21 February 2022

Tim Browne, Director of Children's Services and Skills, Solihull Metropolitan Borough Council
Helen Jenkinson, Chief Nursing Officer, NHS Birmingham and Solihull CCG
Simon Foster, Police and Crime Commissioner
Sir David Thompson QPM DL, Chief Constable of West Midlands Police
Pali Obhi, Service Manager, Solihull Youth Offending Service
Sarah Chand, Regional Director, West Midlands Probation Service
Steve Cullen, Independent Scrutineer

Dear Solihull Local Safeguarding Partnership

Joint targeted area inspection of Solihull

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency response to the identification of initial need and risk in Solihull.

The Secretaries of State for Education, Health and Social Care, the Home Office and Justice, in accordance with section 20(1)(b) of the Children Act 2004, requested that Her Majesty's Chief Inspector of Education, Children's Services and Skills (HMCI), together with the Care Quality Commission (CQC), the Chief Inspector of Constabulary and Fire & Rescue Services (HMICFRS) and the Chief Inspector of Probation (HMIP) for England and Wales, carry out a JTAI in Solihull. The JTAI looked at how all local agencies are working together to protect children and improve their well-being.

This inspection took place from 10 to 14 January 2022.

Headline findings

Children in need of help and protection in Solihull wait too long for their initial need and risk to be assessed. This means that for a significant number of children, they remain in situations of unassessed and unknown risk. Weaknesses in the joint strategic governance of the multi-agency safeguarding hub (MASH) have led to the lack of a cohesive approach to structuring and resourcing the MASH. The Local Safeguarding Children Partnership (LSCP[1] – Solihull's multi-agency safeguarding arrangements) does not have a clear understanding of the impact of practice from the MASH or the experiences of children and their families that need help and protection in their local area.

[1] The lead representatives for safeguarding partnerships are the local authority chief executive, the accountable officer of a clinical commissioning group and a chief officer of police.

Areas for priority action

- Leaders of the local safeguarding children partnership need to take urgent action to understand and identify the initial needs and risks of children presenting to Solihull's 'front door' services. This includes:
  - ensuring that there is sufficient multi-agency capacity within the MASH to meet children's needs promptly
  - ensuring that comprehensive performance information and a robust audit programme, relating to practice and impact for children in the MASH, are delivered and regularly considered by the LSCP
  - ensuring that the right agencies are represented in the range of the LSCP's activities and that there are sufficient resources to support the LSCP to carry out its statutory functions.
- West Midlands Police need to take urgent action to improve the quality of information held on the 'Connect' system to make sure that links to connected individuals are present and accurate, and to reduce multiple records held against the same person, so that risk to children can be clearly seen, recognised and shared when appropriate.

What needs to improve?

- The timeliness and quality of the initial decision-making in the MASH in relation to concerns received about children.
- The communication between health agencies in the MASH and their access to all health information held about children to ensure timely and effective information-sharing that informs decision-making for children.
- All agencies' attendance at, and engagement with, child protection meetings, discussions and information-sharing forums.
- The consistent recording of children's voices across all agencies' records.
- The probation service's management oversight of safeguarding children's referrals, and record-keeping.
- Membership of, and attendance at, the Youth Justice Management Board.
- All agencies' quality assurance processes to ensure that there is consistent and effective auditing, monitoring and oversight by managers and leaders of practice that is designed to safeguard children.
- Sharing learning from significant incidents with the wider workforce across the partnership.

Main findings

Solihull's LSCP has experienced frequent changes of personnel in its membership for a significantly long period of time. This has resulted in a loss of knowledge and experience for the partnership. The business unit does not have adequate resources to support the partnership effectively to meet its day-to-day tasks. The partnership's executive group does not receive regular information relating to the effectiveness of practice in the front door MASH or the impact on improving children's lives.

The MASH is significantly under-resourced by all partner agencies. This means that too many children in Solihull face drift and delay in having multi-agency decisions made to assess their need, reduce risk and provide proportionate interventions. This inspection identified a significant number of children that did not have an initial review of their needs and risk assessed, some of them for over a month. The local authority leaders responded promptly to this and put in place interim measures to address the backlog of work.

The COVID-19 pandemic has had some impact on staffing across all partner agencies at various points over the last two years for Solihull and nationally. While this has brought additional demands and pressures on the MASH, the findings identified from this inspection are long-term systemic issues that cannot be entirely attributed to the impact of the pandemic and have not had a sufficiently robust and sustained response.

Partners within the LSCP have previously raised challenge about insufficient health and police resources in the MASH. While acknowledged, these took too long to address and the current level of resource from health and police partners in the MASH remains insufficient to deal with the demand, resulting in drift and delay in decision-making to reduce risk for children and improve their lives. The local authority has also faced long-standing difficulties in ensuring that there are enough social workers in the MASH and attempts to improve this during 2021 had limited impact. These difficulties were compounded by concerns raised following the court case for the murder of Arthur Labinjo-Hughes in early December 2021, which made social workers highly reluctant to work in Solihull either on a permanent or agency basis.

