB has a functional SCR sub-committee and has entered into partnership with the NSPCC on a programme called 'site bites', to consolidate the learning from SCRs. The findings from previous Ofsted inspections are highly influential on the improvement plan, although senior leaders interviewed felt that this had previously been reactive, and they are now committed to using inspection findings proactively, to inform a programme of sustained service improvement. In other areas, such as complaints, a learning culture was not readily in evidence and overall, there was no indication seen of lessons being drawn together by the council and its partners and used as part of a culture of continuous improvement.

55. Senior elected members interviewed by inspectors are highly engaged, clearly knowledgeable about children's services and committed to their improvement. Suitable arrangements are in place for scrutiny of children's services by elected members, who operate to an appropriate culture of challenge and are aware that they have previously paid insufficient attention to the quality of the service. Sound financial management by the council means that children's services is currently operating to a balanced budget, and this is supported by appropriate commissioning processes which are most in evidence for early help services.

56. Performance reporting of key performance indicators is a strength of the organisation and a dedicated team produce high quality reports, which promote managers understanding of data and its use in service improvement. Some managers reported to inspectors that they have used performance reports effectively, although there is no consistent systemic expectation of the use of performance reports by managers to improve practice. Current progress on robust management oversight is hampered by the lack of a stable management group in front line and middle management positions. Management decision making and case audits seen by inspectors did not evidence a strong perception of acceptable practice standards and a routine commitment to applying them. As part of the strategic partnership, a workflow analysis has recently been undertaken that provides an insightful view of current deficiencies in child

protection services. The council's strategic intention is to recruit a robust middle management group, use this intelligence to deliver a strengthened improvement plan and in the longer term develop a robust and sustainable culture of practice improvement. However, this work is in its early stages and is yet to show positive impact.

57. Social workers report receiving regular supervision and say that managers are available to provide informal supervision as and when required. Some records of supervision seen by inspectors evidence case discussion and reflection with clear actions being identified and tracked. However, this practice is not consistent, as other records of supervision are very brief and task focused. Professional development and training is customarily addressed in supervision, although not all annual performance reviews are completed. Recording on some supervision files shows poor performance being appropriately tackled.

58. Recent action has been taken to end an historical reliance on agency staff, as this was both expensive and resulted in a lack of consistency in providing services. Some headway has now been made in recruiting permanent social workers and, as many recruits are newly–qualified, the council has developed a detailed offer for their professional development, which is aimed at their retention in the longer term. A targeted recruitment programme has also been successful in engaging a number of new team managers and the council's own monitoring indicates that, together with an 'in-house' development programme, vacancies have been considerably reduced. This puts in place the capacity to ensure consistent management decision making and social work allocation in the longer term.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Inadequate
The effectiveness of the help and protection provided to children, young people, families and carers	Inadequate
The quality of practice	Inadequate
Leadership and governance	Inadequate