# Sandwell Metropolitan Borough Council

## Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection date: 6 November 2017 to 30 November 2017

Report published: 29 January 2018

| **Children's services in Sandwell are inadequate** | | |
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| **1. Children who need help and protection** | | Inadequate |
| **2. Children looked after and achieving permanence** | | Inadequate |
| | 2.1 Adoption performance | Inadequate |
| | 2.2 Experiences and progress of care leavers | Requires improvement |
| **3. Leadership, management and governance** | | Inadequate |

## Executive summary

Children's services in Sandwell are inadequate. Since the last inspection, some services have deteriorated, in particular services for children looked after and adoption. There are widespread and serious failures in services for children and families in need of help and protection, children looked after and those requiring permanence through adoption. Most of the recommendations from the Ofsted 2015 inspection have not been fully met and some services have declined in effectiveness. The pace of change to address service deficits has been too slow. Only in recent months, with the appointment of a new senior management team, has the trajectory of improvement quickened. However, the basic elements of good social work practice are not yet in place, for example effective management oversight, a robust response to risk, and timely and thorough assessment and plans.

Improved performance data and regular case auditing have provided the interim senior leadership team with a good understanding of the large scale of service deficits. Since their appointment, senior leaders have worked hard to regain a management grip on services. However, there has been insufficient time for them to create services in which social work practice can flourish, and most actions set out in the improvement plan are not yet achieved.

Despite political support for the recruitment of additional social workers, the workforce stability is fragile: nearly 60% of staff are in their assessed and supported first year of employment (ASYE) or are agency workers. The lack of social workers experienced in complex casework, together with significant turnover in the workforce, means that the overall quality of work is poor and that relationships between children and their social workers are often fragmented. Due to a better understanding and application of thresholds, the number of children on child protection plans has significantly increased. This dramatic rise means that, despite the recruitment of more social workers, caseloads remain high, with the result that workers do not have sufficient time to deliver good-quality work or to attend training to develop their practice.

For too long there has been a lack of a strategic children's partnership. This means that not enough attention has been paid to developing the most effective strategic multi-agency ways of working to improve outcomes for children. Commissioners' plans do not show in sufficient detail which services are required or how they will be obtained and sustained. Senior leaders do not analyse complaints to understand trends and themes.

Services for children and families in need of help and protection have not improved enough from the judgement of inadequate in 2015, although some improvements have been made. For example, the multi-agency safeguarding hub (MASH) works effectively to assess risks and ensure that work is directed to the appropriate service level. Early help services offer a wide range of community-based intensive support to families. The understanding of thresholds for early help and statutory services has improved since the last inspection, but a small number of cases seen were inappropriately held at the early help level.

Other areas of work have not developed since the last inspection. For example, numerous cases in which risk had not been thoroughly examined or addressed in an effective or timely manner were referred back to the local authority. The response to children going missing or at risk of sexual exploitation lacks rigour. Return home interviews for children who go missing are not consistently offered or completed. This means that the reasons for children going missing remain unknown and do not inform future work. When 16- and 17-year-olds present as homeless, they are not routinely informed of the options available to them, including the benefits for them of becoming looked after. Therefore, services may not be fully meeting their needs. The response to children in private fostering arrangements remains underdeveloped.

The quality of assessments, plans and management oversight across all services is poor. Assessments are not regularly updated, they lack analysis and do not provide a clear understanding of a child's lived experience. The child's voice is often lost due to a lack of direct work with children. Children's plans are not specific enough about who will do what and by when to improve children's experiences. The plans are not consistently informed by historical factors or a robust analysis of risks. Management oversight, including that of independent reviewing officers (IROs), lacks urgency and direction to quickly drive forward plans. Plans are not progressed swiftly enough by core groups or child in need meetings.

Decisions to bring children into care are not always taken soon enough and, for many children, there is drift and delay in securing permanence. A large number of children are waiting to be matched to their long-term foster carers, and the local authority has few children subject to special guardianship orders. Adoption is not considered with enough rigour for all children who cannot return home. Permanence plans are not clear by the time that many second reviews of children looked after take place. When adoption becomes the plan, children wait too long to move in with their adoptive family. Many children do not receive timely life story work, life story books or later life letters to help them to understand their background and circumstances. The quality of child permanence reports needs improving in order to provide children and adopters with a child's full history and reasons for adoption. The adoption panel needs to ensure that it meets its quality assurance function regarding panel paperwork and social work practice, with better feedback and regular meetings with the local authority. The local authority has had some recent success in recruiting foster carers. However, overall, there are insufficient numbers to provide enough placement choices and to offer the best possible matches.

The health needs of children looked after are mostly well met. Their educational attainment is lower than the national average. Corporate parents meet with children, and this has resulted in some improved services. Personal advisers remain in touch with most care leavers and there is a good range of support services for care leavers. However, more emergency accommodation is needed for care leavers, and far too many are not in education, employment or training. Care leavers need better access to adult mental health services.

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# The local authority

## Information about this local authority area[1]

### Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection report for the local authority's children's services was published in June 2015. The judgements for the local authority were:

Overall effectiveness: Inadequate.

Children who need help and protection: Inadequate.

Children looked after and achieving permanence: Requires improvement.

  - Adoption performance: Requires improvement.
  - Experiences and progress of care leavers: Requires improvement.

Leadership, management and governance: Inadequate.

Local leadership

- The director of children's services (DCS) has been in post since March 2017.
- The chief executive has been in post since September 2011.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since June 2017.
- The local authority uses the 'Signs of Safety' model of social work.

### Children living in this area

- Approximately 79,853 children and young people under the age of 18 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 21% (the national average is 15%)
  - in secondary schools is 21% (the national average is 13%).
- Children and young people from minority ethnic groups account for 41% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Indian and Pakistani.

[1] 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.

- The proportion of children and young people with English as an additional language:
  - in primary schools is 33% (the national average is 20%)
  - in secondary schools is 28% (the national average is 16%).
- Data from the January 2017 school census shows that the number of state-funded pupils residing in Sandwell who attend schools in other local authorities is higher than the number of pupils who live in other local authorities but attend schools in Sandwell.

**Child protection in this area**

- At 7 November 2017, 2,607 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,042 at 31 March 2017.
- At 7 November 2017, 742 children and young people were the subject of a child protection plan. This is an increase from 428 at 31 March 2017.
- At 7 November 2017, one child lived in a privately arranged fostering placement. This is a reduction from six at 31 March 2017.
- Since the last inspection, 12 serious incident notifications have been submitted to Ofsted and four serious case reviews have been completed or were ongoing at the time of the inspection.