The current MASH workforce is committed and knowledgeable and dedicated to meeting the needs of children. However, staff face immense pressure to meet the daily demand, and this reduces their ability to respond swiftly to all concerns for children. At the time of the inspection, there was not sufficient social work capacity in the MASH to deal effectively with presenting need. However, in partnership with the Department for Education, the local authority has arranged for additional teams of agency social workers to join the MASH, with the first team starting work before the end of January. It is imperative that this capacity be provided and sustained.

The LSCP has appointed an independent scrutineer, who took up his post in summer 2021 and has begun to provide appropriate challenge to the board. This demonstrates the partnership's willingness to listen to challenge. However, until recently, scrutiny has not been focused enough on the oversight of the MASH and it is too soon to see an impact of this on improving children's outcomes.

Learning from significant incidents in Solihull is not shared effectively with the wider workforce. The Child Safeguarding Practice Review subgroup, which was developed in December 2020, meets regularly and is well attended. It monitors identified learning from practice reviews. However, there has been no agreement on how this learning can be shared more widely. In June 2020, Arthur Labinjo-Hughes was murdered. The LSCP partners completed a rapid review in July 2020. Some learning points were identified; however, this was not a comprehensive list of learning points that were present in the information available at that time. The LSCP reviewed the learning points and took some interim actions; for example, it developed learning briefings on professional curiosity and listening to the voice of the child, shared guidance about disguised compliance and bruising to children and worked to develop a new policy on physical abuse (at the time of the inspection, this had not been shared with the wider partnership workforce) and review the multi-agency referral form (not yet implemented). The Birmingham and Solihull Mental Health NHS Foundation Trust and West Midlands Police initiated their own internal enquiries; however, these were not available to the inspection team. The Local Child Safeguarding Practice Review was put on hold at the time when it was announced that a national review would take place.

Each agency provides relevant training to their own workforce, and we saw evidence of some joint agency training, for example police providing training to school nurses on how to advise young people on the risks of youth-produced sexual imagery (also known as 'sexting'), increasing their confidence to discuss this topic with young people. Staff across the partnership report that the learning available is meeting their needs. However, there is no current assessment of the wider partners' learning needs to inform a multi-agency training programme.

The partnership, in collaboration with the Solihull Safeguarding Adults Board and the Safer Solihull Partnership, has worked well to create an All-Age Exploitation Reduction Strategy. This clearly sets out the strategic objectives to assess and reduce risk for all vulnerable people in Solihull. Improved screening tools and a localised National Referral Mechanism process are having a positive impact in identifying risks to children and the partnership response. However, this is not fully effective in practice. Regular missing triage meetings are held but these do not include health and education partners.

The health representatives in the MASH do not have access to each other's records and this makes it difficult for them to provide support to one another when requests for health information are made. Furthermore, the MASH health representatives do

not have access to information stored in crucial health systems, such as Birmingham Children's Hospital and University Hospitals Coventry and Warwickshire. For some children who attend school outside Solihull, their school nursing records are not available to Solihull MASH, and this restricts the extent of information that can be shared in the MASH and used for planning next steps.

The education representative in the MASH has created effective relationships with Solihull schools' staff and has access to appropriate information systems in the local area. The daily demand on resources means that not all MASH education assessments are completed swiftly. School leaders find the advice and support from the MASH very beneficial in supporting them to make safe decisions for children.

Inspectors are concerned about incomplete records within the police 'Connect' system. Inspectors saw examples of separate records for the same person (because a name had been spelled incorrectly), children not linked on the system to their parents/carers, siblings or significant others and connections between children and those who pose a risk. This means that when officers and staff research 'Connect', they may miss important information, potentially leaving children at risk of significant harm.

Inspectors reviewed the records of one young child who was not linked to the father on the police 'Connect' system. The father has a history of domestic abuse and drugs misuse, and is the subject of a non-molestation order. Consequently, a domestic abuse incident the child was exposed to, involving her father, does not appear on her 'Connect' record. It also means that when officers conduct searches on the system, it is not obvious that the man poses a significant risk to her.

It is recognised that some frontline police officers, when making referrals, are continuing to record children in the wrong place, or not at all, on the system. Some of this risk is mitigated with further checks by the police central referral unit. However, the effectiveness of this quality assurance has limitations when the electronic records are not created correctly at the first point of contact.

Management oversight at the children's social care first point of contact provides relevant actions for social workers to complete, although it lacks timescales for these actions to be completed. This has led to drift and delay, with specific actions not being completed promptly within the MASH.

