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18 May 2018

Ms Jayne Ludlam  
Executive Director  
Town Hall  
Pinstone Street  
Sheffield  
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Dear Ms Ludlam

### **Focused visit to Sheffield children's services**

This letter summarises the findings of a focused visit to Sheffield children's services on 24 and 25 April 2018. The inspectors were Graham Reiter, HMI, and Dominic Stevens, HMI.

Inspectors looked at the local authority's arrangements for the 'front door', the service that receives contacts and referrals, both single- and multi-agency. The findings in this letter relate only to cases seen during this visit.

### **Overview**

The front-door contact, referral and assessment arrangements in Sheffield work well to keep children safe. No children were found to be in situations of unassessed or unmanaged risk. Senior managers have worked hard to implement and develop the Sheffield Safeguarding Hub (SSH) over the last year, with timely and effective links to the area fieldwork teams ensuring that children are safeguarded. Multi-agency partners are effectively engaged and contribute positively to the developments and the quality of the work. With safe and robust arrangements in place, the quality and consistency of practice continue to develop. Strong management oversight, the implementation of a practice framework and an enhanced performance management culture are key to this. Local authority staff have been effectively engaged with the service developments and value the leadership, support and training that is

provided for them. Senior managers know the quality of practice and the areas for development well and this is a key foundation for future progress.

### **What needs to improve in this area of social work practice**

- Decisions to exit from S47 enquiries should be recorded at the point at which the decision is made, with a clear rationale for that decision. The decision needs to be clearly and promptly communicated to parents.
- Fathers who are absent or living separately should be engaged promptly wherever possible and work with the child should explore in detail their feelings and views in relation to their absent father.
- Improvements to the timeliness and effectiveness of coordination between the emergency duty team (EDT) and the police should continue and there should be prompt availability of emergency beds out of hours.
- Feedback to families about the outcome decisions from the SSH should always be given promptly and clearly and in ways which are meaningful for the family.

### **Findings**

- Tenacious evidence gathering, including historical and multi-agency information, is well analysed and subject to rigorous management oversight and challenge. This helps to ensure that levels of risk and need are promptly and appropriately identified in the SSH in almost all cases. In the vast majority of those cases when the decisions do take more than 24 hours, this is appropriate to ensure that all information is gathered and analysed to inform decisions relevant to the needs of the child.
- Thresholds are consistently applied within the SSH and this is supported by the use of and reference to the Sheffield Safeguarding Children's Board (SSCB) threshold guidance.
- The quality of referral information received from partner agencies is variable and does not consistently contain all relevant information or provide clarity about what service or response is being requested. Examples of clear and thorough referrals were seen, including well-written assessments, but in many cases staff in the hub had to spend time clarifying or obtaining information that had not been included. There is inconsistent use by partner agencies of the agreed form for referrals to SSH.
- The obtaining of parental consent to share information and for service referrals is consistently sought and recorded in the SSH. Referrers are prompted by social workers in the SSH to obtain this where it is not clear in

the referral. The rationale for decisions to dispense with parental consent are clear and appropriate.