**Children looked after in this area**

- At 7 November 2017, 674 children were being looked after by the local authority (a rate of 86 per 10,000 children). This is an increase from 610 (76 per 10,000 children) at 31 March 2017. Of this number:
  - 382 (or 57%) live outside the local authority area
  - 46 live in residential children's homes, of whom 89% live outside the authority area
  - none live in residential special schools[2]
  - 517 live with foster families, of whom 54% live outside the authority area
  - 47 live with parents, of whom 21% live outside the authority area
  - 22 are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 27 adoptions
  - nine children became the subject of special guardianship orders

[2] These are residential special schools that look after children for 295 days or less per year.

- 155 children ceased to be looked after, none of whom subsequently returned to be looked after
- 51 children and young people ceased to be looked after and moved on to independent living
- eight children and young people ceased to be looked after and are now living in houses of multiple occupation.

## Recommendations

1. Improve management oversight and decision-making across all services to ensure that needs and risks are fully addressed and that assessments, plans and interventions are appropriate. This was a recommendation at the last inspection.
2. Ensure the establishment of a strategic children's partnership across Sandwell to better inform all agencies about the needs of the most vulnerable children, including those who are at risk of sexual exploitation, so that agencies work effectively with these children.
3. Ensure that assessments are regularly updated, and the authors rigorously consider risks and take account of children's histories, wishes and feelings, and diversity to inform planning and provision of services. This was a recommendation at the last inspection.
4. Improve the quality, delivery and review of plans across all service areas to meet the needs of children and ensure that they are not subject to drift or delay. This was a recommendation at the last inspection.
5. Ensure that children who go missing receive a timely return home interview so that risks are analysed to inform future plans and identify wider patterns and activity. Review with the current provider its approach to young people when arranging an interview, to ensure that refusals are kept to a minimum. This was a recommendation at the last inspection.
6. Ensure that permanence plans for all children looked after and those for whom adoption is being considered are clear, systematically tracked and monitored in order to reduce delay. This was a recommendation at the last inspection.
7. Ensure that 16- and 17-year-old homeless young people gain a full understanding of their options and the benefits of becoming looked after. This was a recommendation at the last inspection.
8. Ensure that multi-agency core groups and child in need meetings are held within timescales and drive plans forward. This was a recommendation at the last inspection.
9. Increase the number of foster carers to meet the varied needs of children looked after.
10. Review commissioning documents to ensure that commissioning intentions are fully informed by detailed plans, in order to achieve those intentions.
11. Encourage and promote education, employment and training to ensure that care leavers develop skills to assist in their independence. This was a recommendation at the last inspection.
12. Develop links with adult mental health services to ensure that care leavers' health needs continue to be met when they move from children's services. This was a recommendation at the last inspection.

13. Develop the provision of emergency accommodation to prevent care leavers' use of hotels.
14. Ensure that timely and good-quality life story work is developed for children to help them to understand what has happened in their lives, and that life story books and later life letters are provided at the time when a child moves to their adoptive family. This was a recommendation at the last inspection.
15. Improve the quality of child permanence reports in order that children and adopters have a full and accurate picture of the child's birth family and history, and understand the reasons for adoption.
16. Ensure that the adoption panel meets its quality assurance function by regular feedback and meetings with the agency regarding the quality of social work reports and practice.
17. The analysis of complaints should include those made by children and a log should be kept of informal resolutions of issues of concern to children to better inform the local authority of themes and trends.

## Summary for children and young people

- Services for children and their families in Sandwell have not become better since the last inspection. Senior leaders know that services need to be better and have started to make improvements, but it is taking too long.
- Senior managers have plans to improve services for children, but they have not been in their jobs for very long and therefore have not had enough time to get things running well. They are working hard to check what social workers are doing, and are supporting them with training and advice to make sure that children and families have all the help that they need.
- When social workers find out that children are at risk of harm, they do not always act quickly enough to make sure that things improve to keep children safe. Professionals do not always work well together to make good plans so that children's lives can be improved.
- Too many children in Sandwell experience a change of social worker. This makes it hard for children and social workers to get to know each other well. This means that social workers do not always know children as well as they should or understand what their lives are like.
- Social workers do not receive all of the important information about children and their families to help them to make a plan for things to get better. The plans do not always say what everyone needs to do and when they need to do it by. Plans are not checked regularly enough to ensure that they are making a difference.
- When children go missing, there is not always enough information gathered about the risks that children face or the reasons why they go missing. This means that the risks that children face, such as risks of sexual exploitation or from gangs, are not always known and, as a result, children do not always receive the best help and support to stop them from going missing in future.
- When worries for children are so great that they can no longer live at home, social workers do not always bring them into local authority care soon enough. It takes too long for children to move to live with foster carers or adopters whom they will stay with until they are adults.
- Social workers try to keep brothers and sisters together and, if it is safe, they try to make sure that children see the people who are important to them. When adoption is the best plan, social workers help children to understand the reasons for this, but children do not always receive information soon enough about their family background and the reasons why they are adopted.
- Young people leaving care are supported to make sure that they find the best place to live. They learn how to look after themselves, how to stay in education or find a job and how to manage their money. At the moment, too many care leavers start to learn these important things too late, and not enough are in education or training or have a job.
- The looked after young people's board (LAYPB) is influential in improving aspects of services for children, for example by making sure that savings are securely kept and not lost when a child moves.

| The experiences and progress of children who need help and protection | Inadequate |
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Services for children in need of help and protection in Sandwell are inadequate. Children identified as at risk of harm wait too long for action to be taken. Not all the recommendations from the 2015 inspection have been progressed by the local authority, and basic social work practice is not of a good enough standard. This poor practice is characterised by insufficient managerial oversight and challenge from managers and IROs regarding assessments, plans and social work activity. Consequently, children do not receive timely or proportionate responses to ensure that risks and needs are met. Inspectors identified a large number of cases in which the needs of children had not been recognised or robustly assessed. Insufficient action was taken to address risks until these were identified by inspectors. Senior managers then took immediate action to address the concerns.

Early help services provide effective, community-based, intensive support to children and their families, with access to a comprehensive range of services. Most children have clear, outcome-focused plans. Inspectors identified a small number of cases that were inappropriately held at early help level and which required a step up to children's social care.

The single point of contact (SPOC) manages the vast majority of contacts and referrals in a timely way. Staff in the MASH have a clear understanding of thresholds, and risk assessment is robust. This means that children receive a timely and proportionate response to presenting needs. However, referral information from other agencies is not always clear or sufficiently detailed. In a small number of cases seen, late or absent referrals from health professionals potentially reduced the effectiveness of interventions and timely decision-making.

Assessments are of poor quality and are not updated annually or when a child's circumstances change. The vast majority of children's plans are weak, are not consistently informed by historic and current risk, and lack a focus on outcomes. This leads to a lack of purposeful and effective work and to children being exposed to a 'start again' pattern of social work.