Partner agencies understand thresholds and make appropriate referrals about children to the MASH in a timely way. They provide relevant information about risk and any previous interventions. Consent from parents is mostly sought before sharing information with the MASH. Most partner agencies told inspectors that they were not involved or kept informed about the outcomes of their concerns and that they felt it necessary to 'chase' the MASH for an update on what decisions had been made.

For a significant minority, the decisions made in the MASH are over-optimistic and lack professional curiosity. This often results in repeat contacts to the MASH and an escalation of risk.

Children who require early help support experience delay in accessing this service because their needs are not assessed quickly enough at the first point of contact in the MASH. Once allocated, children and families receive an effective service from skilled and experienced staff. Early help workers identify when risks increase and will refer children's needs back to the MASH.

When a child protection concern is identified, timely decisions are made. However, not all agencies are invited to, or attend, child protection strategy meetings. This means that decisions are being made when those present do not have all the relevant information about a child and their family. For most children, the right decisions are made based on the presenting information, and prompt actions are taken to progress next steps.

Health and police staff report that they often receive an invitation to initial child protection conferences too late. This means they cannot always attend or provide an up-to-date health assessment of the child.

Operational challenges, such as the inconsistent attendance of key partners at child protection decision-making meetings and discussions, are not escalated to the LSCP by any of the individual partners. This means that the LSCP is not being made aware of known gaps in practice that affect children's experiences.

Assessments of children's needs are variable in timeliness and quality. Local authority social work assessments are completed swiftly; however, they do not always involve all relevant agencies. Initial assessments and reviews of children's needs in the Youth Offending Service (YOS) are sometimes delayed and this is attributed to the capacity of practitioners. Children who receive support from substance misuse services have their voice heard and captured in individualised and responsive assessments of need and risk.

When there is an incident of domestic abuse, police staff do not always capture the voice of the child well enough. This has an impact on the quality of information shared with the MASH about the child's lived experience. Police and social care staff review incidents of domestic abuse, and this results in a prompt referral to the MASH. In September 2021, West Midlands Police introduced Operation Encompass and regularly share information about domestic abuse incidents with schools in Solihull. This assists school staff to support children in school. However, school nurses do not receive notification of an incident of domestic abuse.

Children who go missing or are at risk of exploitation are promptly reported to the multi-agency Locate team. This results in swift referrals to the MASH. However, the

timeliness of the response to children's needs by the MASH then varies, with some children not being seen or spoken to for long periods of time. Return home interviews do not happen quickly enough and are not informing wider strategic planning.

All agencies within Solihull's front door services have some form of quality assurance framework for reviewing the practice and management of safeguarding children, although not all of these are fully embedded and operational. Capacity issues for managers in children's social care and the YOS mean that auditing activity is not regularly occurring, the probation service does not routinely collate themes from practice, West Midlands Police focus more on compliance with process and crime recording rather than the quality of practice, and the oversight and understanding of safeguarding risks by operational leaders in health services are inconsistent.

The single and multi-agency audits completed by the local area as part of this inspection demonstrated that there is more to do to ensure that audit activity is informing and supporting leaders' understanding of the impact of practice on improving children's lives. The audits reviewed by inspectors identified too much focus on process rather than the child, a lack of reflection and analysis and the prevalence of over-optimism. Some agencies were stronger at auditing practice and understanding children's experiences, including schools and the clinical commissioning group (CCG). Overall, this means that leaders and the LSCP in Solihull do not consistently have an oversight of practice and an understanding of the impact on improving children's lives and informing strategic planning.

Probation staff do not routinely store information about child safeguarding on their case recording systems. This means that there is a high risk of critical safeguarding information about children not being passed on to new staff upon reallocation and safeguarding information is not accessible for management review or for any quality assurance activity.

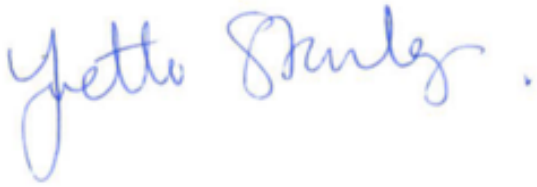
The Youth Justice Management Board has links to appropriate strategic planning boards, including the LSCP. However, police and probation staff attendance at the youth justice management board has not been consistent over the last 12 months and there has also been a lack of school representation. There has been no challenge to attendance, and this has resulted in a lack of robust multi-agency oversight of the needs of the children receiving an intervention or support from the YOS.

Next steps

Solihull Metropolitan Borough Council should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving key partner agencies. The response should set out the actions for the partnership and, when appropriate, individual agencies.

Solihull should send the written statement of action to ProtectionOfChildren@Ofsted.gov.uk by 30 May 2022. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely



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