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Ms Lesley Hagger
Executive Director of Children's Services
Sandwell Metropolitan Borough Council
Council House
Oldbury
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Dear Lesley,

Monitoring visit of Sandwell local authority children's services

This letter summarises the findings of the monitoring visit to Sandwell children's services on 29 January 2019. The visit was the third monitoring visit since the local authority was judged inadequate in January 2018. The inspectors were Peter McEntee, Her Majesty's Inspector and Louise Warren, Her Majesty's Inspector.

Sandwell Children's Trust provides children's services on behalf of the local authority. The Trust is continuing to make progress in improving its 'front door' response to those families, children and agencies seeking help.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in the front door response to concerns from the public and other agencies. We looked at decision-making and initial actions in relation to the operation of thresholds for services, judgements and actions in relation to child protection enquiries and further assessments of need. We also looked at decisions to refer to early help services or step up from these services when family circumstances are complex or might require statutory intervention.

Inspectors considered a range of evidence during the visit, including electronic case records, supervision files and notes, observation of social workers and team managers undertaking referral and assessment duties, and other information provided by staff and managers. In addition, we spoke to a range of staff, including managers, social workers, other practitioners and administrative staff.

Overview

Sandwell Children's Trust knows itself well. It has a robust performance framework which can provide it with accurate information about the quality of practice and the improvements to practice and outcomes for children still required. Senior staff understand that considerable improvements still need to be made. Progress has been made in ensuring that the first response to families and children in need is timely and, in most cases, recognises risk and the scale of intervention required. However, practice is still not consistent. Some cases are too complex for early help services to work with, and this is exacerbated by the separate front door for early help not being subject to the same degree of scrutiny and audit as the rest of the trust's services. Thresholds for services are mostly understood by other agencies and staff within the trust, but there are instances when this is not the case. This leads to delay in recognising neglect, in some cases, and wrong decisions made about the way forward, or what level services should be offered.

Responses to contacts and referrals are timely. In most cases, risk is recognised and processes in the multi-agency safeguarding hub (MASH) ensure that concerns such as domestic abuse incidents are triaged and responded to quickly. Strategy meetings to agree on the immediate response where there are concerns about child protection are held mostly on the same day. However, more care is required to ensure that the right people attend these meetings to ensure that all relevant information is considered. Where these lead to further child protection enquiries, they happen quickly and result in mostly accurate decision-making about further assessment or child protection procedures.

Evidence of management oversight has improved since the inception of the trust, but it remains of inconsistent quality, and there is a continuing need for some managers to ensure that the rationale for decision-making is adequately recorded. The workforce is increasingly stable and there have been further reductions in the use of agency staff, with some electing to work permanently for Sandwell.

Findings and evaluation of progress

The trust has ensured that the front door response to concerns about families and children is timely and processes are in place to ensure that decisions on further action are made quickly. Partners, including the police, health and education, engaged in the multi-agency safeguarding hub (MASH) share information appropriately. No cases were seen where there was an immediate risk to a child and action was not being taken. However, there remains an inconsistency in the quality of response overall, and this results in the wrong decisions being made in a small number of cases.

There is inconsistency in the operation of thresholds for services. In some cases, early help teams are holding inappropriate work which is too complex and where the degree of risk has not been recognised. This is compounded by there being separate front door arrangements for early help and social care, which creates a vulnerability,

particularly where early help is accepting inappropriate work and where cases should have the benefit of a MASH assessment. In addition, some step-up cases have not been accepted by managers in the MASH service when they should have been.

MASH systems and processes are not always robust enough to ensure timely step up and step down to early help. Inspectors saw a small number of early help cases that were waiting to be stepped down but were not being progressed for several weeks because of system process issues. The trust responded to this issue when it was identified by inspectors and has acknowledged some drift and delay for a small number of cases. This means that these families in need of services have been waiting too long.

In the majority of cases, however, thresholds for both contacts and subsequent decisions on referrals are appropriate, timely and result in the provision of services quickly.

Understanding of thresholds by partners is improving and most contacts and referrals are appropriate. However, there remains inconsistency, particularly where there may be issues of neglect, which are not recognised quickly enough by agencies, including schools. This leads to delay in referral.

Decisions made by MASH managers on case transfer to assessment teams and early help is open to challenge by assessment team managers and the single point of contact manager (SPOC), in relation to early help. Assessment team managers and the SPOC manager do not always accept decisions made by the MASH on the need for further assessment or step down to early help. These referrals are then closed inappropriately or changed. This indicates that there is some internal confusion over thresholds for services and, in a small number of cases, results in services not being offered to families when they should be.

Police notifications of domestic abuse incidents are subject to a daily multi-agency meeting to share information and decide on how to respond. Threshold decisions are appropriate, and availability and use of children and families' previous histories considered before final decisions are made. However, the police do not always obtain consent from parents, which means that decision-making can, in some instances, take longer while social workers in the MASH remedy this.

Where children may be at risk, or have been abused, strategy meetings to agree a plan of intervention are held in a timely manner, with almost all held on the same day as referral. Decision-making in the majority of cases is appropriate, including those leading to child protection enquiries. However, the stated practice of the trust to invite agencies involved in the case to strategy meetings is not always happening. In several instances, early help and other agencies such as schools were not invited when they should have been. This means that the most up-to-date and appropriate information may not always be available at a strategy meeting when it should be to ensure good decision-making. The trust has responded to this and says that it will now ensure that early help practitioners are included in strategy meetings.

Some strategy meetings are not clear enough about what should happen next. This includes whether a medical examination should occur if a child has been injured. Some of these decisions are not recorded or are not clear about why a medical examination is not appropriate. This means that it can be difficult to understand the sequence of events and harder to explain why the trust acted as it did in some cases.

Child protection enquiries (S47) are timely. Most recommendations are appropriately made, based on evidence gathered and with children being seen and spoken to. However, despite the trust having introduced a tool for assessing neglect, its use was not seen, despite many cases having a history of repeated assessment and intervention without an improved result.

In the majority of cases, management sign-off and oversight of work is evident. There is evidence that some managers are now better able to understand the requirements of good practice and offer more challenge to poor work as a result. There remains, however, some inconsistency, particularly in ensuring that explanations for decisions made are appropriately recorded and include a clear rationale for the decision made. Not all recording of strategy meeting minutes is timely. This means that minutes are not readily available for practitioners to understand what actions have been agreed.

A need to enter and interrogate different information systems for early help, MASH and single assessment services is unnecessarily cumbersome and time consuming. It does not help practitioners to easily see the sequence of events in a case or help with analysing these.

An audit framework is in place and moderation of audit activity in many cases strengthens the quality of the overview. However, not all audits were sufficiently robust either in their findings or in relation to the robustness of subsequent action plans. Action plans are not always followed in a timely manner. The work of early help does not feature with sufficient priority in the trust's current rolling 12-week front door action plan. The lack of audit activity in relation to thresholds and practice in early help means that the trust does not know how well it helps families at an early intervention point as comprehensively as it should.

The trust has continued to make improvements since the last inspection. Practice, however, remains inconsistent, although staff are responding to a clear vision for improvement and the trust is recognising where it needs to improve its services to children and families.

I would like to take this opportunity to thank you and your staff for your positive engagement with this monitoring visit.

This letter will be published on the Ofsted website and copied to the Department for Education.

Yours sincerely
Peter McEntee
Her Majesty's Inspector