The response to child sexual exploitation and incidents of going missing is not thorough enough. Children do not consistently receive return home interviews, and those identified as being at higher risk of exploitation are not always receiving focused and effective support. The local authority does not have strongly established arrangements in place to be assured that children who are privately fostered are known and are living in safe environments. Inspectors saw delay in assessing carers, and children were therefore living in situations of unassessed risk.

## Inspection findings

18. A comprehensive range of early help services provide effective community-based and intensive support to children and their families. Practitioners are passionate about and committed to children as well as to the work that they do. Creative direct work is undertaken with children, and their voice is well represented. Most children have clear, outcome-focused early help plans. Primary mental health workers are particularly responsive, and the work that they undertake is effective in improving children's emotional well-being.

19. Inspectors saw some children who had experienced delay in receiving early help. Delays varied from three weeks to three months from the initial contact to an allocation for a first visit. Inspectors also saw a small number of cases in which the threshold for stepping up to statutory services had been met yet not applied. Children were therefore not receiving the appropriate level of services to meet their needs. Referrals to statutory services are increasing, and this means that more children are being identified as in need of support.

20. The SPOC manages the vast majority of contacts and referrals in a timely way, and appropriate decisions are made. Cases are progressed before the 24-hour deadline and are informed by previous history. Consent is gained or dispensed with appropriately.

21. Domestic abuse screening is comprehensive. However, there is an unnecessary duplication of meetings when one strategy meeting would suffice. Due to this duplication, not all cases are reviewed as swiftly as they should be. This means that necessary action to protect children could be delayed.

22. The MASH is a strength. Both the MASH and assessment teams have a clear understanding of thresholds. Risk assessment is robust, and the quality of checks and decisions in the MASH results in clear professional judgements. MASH meetings and strategy meetings work well and include sufficient information from a range of professionals. Children receive a timely and proportionate response. However, referral information from other agencies is not always clear or sufficiently detailed. In a small number of cases, late or absent referrals from health professionals reduced the effectiveness of intervention and timely decision-making.

23. There is little evidence of discussion about cultural and ethnic backgrounds in almost all cases seen. This means that important information regarding family background, culture and practice does not inform the assessment of need or how best to intervene.

24. Assessments are of poor quality and are not updated annually (in accordance with the local authority's policy) or when a child's circumstances change. Risk is identified, yet is not rigorously analysed, and children's historical information is insufficiently considered. Direct work with children is not consistently undertaken by social workers, and when it is it lacks analysis. Assessments do not provide a sense of the child or an understanding of children's lived

experiences, and therefore do not fully inform planning to achieve the best outcomes for children. (Recommendation)

25. Management oversight is of poor quality, as social workers do not receive clear direction to progress plans. Supervision is neither reflective nor analytical, and actions are not followed up from one meeting to the next. This contributes to the drift and delay seen in casework. (Recommendation)

26. The vast majority of child protection reviews are held within timescales. However, IROs are not confident in their challenge to the local authority and not enough concerns are escalated on behalf of children. IROs agree that their footprint within case notes is not as strong as it should be and that they do not always record discussions and/or concerns. The use of a challenge tracker is not effective in challenging poor practice, which means that too many children's plans are subject to drift and delay.

27. Since June 2017, the number of children on child protection plans has risen by 71%. This dramatic rise has been analysed by the local authority and attributed to a number of factors: better recognition of risk; fewer children whose plans end after three months; and a better review of child in need cases which have been escalated to child protection. This rise means that, despite significant staff recruitment, social workers' caseloads remain high, and this has an impact on the quality of practice.

28. The vast majority of child protection and child in need plans are of a poor quality. The objectives of the work are not clear, timescales are vague or not recorded and children's voices are not evident. Social workers do not visit children regularly enough and, when they do, the purpose of the visit is not always clear. The recording of these visits is superficial and does not show how they relate to children's plans. Child in need and core group meetings are not held regularly and do not drive plans forward or measure progress systematically. (Recommendation)

29. Risk to children exposed to domestic abuse, parental substance misuse and parental mental health is identified and responded to, supported by a comprehensive range of services. Despite this, many children remain in these environments for too long. Professionals sometimes have an over-optimistic view of parents' ability to change, and decisions are not taken soon enough to prevent further harm.

30. The interface between the emergency duty services (EDS) and the children's social care service is well established and effective, with timely and appropriate responses to children and families. Information sharing and access to the electronic database enables EDS staff to make informed decisions.

31. Arrangements for considering allegations or concerns about paid employees or volunteers working with children are not responded to in a timely and effective way. Inspectors saw 26 referrals from the previous day awaiting screening in the local authority designated officer's email inbox. This represents unassessed risk. Drift and delay are evident, with cases taking 14 weeks to complete. The

local authority is not effective in ensuring that children are safeguarded from adults in positions of trust who may pose a risk.

32. The local authority knows of very low numbers of children in private fostering arrangements. It is aware of the need to promote and develop the private fostering service, to encourage referrals and to ensure that children are known and living in safe environments. However, the local authority does not yet have a stand-alone private fostering action plan to ensure that targets and timescales are set and progressed. Inspectors saw delays in assessment and a lack of effective action, leaving children in situations of unassessed risk.

33. Sixteen- and 17-year-old homeless children are not informed of the options that are available to them, such as becoming looked after, and the benefits of each option. Assessments are not always timely and do not always identify the level of vulnerability and needs of the young person. However, the local authority makes good use of the family solutions team, and there is a wide range of support and services available across early help and social work teams to support young people who are homeless. (Recommendation)

34. Multi-agency risk assessment conference (MARAC) arrangements are robust, with effective multi-agency identification of children who are exposed to serious and continuing domestic abuse. Effective information sharing and analysis of risk result in child-focused recommendations. Children's social care representatives attending MARAC are well prepared and they ensure that feedback to allocated social workers is done in a timely way to inform children's plans. Children's social care is also consistently well represented at multi-agency public protection arrangements (MAPPA) meetings, which consider early safety planning and multi-agency monitoring of high-risk adult offenders who are due for release from custody or are subject to licence.

35. While the MARAC and MAPPA meetings develop clear actions, children do not always receive timely and proportionate interventions. Despite the high level of risk to children in these situations, social work visits are not regular, legal advice is not sought in a timely way, and actions in line with the safety plan are not always progressed. Robust plans are not in place to ensure that these children are being safeguarded effectively.

36. The response to children at risk of sexual exploitation or going missing is not thorough enough. Children who go missing do not consistently receive return home interviews and when these do take place they are not always within the 72-hour time frame or sufficiently detailed. The identification of risks does not result in a sense of timely, protective action. The local authority does not show a sense of urgency when children are identified as being at higher risk of exploitation. Inspectors saw casework that, despite significant involvement, was not focused, tenacious or effective in improving outcomes for children, thus leaving them at continued risk. (Recommendation)

37. The family group conferencing service is effective and well run. It is child- and family-focused, with evening and weekend meetings and accessible venues. The service evaluates effectiveness and receives feedback from children and families which it acts upon. For example, some children and families do not

want meetings to take place in social services buildings. Use of advocacy is promoted for both children and adults. Plans are child- and family-friendly, and are sensitive and responsive to their different needs.

