Aviation House
125 Kingsway
London WC2B 6SE

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

8 December 2016

Mr Alex Hopkins
Director of Children's Services
Civic Centre
Burdon Road
Sunderland
Tyne and Wear
SR2 7DN

Dear Mr Hopkins

Monitoring visit of Sunderland City Council children's services

This letter summarises the findings of the monitoring visit of Sunderland City Council children's services on 8 and 9 November 2016. This monitoring visit was carried out by Her Majesty's Inspectors Fiona Millns and Rachel Holden, and Jan Edwards, Her Majesty's Inspector designate.

The visit was the second since the local authority was judged to be inadequate overall at the inspection of services for children in need of help and protection, children looked after and care leavers published in July 2015. The local authority is making steady progress from an extremely low baseline, in relation to meeting the recommendations made at this inspection, within the scope of the areas outlined below.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in respect of help and protection, with a focus on contact, referral and assessment arrangements and, in particular, six important themes:

- initial responses to children in need of help and protection
- information sharing
- application of thresholds
- the quality and timeliness of assessments
- the voice of the child
- management decision making, oversight and supervision.

Inspectors also considered:

- the arrangements in place to respond to children at risk of sexual exploitation

- the provision of early help
- responses to domestic violence.

The visit considered a range of evidence, including electronic case records, supervision records, observations of social work practice and performance information provided by staff and managers. Inspectors spoke with parents and carers, as well as a range of staff, including managers, social workers and advanced practitioners. Inspectors also met with partner agencies, including police, health and education.

Summary of findings

- Senior managers have purposefully responded to the recommendations made following the single inspection in 2015. They have a comprehensive understanding of the key priorities and actions required to ensure improvement. This is demonstrated clearly through their comprehensive and accurate self-assessment of help and protection provided for this monitoring visit.
- Performance management and quality assurance arrangements focus appropriately on the key priorities, and are used to inform managers at all levels when improvements in practice are needed.
- The number of re-referrals to children's social care is reducing, but is still too high.
- Not all partner agencies have a good enough understanding of the thresholds for intervention, and the quality of information provided by referrers is not always detailed enough to ensure an appropriate response by children's services.
- While improvements can be seen in the management oversight of social work assessments, decision making is not always appropriate and management direction is inconsistent.
- Supervision is more timely, with a clear focus on casework and actions to be taken. However, supervision is not always reflective.
- Social workers feel supported by managers. Despite a continuing reliance on agency staff, there is improved stability in teams at both social worker and managerial level. There is a wide range of training available, including a management development programme.
- The early help offer is not sufficiently coherent or coordinated to support work with children and families.

- Responses to domestic violence are being reviewed to ensure a more robust approach, but currently there is no evaluation of the effectiveness of support services for children and families.

- Arrangements for contact and referrals have recently been reviewed and strengthened to ensure a more coordinated, timely and appropriate response. Many of these changes are recent and not fully embedded, but positive impact can already be seen.

- An emergency duty service has been established to meet the needs of children out of hours.

- Parental consent to share information with other agencies and to undertake assessments is not always appropriately considered or clearly recorded.

- Multi-agency strategy meetings take place at the right time. Minutes of the meetings record decision making, actions to be taken and timescales for completion of tasks. However, police are not always able to attend in person and have to provide information by telephone, which means that action plans to safeguard children may not be fully informed.

- When required, children's cases are allocated to a social worker within 24 hours.

- Caseloads for social workers have been reduced and social workers say that they are manageable. This is despite a recent temporary increase, due to information technology failure across the council.

- The timeliness and quality of assessments are improving in relation to recording, consultation with partners, involvement of children and families, and the use of direct work with children to ensure that their voice is heard. However, the use of chronologies to inform assessment, consideration of all risk factors and diversity issues, and subsequent analysis of what this means for children remains inconsistent.

- Sunderland's multi-agency arrangements to respond to children at risk of going missing and being sexually exploited and trafficked have been strengthened. The quality of information recorded and collated in the risk management tool ensures a well-coordinated multi-agency response.

- Arrangements for return interviews for children missing have been strengthened through the commissioning of a voluntary agency to undertake this work. Analysis of information and intelligence is informing preventative work for individuals and more widely.

Evaluation of progress

The evidence gathered during the monitoring visit demonstrated steady progress and improvement from a very low baseline, although considerable work is still required in

many areas of practice to ensure that children in Sunderland receive the right services at the right time. Importantly, staff within the local authority and partner agencies have increasing confidence in the senior management team, following a period of substantial upheaval that came after the inspection in 2015. Staff who spoke with inspectors feel well supported in Sunderland and commented on a change in culture, with senior managers being visible at the frontline.

The senior management team has a clear focus on the key priorities for improvement in Sunderland. This includes ensuring that arrangements are responsive and sustainable. The self-assessment submitted as part of this monitoring visit was an honest and accurate appraisal of the current situation with regard to contact, referral and assessment arrangements.

Appropriate performance measures have been put in place and there has been a strong focus on ensuring improved stability of social workers and managers, and a reduction in caseloads. These actions have resulted in greater consistency of practice for children.