- The thoroughness of the screening and decision-making processes in the SSH had led to short delay in the transfer of a small number of cases to area teams. As a result, some initial visits could have been undertaken more quickly. In these cases, it was clear that the threshold for social work intervention was met before all information gathering was complete, but the delays did not impact negatively on the child or family.
- When children's cases are transferred to area teams from the SSH, the swift allocation of their cases is underpinned by strong management oversight that gives the social workers clear and helpful case direction. Children are visited in a timely manner to assess their needs and to obtain their wishes and feelings. Further work is required to ensure a consistently high standard of recording of children's lived experience in these visits.
- Feedback about the outcomes of referrals to the SSH is provided to families and referrers in the majority of cases seen. The quality and consistency of feedback to families could be improved and, in particular, could be more reflective of their individual circumstances. Good examples of sensitive and personalised feedback to families were seen. Standard template letters are not used consistently, but where these had been personalised, they were more meaningful for the family. Other methods of feeding back to families need to be clearly evidenced and recorded.
- When the SSH makes decisions to refer to early help services, these decisions are generally appropriate and balance risk and need well. Social workers in early help provide an effective link to and support for this decision-making.
- Immediate risk of significant harm is identified effectively and responses are prompt and well-coordinated. Strategy meetings are timely, well attended by relevant partners and clearly record the evidence and rationale for decisions. Action planning is detailed, but, for complex joint investigations, clearer timescales for actions would further enhance the quality of planning.
- The detailed rationale for decisions to exit S47 enquiries and the actual time at which this decision is made are not clear for cases which do not progress to initial child protection conference. It is also not clear whether the decision is communicated to parents in a timely way so that they understand the status and level of intervention.
- When decisions are made to accommodate children or young people, these are appropriate and matched to children's needs and risk. Decisions to provide accommodation are carried out promptly, whether the need arises during the day or is managed by the local authority's emergency duty service during the night or weekend. This includes more complex situations, for example when

children have been trafficked or they and their parents do not have English as a first language

- Specific areas of risk to children are identified well, assisted by the use of screening tools within the SSH. Risk to children of sexual exploitation is well considered, with access to a specialist child sexual exploitation worker for advice further supplementing the use of the child sexual exploitation screening tool.
- Risks to children from domestic abuse are identified well and responded to effectively, supported by the use of a domestic abuse screening tool. There is appropriate consideration of history and victim vulnerability, which informs the identification of both chronic and acute risks to children. The daily multi-agency domestic abuse (MADA) meeting rigorously analyses all risk factors and identifies clear and appropriate actions to address risk to and safety of children and adult victims. The effective functioning of this meeting would be enhanced by the attendance of police colleagues to further ensure swift information-sharing and immediate safety planning.
- Assessments contain relevant information on areas of need, parenting capacity and family and environmental factors and do consider issues of diversity, culture and identity. This is supported by good access to translators when required. The lived experience of children comes through strongly in a majority of the assessments seen.
- The analyses within assessments do consider risk and protective factors and are balanced in the conclusions reached. This has been well supported by the implementation of the practice framework and can be further improved by ensuring that the impact on the child of all the factors is more consistently articulated. The analyses and judgements underpin appropriate decisions for future work. Assessments are generally completed within timescales that are well matched to the level and immediacy of risk and need.
- There is insufficient consideration of or engagement with absent fathers or fathers who live separately, and what this means for the children, within the majority of assessments. One example of good practice creatively engaged a young child, clearly eliciting the importance of his father for him, and subsequent work has re-established their relationship.
- Threshold decision-making within area teams, for example when to escalate from child in need to child protection or step down to early help, are generally appropriate to children's individual circumstances.
- When intervening in crisis situations, social workers in the out-of-hours emergency duty service take effective action to ensure that children are safe. Improvement actions from a review of the service in 2017, including more appropriate staffing arrangements and clear practice guidance, have

supported progress in the quality and effectiveness of the service provided to children.

- Areas for further out-of-hours service development remain, including reducing delays in moving children being held in custody due to a lack of suitable alternative accommodation. For a very few children, this has meant remaining in a cell overnight. Increasing placement choice, including suitable access to out of hours placements, is being addressed through the local authority's sufficiency strategy. Strategy discussions with the police are not always held promptly and when they do take place, they are not always recorded. This means that actions to protect children taken by the local authority and the police are not as consistently coordinated or effective as they could be.
- Staff are positive about working in Sheffield and about the support, guidance and training they receive. Senior managers have, after a period of some turbulence, been successful in creating this environment, which is conducive to continued improvement. The development opportunities have been key in recruiting and retaining experienced staff. The increased stability of the staff group and their largely manageable caseloads mean that children have the opportunity to build relationships of trust with workers who do not change and who know their area. Staff morale is good.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Graham Reiter

Her Majesty's Inspector