38. The local authority works closely with partner agencies to minimise the risks to children when they go missing from education. Any cases in which children appear to have moved from the local authority are kept open and shared across other local authorities to try to identify where they have gone. The local authority has clear records of children not in full-time education, and these are updated every half term. The team that tracks children missing education also monitors the progress of children not in full-time education to ensure that they receive good support and make progress.

39. In common with most local authorities, Sandwell has seen a sharp increase in the number of parents who elect to home educate their children. Increasingly, effective work with these parents has resulted in a significant increase in the number of families who now engage with the local authority and cooperate in monitoring how well their children are progressing (from 30 out of 165 families in 2016, representing 235 children, to 130 out of 262 families in 2017, representing 318 children). The local authority knows the risk that parents may use unregistered settings to support their home education, and has built closer links with community and faith groups to explain its concerns to parents to try to minimise these risks.

| The experiences and progress of children looked after and achieving permanence | Inadequate |
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Services for children looked after in Sandwell have deteriorated since the last Ofsted inspection in 2015, resulting in children receiving an inadequate service. Although no cases were seen in which children who were looked after did not meet the appropriate threshold, action is not always taken in a timely manner to assess and reduce risk. Decisions to bring children into care are not swift enough.

Children experience unnecessary drift at various points in their journey, from child in need and child protection planning to the pre-proceedings stage and becoming looked after. As a consequence, permanence planning is not consistently achieved within children's timescales.

Assessments are neither thorough nor analytical. They do not take account of historical involvement and concerns, and are not updated regularly to reflect children's lived experience. Care planning is not specific enough regarding actions, and who should do what within what timescales. Written plans are not robust or child-focused. It is therefore not clear what outcomes are expected for children.

Management oversight is not effective and is not driving case progression. Independent scrutiny has not always been sufficiently challenging in progressing plans and addressing drift.

Systems for monitoring and tracking permanence planning are not yet sufficiently robust or embedded, resulting in children living in temporary placements for too long and with uncertainty about their future. Adoption is not considered in a timely way for all children.

Processes to ensure that children who go missing are interviewed and supported when they return home are not effective. Work with children and families is not consistently child-centred and the voice of the child is not a strength in casework. Life story work is not routinely or consistently undertaken by social workers.

There is an insufficient number of local foster carers to meet the range of needs of children looked after in Sandwell.

Although the education gap between children looked after and their Sandwell peers is closing, overall attainment remains lower than nationally. Personal education plans are not detailed and actions are not specific enough to be useful.

Most care leavers live in suitable accommodation and are in regular contact with their personal advisers. A good range of support services are available, but independence work starts too late. Overall, not enough care leavers are in education, employment or training.

## Inspection findings

40. No children seen during the inspection were looked after unnecessarily. Immediate risk is recognised and acted upon, but ongoing and emerging risk is not well assessed or managed effectively. Decisions to bring children into care are not swift enough and delay was seen, particularly in cases of long-term neglect.

41. The Public Law Outline (PLO) is not always used effectively. There is delay in initiating legal planning meetings or starting pre-proceedings work for some children. Pre-proceedings reviews are not consistently timely, the rationale for not taking more authoritative action sooner is not clearly evident, and the legal advice provided is not always robust. A legal gateway panel has been established recently. However, it is too early to evaluate its impact.

42. Assessments completed for the courts are mostly of good quality. In the majority of cases, care plans are accepted by the courts without the need for independent or expert assessments. Care proceedings are not progressed in a timely manner and are well above the recommended time frame target of 26 weeks. The average time rose from 38 weeks during 2016 to 2017 to 44 weeks during the first quarter of 2017. This shows that not all children are receiving timely permanence decisions.

43. For children on the edge of care, effective support and intervention are provided by a number of services. A family solutions team, multisystemic therapy team, youth services and family group conference team all help to support families to meet children's needs and enable them to remain at home.

44. When children are placed with parents under a care order, assessments and support plans are appropriate. However, the reunification processes for children outside of court proceedings lack clarity about continuing risk and effective planning. A number of children subject to care orders have lived with their parents for some years without timely and purposeful review of whether the order is still required. This means that children remain in care for longer than they should and are subject to social work involvement unnecessarily. The local authority has recently begun a targeted review of these cases.

45. Children do not experience assessment as an ongoing process. The majority of assessments are of poor quality and are not updated to reflect changes in a child's circumstances and current needs. Historical concerns are not routinely considered during assessments, and the way in which risk is examined and recorded is not thorough enough. Diversity is not sufficiently explored. In particular, the experiences of separation and the impact of loss on the identity of children looked after are given very limited consideration. Written plans are not informed by up-to-date assessments, they are not specific and it is not always clear which version of the plan is most up to date. Just over half of care plans have been updated in the past six months. This means that, for many children, outcomes are not being addressed in a timely manner. (Recommendation)

46. Visits to children are in line with statutory requirements, and social workers see children alone when appropriate. However, the voices of children are not strongly evident in casework and it is unclear how children's views inform planning. Social workers in the disability team have not had training in communication skills, such as sign language, to assist them in working with children. There is very little evidence of child-centred direct work being undertaken to support children to make sense of their experiences. Management oversight is regular, but does not result in effective and robust decision-making. Consequently, most children's care experience is negatively impacted by drift and delay.

47. IRO caseloads are high and consist of both child protection and children looked after cases. Despite this, reviews are generally timely. Children's participation in reviews is increasing through direct attendance or use of the 'Mind of my own' (MOMO) app. IRO activity is recorded in most cases, yet it does not show that IROs use statutory reviews or the dispute resolution process effectively enough to challenge weak practice or delays in progressing plans.

48. When children looked after go missing or are at risk of sexual exploitation, safeguarding concerns are not assessed effectively. In the vast majority of cases, return home interviews (RHIs) are not being routinely undertaken within 72 hours. In the last six months, of 258 missing episodes of children looked after, only 17 return home interviews were conducted within the required timescale. As a result, very few children benefit from an RHI being completed quickly enough to understand their experience and to support them as part of the risk-reduction strategies. (Recommendation)

49. Progress has been made since the last inspection in promoting the health and well-being of children looked after. Timescales have improved for initial and review health assessments and dental checks, and this ensures that any health needs are identified quickly. Completion rates of strengths and difficulties questionnaires are also improving. This means that more of children's emotional well-being and health needs are better understood and can inform planning. Access to the child and adolescent mental health services (CAMHS) support is not always timely. Foster carers and social workers expressed frustration about the delays and thresholds for children to access CAMHS. The impact of this is mitigated for some children through spot purchasing of individual therapeutic support.

