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19 January 2018

Mr Colin Diamond CBE
Corporate Director, Children and Young People
Birmingham City Council
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Dear Mr Diamond

Monitoring visit of Birmingham's children's services

This letter summarises the findings of the monitoring visit to Birmingham children's services on 12 and 13 December 2017. The visit was the third monitoring visit since the local authority was judged inadequate in November 2016. The inspectors were Peter McEntee HMI and Dominic Stevens HMI.

The local authority is making continued progress in improving services for its children and young people, although significant concerns remain in relation to child protection plans ending too early and leaving children at potential risk of harm.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of children subject to current child protection plans. We looked at whether plans enable progress to be made in reducing risk to children and at the support offered by partners to assist in that work. We also looked at the operation of the Public Law Outline (PLO) process, which identifies the families at risk of care proceedings and the work undertaken to ensure that there is an appropriate evidential base to make a court application in proceedings, if necessary. We considered whether the authority has been able to tackle the numbers of child protection plans that end too early and the possible implications for children.

The visit considered a range of evidence, including electronic case records, supervision files and notes, discussions with social workers and senior practitioners undertaking child protection work, and other information provided by staff and managers.

Overview

Senior managers continue to be aware that much work needs to be done to ensure that services for children in Birmingham are of a standard at which outcomes for children are consistently good. The progress made since the last inspection has been maintained. Caseloads for social workers have been reduced, and this reduction has been sustained. The reliance on agency staff has also been reduced and shows a continuing downward trajectory, helping to ensure greater consistency in the way that work is progressed and also in the stability of relationships between social workers and families. Children subject to child protection plans are being seen regularly. However, progress in plans for these children is not consistent and is hampered at times by a lack of participation by partners in key processes such as review conferences and core groups. The authority is active in identifying families in which poor parenting and risks to children mean that an application to court may be necessary if changes are not made through the PLO process. Senior managers are able to evidence progress in reducing risk or, if this is not possible, seeking alternative care for children, to help to improve their overall outcomes. Some significant risks remain. Since the last inspection, there has been no improvement in the number of child protection plans ending too early. The number of children subject to a second child protection plan has risen. More work needs to be done to ensure that plans end only when risk has clearly been reduced and when improvement can be sustained.

Findings and evaluation of progress

The authority has sustained the progress made since the last inspection in reducing caseloads for staff. This, together with reductions in the numbers of agency social work staff, has given greater stability to the workforce and more stable relationships with families and children.

Child protection plans are outcome focused and reviewed regularly. Areas of risk are clearly identified. The majority of plans have clear action points, designed to focus the work and make progress in reducing risk. However, in an attempt to achieve greater simplicity, some plans have failed to identify clearly significant areas of further work, and this has reduced their effectiveness in ensuring timely progress. Almost all children subject to a child protection plan are being visited at the intervals laid down in the plan, and often more frequently. No child was seen to be the subject of a child protection plan who should not have been.

Core groups are being held on a regular basis and are using the child protection plans and further work undertaken as measures of progress. Although additional information relevant to the plans' progress is being added to records, child protection plans are not being updated as a result of the core group. This remains an issue outstanding since the last inspection in 2016.

Too many examples were seen of child protection review conferences and some core groups that key professionals from other agencies, including school nurses and workers from drug and alcohol services, although invited, had not attended. Some

cases were seen in which a lack of engagement by key staff hampered both progress and access to information, services and resources. There was a lack of challenge to this absence by the chairs of child protection conferences. There were also some examples seen where chairs, in order to be compliant with timescales, required conferences to go ahead despite not being quorate. These weaknesses lead to decisions being made without appropriate information, at times, and without access to the skills and experiences of other professionals. They also mean that the cross-agency understanding of and responsibility for child protection are not as well developed as they should be.

Assessments for review conferences are generally completed within an appropriate timescale. They contain a clear rationale and management oversight, provide a sense of the wider context and history behind children's current circumstances, and highlight key risk and protective factors. However, they do not consistently provide a clear analysis of what these risk and protective factors mean for children and they do not all contain a sufficiently strong sense of children's lived experience.

Regular management oversight is evident in the cases seen by inspectors and is helping to ensure some progress in the majority of cases. However, while the actions decided are clear, they are often lacking in timescales, and there is little evidence of reflection. This means that opportunities are being missed to enhance case practice and staff's understanding of how they can make a difference.

The local authority reports a renewed focus on the PLO process, and 175 families are currently being worked with. In conjunction, the number of care proceedings initiated has fallen from an average of 25 per month, in the first four months of 2017, to 15 per month, in the four months to December 2017, indicating a more robust parenting assessment and support service. This builds on the findings of the last Ofsted inspection, which reported that, 'increasingly, the PLO process is being used to good effect'. In the PLO cases seen, the letter to parents and subsequent initial pre-proceeding meetings detailed areas of concern and risks to children. They were also clear about what parents needed to do and to change, if court was to be avoided. In the significant majority of cases seen, this meant that the assessments of parents' ability to care for their children and sustain that care identified the support that was needed to manage and reduce risk to children. In the majority of cases seen, the PLO process was timely, and progress has been made and, as a result, outcomes for children are being improved.

The authority reports that, as of October 2017, 37% of child protection cases ended at the first review that takes place three months after a protection plan is initiated. At the point of the last full Ofsted inspection in November 2016, this figure was 29%. This indicates a lack of progress in this area since the inspection. In parallel, the number of children becoming subject to a second plan has risen since the last inspection from 21.7% to 24%, compared to the England average in 2016–17 of 18.7%, indicating that the local authority is not having sufficient impact on presenting risk issues at the point of the first child protection plan. The last inspection found that the authority was removing children too early from plans and potentially leaving them at continuing risk. The authority has not established a

trajectory for improvement and, on this basis, children may continue to be left at potential risk of harm for too long. The authority has recognised this as a significant concern and has recently established a review of how practice can be improved.

The authority has demonstrated that it has made some continued improvements in the quality of social work practice since the last inspection. Further work remains to be done to ensure that practice is consistently good and that the best outcomes for all children are achieved on a timely and consistent basis.

I would like to thank all the staff who contributed to our visit and their positive engagement with the process.

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

Yours sincerely

Peter McEntee HMI

Her Majesty's Inspector

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Chief Executive
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Po Box 17363
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