The Axis
10 Holliday Street
Birmingham
B1 1TF

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

6 October 2016

Mr Matthew Sampson
Director of Children's Services
Sandwell Council House
PO Box 2374
Oldbury
B69 3DE

Dear Mr Sampson

Monitoring visit of Sandwell Metropolitan Borough Council Children's Services Department

This letter summarises the findings of the monitoring visit to Sandwell Children's Services on 6 and 7 September 2016. This was the second monitoring visit since the local authority was judged inadequate in February 2015. The visit was carried out by Jenny Turnross and Karen Wareing, Her Majesty's Inspectors. The local authority is making positive progress in improving services for children.

Areas covered by the visit

During the visit, inspectors reviewed the progress made to ensure that services to help and protect children are effective. They focused on the multi-agency safeguarding hub (MASH), the understanding and application of thresholds for statutory intervention, and the quality of management oversight and decision making. Inspectors also reviewed the arrangements to protect children who are at risk of, or who are, being sexually exploited.

The visit considered a range of evidence, including electronic case records and from interviews with a range of staff, including managers, social workers and other practitioners. Inspectors also referred to the authority's post-inspection improvement plan to assess whether progress has been made.

Summary of findings

Since the last monitoring visit, the local authority has revised and implemented its improvement plan, resulting in some early, positive developments. Senior managers and leaders acknowledge that time and perseverance are required to ensure that the quality of practice is of a consistently good enough standard to effectively help and protect all children. The council has invested additional resources to increase social work capacity and management oversight in the safeguarding and assessment

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teams. This action has resulted in a much needed reduction in social work caseloads across the entire social work service. These positive changes are very recent and, as yet, the desired improved outcomes for children are not being demonstrated.

Guidance on the application of thresholds for intervention has been revised and re-issued to all social care staff and partners. This has resulted in a greater awareness by partner agencies and an improved response by staff and managers in the MASH; child protection concerns are starting to be identified and responded to without delay.

Further work is needed to ensure that partner agencies, particularly the police and health services, fully understand and implement their roles and responsibilities in processes to protect vulnerable children in the borough.

The senior manager responsible for help and protection has increased the time spent with staff and managers to review their practice and to support them to make required improvements. While this is positive, the quality of case recording and management oversight on children's case files remains an area of concern.

More needs to be done to improve the effectiveness of the operational arrangements for identification, management and intervention for children and young people who are at risk of child sexual exploitation. The elements required to develop an effective service are in place, but work remains to ensure that good standards of practice are routine. Work at a strategic level is more effective, with appropriate and positive engagement by partner agencies.

Evaluation of progress

Thresholds are now being consistently applied by children's social care staff in the MASH. Managers in this team are making safe and appropriate decisions alongside supporting partner agencies through the provision of well-considered information and advice. This is an improvement in practice, resulting in children who are referred to Sandwell receiving an appropriate and timely initial response.

Strategy meetings convened in the MASH are now led by a team manager from the relevant safeguarding and assessment team which will take the work forward. This practice has improved the service and created additional management capacity in the MASH and is resulting in more timely decisions at the point of referral. Work is now swiftly transferred to the safeguarding and assessment teams or to the early help service and is allocated on the same day. Children's needs are now responded to more promptly and all children are seen on the day of referral when there are identified child protection concerns. This is a demonstrable improvement in practice.

The quality of multi-agency information gathered in the MASH is good. Partners share information quickly, it is relevant and supports appropriate decision making. Further work needs to be done to strengthen the quality of written referrals from

partner agencies. Social workers are spending too much time clarifying safeguarding concerns. Further difficulties arise when partners do not obtain consent before they make a referral. The absence of consent continues to create delay in responding to some concerns.

The quality of decision making and oversight across the service remains inconsistent. Since the last monitoring visit, there have been improvements in the recording of supervision and case direction, including recording by independent reviewing officers, who have increased their role in quality assurance and oversight. However, in a number of cases, an absence of appropriate management oversight resulted in poor practice. In particular, children should always be seen by a qualified paediatrician, in line with established procedures, when an allegation of physical harm has been made.

Overall, the quality of social work assessment and plans is poor. This remains an area for development and senior managers acknowledge this as a priority for the service. Further, managers are aware that poor assessments and weak plans have led to unfocused intervention, making progress and impact difficult to evaluate. Some improvement is evident in assessments, with a recognised model of practice beginning to be used to consider risks and strengths in families. Practitioners and families find this approach helpful to aid understanding and address concerns. In addition, the use of research to support analysis is present in a small number of assessments.

Work to address child sexual exploitation at a strategic level demonstrates that partner agencies are engaged positively and that there is appropriate collaboration with regional colleagues to work together, share intelligence, identify victims and pursue perpetrators in most cases.

At an operational level, multi-agency sexual exploitation meetings (MASE) need to be strengthened to become fully effective. Key agencies do not always attend, action plans are not specific about what work needs to be completed and to what timescales. As a result of progress being poorly recorded, information is not effectively carried forward from one meeting to the next. Further, the records from MASE meetings are not always used to inform key meetings, such as care planning reviews for children looked after. This means that plans are made without the benefit of all information about a child's experiences being considered. The views of children and young people are not always clearly detailed in the records of meetings about them.

The multi-agency child sexual exploitation team has been strengthened by the recent appointments of key individuals who provide strong management oversight and grip on this work. A new child sexual exploitation workspace recording system assists staff as it holds case records, shows workflow and gives ready access to data.

Decisive action to address risk is evident in most cases seen. Direct work by the child sexual exploitation team with children, young people and their families is thorough and sensitive. Using a wide range of methods, families are helped to understand the process that underpins the sexual exploitation of children and young people, such as the control and manipulation used in relationships and how young people can stay safe when they use the internet and social media. However, this work is yet to be evaluated and this means that the local authority cannot be assured that these services reduce or minimise risk.

The records of return home interviews now provide details of the reasons for a child going missing, as well as exploration of the incident and children's wishes and feelings, but it is not clear in all cases how this information is then used to inform further work to reduce risks. The case records for children placed outside of the local authority do not always include details of return home interviews and more needs to be done to ensure that these are completed and recorded in a timely way. Valuable work by the child sexual exploitation coordinator to collate intelligence gained from return home interviews informs and supports the linking of information about children, perpetrators and hot spots.

In summary, positive changes have been made since the last monitoring visit, resulting in improved processes to help and protect children.

I would like to take this opportunity to thank you and your staff for your continued positive engagement with the programme of monitoring visits. I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Jenny Turnross
Her Majesty's Inspector