50. In the academic year 2016/17, most children looked after attended good or better schools at primary age and the very large majority attended good or better schools at secondary age, both in and out of Sandwell. Improvements in education have helped to close the gap between children looked after and their peers in primary and secondary school, although the improvements have been modest and not across all subject areas. At GCSE stage, the gap was reduced partly because the attainment of other children was lower.

51. School attendance by children looked after is in line with similar authorities. In the last two years, no child looked after has been permanently excluded from education, and fewer children are excluded for a fixed term than in similar

authorities. When alternative provision is considered to be in the best interests of a child, moves are discussed with the virtual school and challenged if deemed inappropriate. The quality of alternative provision is overseen through the fair access panel. Personal education plans lack sufficiently 'SMART' (specific, measurable, achievable, realistic and timely) targets or actions to drive improvements. The virtual school leadership team is aware that it needs to make improvements in this area.

52. Local authority officers work well with schools and relevant partner agencies to combat bullying and develop children's resilience and well-being. The 'Sandwell against bullying charter mark' is a well-devised set of principles and an assessment model that supports schools to combat all forms of bullying. However, only about a quarter of schools have signed up. The latest project, 'Clickwise', is a parent and child workshop for children in Years 7 to 11 which aims to provide practical advice about staying safe online, avoiding exploitation and building healthy relationships. This should assist parents to help their children, but the project is a new initiative and has not yet been evaluated for its effectiveness.

53. Children at risk of going missing from education are monitored carefully. The local authority shares information gained from schools, adult social care, housing maintenance teams, the police and the UK Border Agency to trace missing families. The team that tracks children missing education also monitors the progress of children not in full-time education to ensure that they receive good support and make progress. A very small number of children looked after attend the pupil referral unit, where they are supported well with an individual curriculum.

54. Most children looked after do not have a clearly defined plan for permanence by their second looked after review. Consequently, timely permanence is not achieved. The type of permanent placement needed for each child is not well analysed or understood. Children remain in foster placements and a small number of unregulated placements, with the result that these become long-term placements by default rather than design. The local authority is taking action to review all of these cases to amend or formally ratify the care plans. However, many children continue to wait for this work to progress and, at the time of the inspection, 178 children with a plan for long-term fostering were waiting to be formally matched to their carers. The recently established permanence monitoring group aims to track all children looked after to ensure that plans for permanence are achieved in a timely manner. This is not yet well established, and permanence tracking is not sufficiently comprehensive. (Recommendation)

55. The use of voluntary arrangements is not always appropriate to children's circumstances when children become looked after voluntarily under section 20 of the Children Act 1989. For most children accommodated under section 20, there are shortfalls in planning. Many children have remained subject to these arrangements for too long, resulting in significant delay in securing them a permanent home either back with their families or in care.

56. When the plan is to place children with connected person carers, assessments take too long and the reports contain too much narrative, with little analysis or focus on the needs of the children. Special guardianship orders (SGOs) remain underused as an option for securing permanence, and in the last 12 months only nine children became the subject of SGOs. The quality and timeliness of SGO assessments and reports are variable. SGO support plans are written in general terms and lack specific actions, timescales and clear financial agreements. This means that plans do not provide an accurate picture of support for carers to refer to, now or in the future, in order to ensure that children's needs are met.

57. The local authority's sufficiency planning has not secured the range and number of foster carers to meet the needs of the children looked after by Sandwell. Although the local authority is successful in placing a high percentage (86%) of children within 20 miles of their home address, as at 31 March 2017 54% of children were placed out of the local authority area and over 80% of disabled children were placed out of the local authority area. (Recommendation)

58. Children placed out of the local authority area are well supported and have good access to services and advice. Social workers undertake regular visits, reviews are timely and children are supported to maintain contact and links with family and friends. Children have good access to primary health services and their educational attainment is monitored by the virtual headteacher. The children in out of area placements who were spoken with did not feel disadvantaged in any way.

59. Sandwell has some very committed and skilled foster carers who are providing good-quality care for children. Most of the children looked after live in stable placements that meet their needs. Brothers and sisters are placed together unless their plans identify that this would not be in their best interests. Contact arrangements with family members are well supported and supervised by trained staff.

60. While foster carers were positive about their experiences, support and professional development opportunities, they were unclear about the use of delegated authority. They reported that they do not consistently receive sufficient and timely information about children. This hinders their ability to make informed decisions and to ensure that they are able to fully meet the needs of children.

61. The fostering service is not consistently compliant with regulatory standards. There are delays in progressing assessments and reviews, not all visits are timely and the quality of work is variable. Only 65% of the number of required foster carers have completed their training support and development standards as evidence of their competence and abilities as carers.

62. Allegations against foster carers are not dealt with in an effective or timely manner. In the cases seen by inspectors, there were delays between allegations being made and position of trust meetings. There is significant delay in cases being presented to the fostering panel, and some take more than a year to be concluded. The lack of urgency in resolving cases does not assist the

local authority in carer retention, and keeps carers 'on hold' while they might be offering a service.

63. The majority of children looked after have not had life story work completed and are therefore not fully supported to make sense of their early experiences and trauma. Consequently, children are in long-term placements in which carers do not have the fullest information to enable them to support children to understand their background and experiences. (Recommendation)

64. Children looked after have timely access to advocacy and independent visiting services. There are no waiting lists for the services, and provision is available to those children placed out of area. All children placed in Sandwell and their foster families are provided with a leisure pass. The children spoken with described a number of activities that they attend and enjoy.

65. A vibrant, established and well-supported LAYPB has contributed to the development of the 'Sandwell's pledge to you' and the 'Show me that I matter' children's guide to being in care. The LAYPB's contribution to and impact on improving support and services that children receive are well evidenced through the range of work that is undertaken. It has organised and run the achievement awards evening and has effective links with the corporate parenting board. This means that corporate parents are updated with any worries or concerns voiced by children looked after and can discuss how these might be resolved.

