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Regional Director, West Midlands

Mr Matthew Sampson
Director of Children's Services
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Dear Mr Sampson

Monitoring visit of Sandwell Metropolitan Borough Council children's services

This letter summarises the findings of the monitoring visit of Sandwell children's services on 7 and 8 June 2016. Her Majesty's Inspectors who carried out this visit were Susan Myers and Jenny Turnross.

This was the first monitoring visit since the local authority was judged inadequate in February 2015.

Areas covered by the visit

During the visit, we reviewed the progress made in the area of help and protection with a particular focus on the multi-agency safeguarding hub (MASH), the application of thresholds for statutory intervention and assessment and planning processes for children in need of help and protection. We also considered the progress achieved in strengthening management decision-making and oversight.

The visit considered a range of evidence, including electronic case records, supervision notes, observation of social workers in the MASH and other staff undertaking referral and assessment duties. In addition, we spoke to a number of staff including managers, social workers, other practitioners and administrative staff.

Summary of findings

- Despite the last Ofsted inspection being 15 months ago, there are still some outstanding actions, which means that responses to children in need and in need of help and protection are not yet consistently effective.
- Operational management oversight is still not effective and case file audit arrangements are not rigorous enough in challenging poor practice or helping managers to better understand where improvements need to be made.
- The time that service leads spend with staff observing and checking practice is

not sufficient to ensure that they have a real grip on what is happening in their service. For example, there continues to be poor application of thresholds. The quality of assessments and planning for children is inconsistent and often lacks detailed information. Risk to children is not always responded to appropriately.

- Caseloads are too high in the multi-agency enquiry team (MAET) and this means that social workers cannot provide the quality of social work that they should.
- The draft improvement plan lacks clear focus and does not address priority actions, measure timescales or report on progress made. This means that when necessary improvements have not been made, it is difficult to hold responsible officers to account and this does not support a culture of improvement.

Evaluation of progress

Thresholds are not yet consistently applied by children's social care staff in the MASH. This results in child protection issues not being recognised and responded to appropriately.

Inspectors saw cases being inappropriately closed by social care services. This means that children are not receiving the right service at the right time and the support offered to them lacks a statutory framework and focus.

Arrangements for moving cases to early help provision from statutory intervention remain unclear and inconsistently applied. Inspectors saw a number of cases that were stepped down to early help services without sufficient regard to risk, assessed need or the history of the case. These cases should have had a formal statutory overview. The local authority has an agreed model for stepping down cases but this is not being applied consistently.

Decision-making and oversight remain inconsistent. First line managers are not always making safe decisions about carrying out child protection investigations, and closing cases when these are being stepped down to early help services. Managers do not always give direction and challenge when social workers do not deliver high quality work. Practice and management directions are not always followed by social workers.

Risk is not being consistently identified, recognised and managed. This means that children are not always appropriately safeguarded and there remains variation in the quality and standard of social work practice. Consequently, vulnerable children do not always receive an adequate and timely assessment of their needs. A continuing significant shortfall in the number of experienced social workers and an over-reliance on high numbers of agency staff contribute to this problem.

Assessments are too brief, with significant gaps in information and history, and they lack a thorough analysis of risk. The voice and experiences of children are not always present in assessments and case recordings and there is a lack of partner agency contribution to assessment. This is particularly an issue for adult social care services, which should contribute to assessments of parents where there are enduring mental

health concerns, domestic abuse and alcohol or drug problems. Child protection and child in need plans lack specific and measurable goals and contingency planning. This leads to unfocused intervention and makes progress hard to evidence.

Diversity is not considered in assessments and planning for children. This means that children's individual circumstances are not fully taken account of and understood.

There was some evidence of positive progress, such as the implementation of the Signs of Safety model, which has been well received by staff and families who now better understand assessment processes and expectations about what needs to change.

Caseloads have reduced and are now manageable in some teams and newly qualified social workers are well supported through protected caseloads, regular supervision and group reflection sessions. However, caseloads in the MAET are too high to allow quality work to be carried out.

Effective multi-agency work in the MASH, which was identified in the last Ofsted inspection, has been maintained and strategy discussions convened in the MASH involve a wide range of agencies. These discussions are well informed and purposeful, and the use of a Signs of Safety model in these discussions supports decision-making and planning for next steps.

Leaders and managers know what the shortfalls are and they have some insight into what needs to happen. However, the lack of a coherent improvement plan which is measurable and outcome focused to raise the quality of social work practice is hindering much needed progress. You agree that more needs to be done to support frontline staff and their managers to understand what good practice looks like. Service leads are not spending enough time observing practice, checking that policies and procedures are being followed, and coaching staff and managers as they do their day-to-day tasks. You agree that this work, which needs to include improving the quality of management oversight and decision-making, is critical to ensure a consistent approach at the social work frontline.

Based on the evidence gathered during the visit, we considered that there has not been sufficient progress since the last inspection to improve services to children in need of help and protection.

The pace of change has been too slow and senior managers have been unable to fully implement or to drive forward an improvement plan that demonstrates results in improving the quality of social work practice.

I would like to take this opportunity to thank you, Sharon and all the staff for their engagement, openness and constructive approach to this monitoring visit. In line with our published guidance, I am copying this letter to the Department for Education. This letter will not be published on the Ofsted website but subsequent letters will be.

Yours sincerely

Susan Myers

Her Majesty's Inspector