The single inspection in 2015 highlighted serious failings. Significantly, in June 2015 there were 269 children's cases unallocated. The figure for unallocated cases in August 2016 was two. While there is a reliance on agency staff, many of the agency staff have remained with the local authority on longer-term contracts, and there is improved consistency for children and families.

Senior managers have strengthened multi-agency arrangements at the 'front door'. The multi-agency safeguarding hub has been replaced by the integrated contact and referral team, and this has resulted in safer, more coordinated practice. There are improvements in timeliness, decision making, and attendance at and recording of strategy meetings. However, re-referral rates are too high and, although these have been reduced in recent months, children are not receiving a consistently appropriate response to meet their needs.

Contributory factors to the number of re-referrals include a lack of understanding and application of thresholds by partner agencies, poor-quality information contained in referral documents, inappropriate management decisions, a lack of feedback to referrers, a lack of clarity about consent to share information and insufficient early help services.

Children do not always receive timely support to ensure that their circumstances improve, and some children and families may have been subject to unnecessary intervention. Of the 767 re-referrals in the past six months, 713 had an assessment and 45 became subject to child in need plans, eight became subject to child protection plans and 43 children became looked after.

There is no clear, coordinated early help offer, and the numbers of families in receipt of services are low. Senior managers recognise this and are initiating a further review of the service to strengthen the strategy developed in collaboration with partner agencies following the inspection in 2015. This appropriately focuses on prevention and will be led by the newly appointed strategic manager for early help services.

Responses to domestic violence are not sufficiently coordinated. The Sunderland domestic violence partnership has been refreshed and new guidance developed, but this is yet to be distributed. Sunderland has been chosen as one of the three pilot areas for the 'change that lasts' programme, a strengths-based, needs-led model that supports domestic violence survivors and their victims. Operation 'Encompass' is being rolled out early next year, enabling schools to have details of any domestic violence incidents to offer children support. However, services are not currently sufficiently robust. Information shared at the multi-agency risk assessment conference is not used to inform work being undertaken in cases open to children's social care. Information about re-referrals is not reviewed to monitor the effectiveness of support or preventative work.

Improved practice is seen in the completion of assessments. The local authority currently reports on assessments completed within 45 days. Current data demonstrates much better performance than that reported at the time of the single inspection in 2015. The local authority does not report on information on whether assessments are completed within a timescale appropriate to meeting the child's needs. The quality of assessments, including those undertaken as part of section 47 enquiries, has also improved, particularly in relation to case recording and work with partner agencies. Children are now consistently seen, and seen alone, by social workers as part of the assessment process.

The views of children are recorded more consistently, and social workers are using direct work to elicit children's views. However, further work is needed to ensure that assessments are informed by more comprehensive analysis of risk, chronologies, wider issues of identity and consideration of the extended family. Senior managers have identified these deficiencies and have introduced new practice standards documents, including an assessment template, and have provided training to staff.

Arrangements for coordinating responses to missing, sexually exploited and trafficked children have been strengthened. The coordinator for missing, sexually exploited and trafficked children works closely with social workers to offer support and guidance. The child sexual exploitation referral tool is a comprehensive assessment document that has a strong focus on the views of the child. Examples seen were detailed and focused on risk, and were used well within the missing, sexually exploited and trafficked children meetings to inform practice on individual cases and also in relation to wider disruption activities. In August 2016, all children identified as being at risk had a risk matrix assessment in place, compared with 73% of children in June 2015.

Newly commissioned arrangements to undertake return home interviews when children go missing are supporting children's services effectively in their preventative work with children at risk of sexual exploitation or with other risk-taking behaviour. The service provider's analysis of the findings from interviews is used well to inform individual planning and wider intelligence gathering and action. Determined efforts are made to contact children and undertake interviews. When contact cannot be made, children's cases are referred for further action.

Progress has been made through the development of a dedicated children's emergency duty team to ensure a response to any concerns arising outside office hours. There are three full-time workers, a manager and sessional workers. Sometimes there is a challenge in ensuring a timely and effective response to concerns because the police are not available.

Supervision arrangements have improved and staff receive more timely supervision, with managers providing a clear direction on case work. In addition to one-to-one supervision, regular team meetings are taking place. However, the recording of the supervision seen did not consistently demonstrate reflective practice.

Management oversight is improving, yet is not consistent, and some of the decision making seen during this visit did not ensure that children received appropriate intervention. Decision making is recorded, but the rationale for the decision is not always clear. Senior managers have already identified this and taken action through the introduction of weekly performance meetings, auditing programmes and the development of clearer guidance for recording on the electronic case record.

Performance management processes are being used effectively to focus on key priorities and to help to drive improvement in services and practice. Quality assurance processes, including auditing on children's cases and thematic audits, are enhancing senior managers' understanding of the underlying factors influencing performance. Since April 2016, managers and workers are using child-level data to inform their practice and performance.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely,

Fiona Millns

Her Majesty's Inspector

Addendum

During September and October 2016, the local authority was subject to a major information technology systems breakdown. Emergency arrangements were put in place to ensure that services to children and families continued. Action taken by the local authority prioritised the protection of children during this time. The breakdown resulted in a backlog of work needing to be uploaded to the electronic recording system.