**The graded judgement for adoption performance is that it is inadequate**

66. Adoption is not considered sufficiently or pursued rigorously enough for all children in Sandwell who need an alternative permanent home outside of their birth family. The local authority has a system to track children when they first come into care, in order to support children in achieving permanence as soon as they can. However, the timescales for achieving permanence through adoption continue to be too slow. Managers and IROs do not consistently review children's care plans or ensure effective parallel planning, and this results in significant delay for children. These gaps in management oversight and monitoring mean that children do not live with their adopters as soon as they can. (Recommendation)

67. Too many children experience considerable delays in being matched and placed with their adoptive families. Performance on the adoption scorecard shows that the local authority is 127 days over the government threshold of 426 days. Furthermore, there is no meaningful improvement in reducing the timescales for children who are waiting to be placed with their adopters. The performance measure for the time between the court authority to place and deciding on a match for a child is deteriorating significantly. Children are now waiting an average of 247 days to be matched to their adopters. Consequently, children are facing lengthy delays to secure permanence through adoption. These significant delays demonstrate that adoption planning is not effective or well embedded in Sandwell. (Recommendation)

68. The high turnover of social workers means that some social workers do not know children well. The lack of experience within the workforce means that many practitioners do not understand the complexity of adoption casework. This can compound the delays experienced. Ten children have plans to discharge their placement orders that date back over five years. This substantial delay in progressing children's plans demonstrates poor management and case planning oversight and a lack of security for the children.

69. 'Foster to adopt' is considered by social workers during the recruitment process, and two children have been matched through this process. However, this practice is not yet established across the service and has resulted in some children experiencing unnecessary placement moves.

70. Since 1 April 2017, 18 children have achieved permanence through adoption. Only a further three children who have a plan for adoption will have achieved this permanence by the end of March 2018. This is a decline in performance from last year, when 35 children were adopted. The adoption team has made use of the Black Country consortium as well as a variety of other methods of finding adopters for children, including activity days and 'bump into' meetings where adopters meet children. Sandwell is successful in placing brothers and sisters together and in placing children from minority ethnic backgrounds. However, the local authority has not been successful in placing older children for adoption, and only three children adopted in the last 12 months have been over the age of five years. At the time of the inspection, 15 children aged six years and over were waiting for an adoption match.

71. Adoption social workers undertake good-quality direct work that prepares some children well for adoption. All children who are placed for adoption have life-appreciation days, allowing adopters to meet with the significant people in children's lives. However, not all children who are placed for adoption are fully prepared, as life story books and later life letters are often delayed. Adopters do not receive the right information at the right time to allow them to have insight into the child's background and history and the reasons for adoption.

72. Child permanence reports are variable in quality. The reports do not always include the required information. The voice of the child is not sufficiently represented and children's life histories are missing from some cases. Social work analysis does not take account of the effect of the child's experiences on their future. Although reports are not always of a good quality, the adoption panel is still able to match children effectively to prospective adopters. There have been no disruptions to adoptive placements over the last 12 months, demonstrating good-quality matching of children. (Recommendation)

73. The Black Country consortium is responsible for recruiting, preparing and training adopters. A marketing and recruitment officer supports the team with advertising and the initial screening of potential adopters. The timescales for completing adopter recruitment assessments do not meet the statutory guidance. The delays at stage one of the process lead to overall delays in completion. The 12 adoption assessments undertaken in the last year have

taken an average of 401 days to complete. This has resulted in Sandwell not recruiting a sufficient number of adopters to meet the need. There are 46 children with a plan for adoption or who have a placement order, and 34 children are waiting for a link. However, there are only 19 potential adopters currently in the assessment process. This means that there are insufficient numbers of adopters, resulting in delays in placing children.

74. Prospective adopter reports are of a good quality. They evidence how adopters are prepared for the challenges of adoption. Reports describe the strengths and areas of development for adopters, and demonstrate good analysis. Adopters describe the process of assessment as thorough. They feel that the assessment, training and support offered prepare them well for the challenges that they may face. The quality of the prospective adopter reports enables the adoption panel and the agency decision-maker to make informed recommendations and decisions.

75. Adopters are complimentary of the support that they receive from social workers throughout their journey. They feel that they were challenged appropriately throughout the recruitment process. The preparation groups and training provide positive experiences, enabling prospective adopters to have an insight into being an adopter.

76. The adoption panel chair is appropriately experienced in adoption. Members of the panel are drawn from various backgrounds and professions. However, the panel membership lacks diversity. The minutes from panel meetings demonstrate a good level of scrutiny when considering matches and approvals. Panel members are confident in asking challenging questions of both professionals and adopters.

77. The adoption reports presented to the adoption panel, including child permanence reports and adoption support plans, are not rigorously quality assured. Consequently, panel members have to work hard to find the necessary information in reports to make appropriate recommendations. Reports do not always provide a full picture of the child or describe their wishes and feelings. For over six months, the panel has not had a consistent adviser to assist in addressing the concerns relating to quality. The adoption panel chair has not felt able to comment on reports, which is a key omission from her quality assurance role. No meetings have been held between the panel chair and the agency decision-maker to share findings or to address the poor quality of practice. This deficit limits the scope for improved practice. (Recommendation)

78. The agency decision-maker is suitably experienced. Adoption panel recommendations are ratified in a timely way, with a clear rationale for each decision. The agency decision-maker acknowledges the delays that some children experience and that the quality of reports needs to be improved.

79. Adopters and children are informed of their adoption entitlements. However, post-adoption support plans are often vague and do not identify who will be conducting the work. They do not have a timescale for the progress to be reviewed, which means that the service cannot demonstrate how children's circumstances improve through receiving adoption support. There has been an

increase in applications to the adoption support fund, resulting in greater access to therapeutic support for children. Support has been offered by an independent agency to 26 birth parents, and there are plans to extend this in future to all birth parents whose children are adopted.

80. A dedicated worker supports a well-organised letterbox service for children, adopters and birth families. Letterbox activity is tracked and monitored, and the learning from complaints has been used to develop better communication with birth families regarding contact arrangements.

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

81. Most care leavers have a pathway plan that has recently been reviewed, although not all are complete. The plans are very detailed and to update them can involve several meetings between care leavers and personal advisers. The sections that are completed are written to a good standard, yet in some cases they need to be more specific about the timescales and measures of success. (Recommendation)

82. Personal advisers have made good progress in ensuring that most care leavers have access to important personal information, such as birth certificates, national insurance numbers and health histories. This was a recommendation in the last inspection. This work is prioritised by managers, who have set aside protected time and targets for its completion, and these are monitored during personal advisers' supervision.

83. Care leavers benefit from easy access to a range of services co-located with their personal advisers, including adult services. Care leavers talk positively about the support that they receive. This includes impartial careers guidance from Connexions workers, help to cope with substance misuse and advice from the specialist nurse, who runs a monthly drop-in service. A women's aid voluntary group supports care leavers to recognise and reduce the risks of sexual exploitation and to build healthy relationships. A link with the refugee council provides support for the 13 unaccompanied asylum-seeking children who are care leavers. Partner agencies such as the youth offending team and community police teams work in the same offices, which helps to support those at risk of offending and those returning from custody. However, children moving to adult mental health services do not experience a seamless progression, due to different thresholds and the limited capacity of the service. This means that some health needs remain unmet. (Recommendation)

84. Personal advisers know their care leavers well. They have all been in contact with most of their care leavers in the last two months, mainly face-to-face or by telephone. The care leavers value these relationships. Personal advisers also organise social events, such as meals out, to help care leavers to build supportive friendships and share experiences.

