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Dear Jill

**Monitoring visit of Sunderland children's services**

This letter summarises the findings of the monitoring visit to Sunderland local authority children's services on 21 and 22 May 2019. This visit was carried out by Her Majesty's Inspectors, Neil Penswick and Peter McEntee.

The visit was the second monitoring visit since the local authority was judged inadequate for overall effectiveness for a second time in July 2018. Following a judgement of inadequate at a previous inspection, in July 2015, Sunderland city council set up Together for Children (TfC) to deliver children's services functions on behalf of the council.

Since the last monitoring visit, there has been a deterioration in the quality of some services, and not all children are being protected. Management oversight and quality assurance are not sufficiently robust in identifying and addressing weaknesses in practice. Information to the council and the quality improvement committee (QIC) does not provide an accurate picture of the quality of work and progress being made.

**Areas covered by the visit**

Inspectors reviewed the progress made in response to requests for social work support for vulnerable children, in particular whether risks to children are identified and whether thresholds to children's services are applied appropriately. They considered the immediate response to children in need of help and protection and the quality and timeliness of assessments and plans. They also looked at management decision-making, oversight and supervision.

A range of evidence was considered during the visit, including electronic case records, performance management data, audits and quality assurance reports. In

addition, inspectors spoke to a range of staff, including managers, social workers and other practitioners.

## Overview

Management oversight is still weak and quality assurance arrangements are not robust. Many of the findings of this visit were not known about by TfC, the council and the QIC, and the information they collectively receive does not assist in them knowing accurately the quality of the work and the consequent impact on children.

Since the monitoring visit in January 2019, the quality of the front door response to some safeguarding issues has deteriorated. Unless the presenting concern is obvious, children are not always protected from harm. Other agencies, in particular Northumbria Police, do not provide enough information to ensure that TfC can provide timely and appropriate responses to concerns. Due to the poor quality of information being received, risks are not always fully recognised, and child protection work is not commenced by TfC when it should be.

When immediate safeguarding concerns are recognised, in the main child protection investigations and assessments are of a good quality, and are timely and thorough. This is an improvement from when this was last looked at on the inspection in 2018. However, inspectors saw a smaller number of examples of poor work.

The locality teams are not sufficiently resourced with social workers or well-trained managers to enable the delivery of high-quality services to children and their families. There continue to be issues with allocation of casework in locality teams. Since the last visit, some children have not been allocated a social worker, visits have not occurred, and essential work has not been undertaken. Management oversight has been poor and has not identified or addressed the issues.

TfC have successfully recruited to the remaining management posts and are continuing their steady progress in recruiting to the permanent workforce.

## Findings and evaluation of progress

Management oversight and quality assurance remain too weak to ensure that essential improvements occur in children's services. On this visit, inspectors identified far too many children whose needs were not being identified and addressed soon enough. Much information is provided by TfC to the council and the QIC, who have responsibilities to hold them to account and to support them to achieve. However, there is too much focus on process information and not on the quality of work. This has given a misleading picture of the experiences of children and their families when receiving a service from TfC and therefore of the overall progress being made in improving children's services in Sunderland.

Senior managers told inspectors that there were capacity issues within the management, social care workforce and quality assurance staff in TfC. TfC had appointed to all the management positions and experienced managers have either

recently joined or are about to start. This is too early to demonstrate impact. TfC has also been successful in recruiting to some social worker posts, and positive feedback given by staff is testament to the experience they have working in Sunderland. However, continuing staffing issues in the social work locality teams are impacting negatively on the quality of the work and on the experience of children.

Since the last monitoring visit, the response to child care concerns at the front door has deteriorated and not all children are being effectively safeguarded. Inspectors identified a number of children's cases which needed to be urgently reviewed to ensure that children were safe.

TfC had inappropriately introduced a new policy of not acting on children's cases where there were lower level concerns when consent had not been sought by referring agencies. In some cases, this had been applied in child protection matters, leaving some children at risk of significant harm without a response from children's services.

The quality of information provided to TfC from some agencies continues to be poor. For example, inspectors saw insufficient information being supplied by Northumbria Police to enable an understanding of risks to children. The multi-agency 'triage' arrangements, where decisions are made about whether further actions are necessary to protect children, are well resourced by the police but are not fit for children's services purposes. All of the decisions are further reviewed by a social work manager. However, this is ineffective. Most of these children's cases reviewed by inspectors did not include sufficient information on the presenting risks, and there was a lack of clarity about what actions had already been taken, to ensure robust decision-making. Immediate further work was necessary to ensure that appropriate actions were being taken and that children were safe.

Due to the poor quality of information from other agencies, further interventions are not always provided at the correct level of support. Most contacts are appropriately identified as needing a child in need assessment. However, social workers were carrying out some assessments when it was unnecessary because the referral information from other agencies was inaccurate. This had resulted in some children and families being unnecessarily involved with children's services. Inspectors also saw a number of cases where children had not received a child protection response when this would have been appropriate: all the risks had not been recognised and immediate actions were not being taken to protect children. Front door staff did not have a clear understanding of child protection procedures in relation to pre-birth concerns and these procedures had not been updated to reflect current practice. This had resulted in delays in actions being taken.

When child protection issues are identified, in the main the quality of work is effective. Multi-agency strategy meetings are well attended, with clear recording of actions to be taken to reduce risk. Visits are undertaken promptly by the police and social workers, ensuring that children are immediately protected. When children

need to be removed from their home due to identified safety issues, this is done in a timely manner with other options robustly considered.

Workers in the assessment teams have small caseloads, which allows them to work with families and carry out direct work with children. The workers know their families well, and in these teams the morale is improving. Experienced and recently qualified workers and student social workers described being well supported. Inspectors met workers who considered that their recent move to work for Sunderland has been a positive career choice.

In the main, when assessments are undertaken, they are of a good quality, evaluating the concerns and presenting well the views of the children. However, examples were also seen of much poorer work lacking consideration of all of the risks and strengths in the family. This is due to poor management oversight.

Since the last monitoring visit, in the social work locality teams some children have not had an allocated social worker and had not been visited regularly. Necessary work has not been undertaken and managerial oversight is also poor. This has resulted in children not having their needs met in a timely manner and, in some cases, safeguarding issues not being responded to robustly.

When team managers are allocating a child's case, they do not identify the direction and tasks needing to be undertaken. The recording of supervision is too limited to enable robust oversight and is insufficiently reflective. Subsequent plans remain too parent focused and are not always specific about timescales for actions to be completed.

Quality assurance of children's cases is weak. Audits do not enable TfC to fully understand the quality of the social work and outcomes achieved by children. Auditors do not evaluate activities from the perspective of the child's experiences. The quality of audits is inconsistent, not always recognising risks or identifying when there are deficits in the casework. Remedial actions are not always identified and escalated. Follow-up actions identified as necessary have not always been undertaken.

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

Yours sincerely

Neil Penswick
**Her Majesty's Inspector**