85. There is intensive support for care leavers who are young parents, particularly for those who are first-time parents. Good links to universal services ensure that these young people and their children benefit from using children's centre facilities and courses to improve their parenting skills, while also building links with other young parents.

86. Care leavers are well informed about their entitlements, such as financial help with transport and fees for college or university courses. Seven care leavers have successfully completed degree-level qualifications and a further 20 are working towards these in a wide range of subjects. Fourteen care leavers have completed apprenticeships. They are proud of these achievements. The leaving care handbook is a comprehensive explanation of entitlements and options. It includes a care leavers' pledge and makes explicit reference to the requirement for local authorities to provide support for children looked after until they reach 25 years of age. Care leavers are represented on the corporate parents' panel, for which they have designed a logo. The very active care leavers' forum can identify a list of activities that members have taken part in to support other care leavers. These include inspecting new providers' accommodation, lobbying the authority for council tax exemptions, and regular and productive meetings with the lead member for children looked after.

87. Care leavers under 18 years of age who live in the 15 training flats benefit from being required to take part in the 'house to home' training programme. Supported accommodation providers run similar programmes for their residents, and one provides emergency accommodation for homeless 16- and 17-year-olds. However, for care leavers over 18 years of age, the structured training programme to help them to prepare to move into independent living, as seen at the previous inspection, is no longer offered. This means that personal advisers provide all of the preparation for independence, but this starts too late as they do not start working with the care leavers until they are 18 years old. The local authority has recognised that this work starts too late and has plans for it to start sooner.

88. Care leavers too often struggle to provide the evidence that they need to bid for independent housing tenancies without considerable support from their personal advisers. Very few care leavers have taken up the option to stay in their current accommodation when they reach the age of 18, despite encouragement to do so. Ten care leavers are in 'staying put' arrangements. The lack of emergency accommodation for care leavers aged over 18 years has resulted in three young people being housed for short periods in hotels (bed and breakfast arrangements) in the last six months. (Recommendation)

89. Despite widespread pressure on accommodation, the very large majority of care leavers live in suitable accommodation in which they feel safe. A particularly useful initiative to increase the availability of accommodation is the secondment to the children's services team of a maintenance officer from the housing department, who inspects all prospective accommodation before it is accepted by the local authority. This gives the local authority and providers valued reassurance that the accommodation meets statutory requirements. Twelve care leavers are currently in custody, where their personal advisers do

their best to support them with frequent visits. However, too often the young people are moved to different custody settings without the personal advisers being informed.

90. The proportion of care leavers who continue in education, employment or training has declined to well below the national rate, partly because of very low participation by a single group of young people over successive years. Despite clear efforts to promote apprenticeships to care leavers leaving compulsory education, too few take up this option. Too many care leavers do not attend appointments or do not engage with the training offered. Of those care leavers who take up an apprenticeship, the number that actually complete it and move into employment is very low. (Recommendation)

| Leadership, management and governance | Inadequate |
|---|---|

There has been no overall improvement in services to children in Sandwell since the last Ofsted inspection in 2015. For some children, particularly those in the care of the local authority, services have deteriorated and many of those who need timely permanent arrangements made for their care have experienced drift and delay. For children at risk, interventions are often not made soon enough. This includes those children who may be at risk of child sexual exploitation and those who go missing from home.

Drift in establishing a trajectory for improvement has only been halted by the appointment of a new senior management group in 2017. Prior to this, there had been a corporate failure to fully grasp the extent of deficits and what was required to improve services. There has been insufficient time for the new senior managers to establish a culture of practice improvement and to ensure that key services are now making a difference for children.

Management oversight and reviews of assessments and plans are poor. The majority of social workers are temporary or have less than one year's social work experience. Turnover of staff is high, and this has resulted in continued deficits in planning and in the progression of plans.

The lack of a strategic children's partnership and children and young people's plan means that there is an insufficient overview of children's services at a multi-agency level. As a result, commissioning of services at this level and internally within children's services is less well informed than it should be.

Senior managers are now much better informed, with the establishment of effective performance data enabling them to understand weaknesses and trends. A quality assurance framework is partly in place, with casework auditing helping to create baselines for improvement.

A comprehensive early help offer is established and there is an effective, well-developed multi-agency partnership in the MASH that ensures a timely initial response to children and families.

The local authority has recognised the importance of corporate parenting and refocused its approach to ensure councillor participation and leadership. Young people's voices are heard through attendance at both the children in care council and the care leavers' forum. Both these groups are well established and have begun to make a difference to services.

Care leavers have good relationships with their personal advisers. The large majority have pathway plans and receive appropriate levels of support. More needs to be done to ensure that a majority are in receipt of education, training or employment.

## Inspection findings

91. Children in Sandwell have seen no sustained improvement in services since the last Ofsted inspection in 2015. Despite the oversight of an improvement board, many services continue to have widespread and serious failings that have not yet been tackled effectively. Many of the shortfalls identified in 2015 have not been resolved. These include ensuring that front-line management oversight is effective in directing plans and ensuring that progress is made. In addition, the recommendations to ensure that children who go missing and who may be at risk of child sexual exploitation receive a timely response when they return home have not been met. The quality of assessments and plans is not sufficiently improved or informed by an understanding of historical involvement. Children who are privately fostered or who present as homeless at 16 or 17 years old still do not receive timely and good-quality services. Some services have deteriorated further, notably those for children looked after. Arrangements to secure timely and permanent alternative care, including adoption, have declined.

92. A commissioner, appointed in October 2016, identified continued drift in the strategic direction and impact of children's services since the last inspection. As a result, a new senior management team was appointed in March 2017. This development, together with a recognition among political leaders that there has been delay in getting to grips with deep-seated performance issues in children's services, has helped to establish a coherent improvement plan. However, there has been insufficient time for this group of highly experienced managers to create sustained changes in practice in order to have an impact on the quality of the work undertaken and improve outcomes for children. Much work has been initiated in the last six months, and many policies and processes have been reviewed and reissued or developed very recently. While very relevant to ensuring that staff understand what is required of them, these have not yet had time to become embedded or to create changes that will improve outcomes for children.

93. Managers have begun to put in place a framework for practice improvement. They have established baselines for practice both at social worker and first-line management level. They have begun to ensure that basic processes are in place. Compliance with procedure has improved as a result, but it is not yet assured. There are the beginnings of a cultural change to a more professionally responsible approach to work, but this is not yet established.

94. The local authority now knows itself much better through effective performance data that has enabled it to identify weaknesses, trends and compliance levels. Some quality assurance processes are in place, and auditing of casework is now established. However, the audits are still showing that an average of one third of cases seen are inadequate. More needs to be done to establish a thematic approach to audit activity and to begin to have a greater focus on the quality of practice.

95. There is an insufficient overview of children's services at a strategic multi-agency level. This is because there is no strategic children's partnership and no

children and young people's plan. This is recognised as a gap by both the chief executive and the director of children's services. The health and well-being board, through the joint strategic needs assessment (JSNA), has not compensated for this absence. Although there are two JSNA reports focusing on children from birth to four and aged five to 19, both reports are insufficient in depth and analysis to fully inform any commissioning process. Significant issues such as neglect are insufficiently highlighted, and the implications of the 2015 inspection of children's services are not analysed fully to ensure that weaknesses in service delivery are fully understood. (Recommendation)

96. A commissioning cycle is in place and current contracts are monitored appropriately for compliance and quality. However, the identification of commissioning needs is not well informed. There is a placement strategy which presents a robust analysis of needs. However, aspects of commissioning intentions, such as future recruitment of foster carers, are unrealistic and not grounded in current recruitment abilities. For example, while there is a need for a further 90 foster carers offering 150 places over the next three years, only four carers were recruited last year. (Recommendation)

97. The well-established early help offer recognises and assesses need effectively. Thresholds are now better understood by partners, but some variability in application remains. Early help services are offering many families appropriate intervention.

98. The MASH is operating effectively on a multi-agency basis and work is being triaged appropriately. Risk is being correctly identified and prioritised for assessment and intervention.

99. Children's services in Sandwell are facing significant challenges. Successful attempts to ensure that risk is recognised have resulted in a very significant increase in the number of children on child protection plans, with a rise of 71% since June 2017. Politicians and the senior management team have responded to this by increasing staff levels significantly. However, nearly 60% of staff at social worker level are employed through an agency or have less than a year's experience since qualifying. Many social workers have started working in Sandwell since June, making the staff profile vulnerable to instability and requiring significant input in terms of management oversight and supervision.

100. Regular management oversight and supervision have been established, but in many cases do not yet provide clear or timely case direction and progression of actions agreed. Staff turnover has been significant, amounting to 30% in 2017 overall and up to 60% in some teams, notably in care management. Together with the overall staffing profile and lack of consistent first-line management, this has contributed to significant deficits in case continuity, planning and progression of plans. This is compounded by the lack of effective independent challenge by IROs. (Recommendation)

101. In too many cases, risk, while identified, is not subject to timely or appropriate interventions. There is drift and delay in progressing work and, in a large number of cases seen, this has led to children being left for too long in

situations of risk without effective action to reduce that risk and to sustain better outcomes.

102. There is a sufficiently strategic approach with partners to identify children at risk of sexual exploitation and other vulnerable children. There is an understanding of hotspots in Sandwell, and information is gathered about contacts and perpetrators. Multi-agency meetings with groups such as the multi-agency sexual exploitation (MASE) group and the children missing operational group (CMOG) help to track vulnerable young people and identify interventions to minimise risk. However, in too many cases social work actions have not been progressed on a timely basis or there has been a lack of planning to ensure effective intervention.

103. Processes to ensure that children who go missing are interviewed and supported when they return home are not effective. Very few 'missing' episodes are subject to a return home interview (73 of 518 within 72 hours, April to September 2017) and even fewer if the young person is in the care of the local authority (17 of 258 episodes). This means that significant information is being lost, together with opportunities to intervene and help young people. This was an area of poor performance identified at the 2015 inspection. (Recommendation)

104. Awareness raising about child sexual exploitation needs a more coordinated and focused approach. The CMOG strategic group has led the work on child sexual exploitation awareness raising in the community, including work with taxi drivers and the local landlords association. However, more needs to be done, particularly with hotel staff and with schools. It is of concern that not all schools are responding to issues and contact from the child sexual exploitation coordinator.

105. The experience of children in the care of Sandwell has deteriorated since 2015. Assessments of need for children in care are not updated regularly, and in recording or planning there is little sense of the child's journey through care. For some children, the response to neglect is not timely and, as a result, they have entered care later than they should have done. Children are ending up in longer-term placements by default rather than by design, because effective processes and practices to make early decisions on permanence are not in place. Too many children remain in unregulated placements, and permanence arrangements are not achieved quickly enough. Not all children coming into care receive sufficient consideration in relation to adoption as an outcome.

106. Both the Children and Family Court Advisory and Support Service (Cafcass) and the local designated judge consider that, while cases brought to proceedings are appropriate, some cases have waited too long to be initiated. As a result, there have been missed opportunities to intervene earlier. The quality of pre-proceedings work is variable, with poor support, at times, from legal services. The timeliness of proceedings has deteriorated as a result of the local authority's poorly formulated plans, which have required further revision, and court availability issues.

107. While little progress has been made in developing the care leavers' service since 2015, care leavers continue to have positive relationships with personal advisers. A majority of care leavers now have completed pathway plans. However, more needs to be done to ensure that higher numbers of care leavers benefit from ongoing education, employment and training. The local authority understands that a more focused service needs to be offered from age 16, instead of 18, to improve outcomes for these young people, but it has been very slow to redesign the service to put this into practice.

108. There is an established children in care council and care leavers' forum. Young people have opportunities to meet and influence senior staff and councillors, and have been able to make contributions to policy change and development. Young people's achievements are celebrated by the local authority regularly.

109. The corporate parenting board was reorganised during 2017 and its scope enhanced. Individual councillors now lead on agreed corporate priorities for progress and report back to the board. This is helping to ensure a focus on performance and practice in services for children. Young people are included on the board, with representatives from the care leavers' forum and the LAYPB. There is evidence of some challenge, and the inclusion of the board and young people is making a difference. Examples of the differences made include the recognition that young people leaving care should pay less council tax, and an initiative to ensure that the savings built up by young people in care are kept securely in a central location, rather than having to follow them and sometimes getting lost between placements.

110. Senior leaders have increased their focus on staff support, with 'back to basics' training programmes such as assessment and planning and management supervision, although these are yet to have significant impact on practice standards. Practice evaluation is not yet developed and, as a result, cannot demonstrate the effectiveness of training or what may need to change as a result of feedback. Newly qualified social workers benefit from a well-developed ASYE programme. The Aspire programme helps new front-line managers to develop the skills for effective management. However, while the authority is attempting to ensure that learning can be undertaken in a protected environment, this is challenged by significant work pressures.

111. The annual report detailing complaints and compliments provides a brief overview of activity, but has little analysis of the weaknesses in service delivery that are identified by complainants. Complaints by young people are not identified separately, and this is a missed opportunity to gather the concerns expressed by young people about the services. (Recommendation)

## 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 differences adults make to the lives of children, young people and families. They read case files, watched how professional staff 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 whom 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 inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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