

Inspection of local authority arrangements for the protection of children

Birmingham City Council

Inspection dates: 10 – 19 September 2012
Lead inspector Marie McGuinness HMI

Age group: All

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Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Birmingham City Council is judged to be inadequate.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Birmingham City, the local authority and its partners should take the following action.

Immediately:

- ensure compliance with statutory requirements for children in need and ensure that those children who require an assessment and a child in need plan have one in place with identified needs and services required
- ensure that the Birmingham Safeguarding Children Board (BSCB) reviews all its work programmes to ensure that it is compliant with all of its statutory duties and in particular reviews the arrangements for safeguarding children and children at risk of sexual exploitation so that inter-agency work is effectively coordinated and better identified and responds to children's needs
- ensure that children who are subject to child protection plans receive statutory visits within appropriate timescales
- ensure that delays in the protection of children through over-long periods of information gathering and assessment are eradicated
- improve the quality of assessments so that they are focused on robust assessments of risk.

- take further action to reduce the proportion of children missing from education and minimise risks to them
- equip all managers to understand and challenge less than acceptable practice at all levels, specifically in relation to the sharing of information between professionals, the identification and assessment of risk and the subsequent plans and reviews to secure the protection of children and young people
- ensure that children and families are consulted and included as part of child protection planning and review processes, including core groups, and that they understand what is happening to them with the help of support and advice from advocacy services where appropriate
- ensure that there is a single recording system for use of the common assessment framework (CAF) and that the assessment process fully involves children and families
- ensure that the BSCB and partners improve working at all child protection conferences and reviews so that risk is assessed using all available information.

Within three months:

- implement an overarching strategy for early help on a multi-agency basis through the Strategic Partnership supported by the BSCB which addresses the balance of intervention so that vulnerable children receive help earlier
- review the purpose, role and functioning of the integrated family support teams so that they are fit for purpose
- ensure that BSCB works effectively with other strategic boards to safeguard and protect the welfare of children and that there is coherence and connectivity between all key strategic plans
- BSCB to review the thresholds document and ensure that all agencies understand their roles and responsibilities in referral practices and managing risk, and to address inconsistency in practice and avoid delay in responding to concerns about children and young people

About this inspection

4. This inspection was unannounced.
5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.
6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.
7. The inspection team consisted of six of Her Majesty's Inspectors (HMI).
8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Birmingham City Council is the largest local authority in England. It has a population of over 1,000,000. There are an estimated 287,000 children and young people under the age of 19, representing 28% of the overall population. This number is anticipated to rise to 314,000 by 2020, a 9% increase. Approximately half of these children and young people are from minority ethnic groups with more than 50 community languages spoken. The largest minority ethnic communities are Pakistani (20%), African Caribbean (10%), Indian (7%), Bangladeshi (4%) and children of mixed heritage (6%).
10. Birmingham has significant areas of deprivation. Only five of the 40 wards in the council area have fewer children living in poverty than the national average (20.64%). In the seven wards with the highest levels of deprivation, the percentage of children living in poverty ranges from 42.1% to 49.9%.
11. Early help for children and families in Birmingham is provided through a range of directly provided and commissioned services. Responsibility for the nature and range of the services offered is located within the

integrated services and care division of the local authority. Services are arranged so that the majority of early help services (council or partners) are delivered through or by children's centres and integrated family support teams.

12. Contacts and referrals for targeted children's social care support are managed by the council's four integrated access teams. Once it is determined a children's social care service is required, an assessment of need is undertaken by geographically based first response teams. Services for children assessed to be in need of protection or requiring a child in need plan are managed and delivered by geographically based safeguarding and support teams.

Overall effectiveness

13. The overall effectiveness of local authority arrangements for the protection of children is inadequate. In February 2009, the Secretary of State issued an improvement notice to Birmingham City Council due to poor performance in safeguarding children and young people. A further improvement notice was issued in September 2010 and during 2011, a major restructure and overhaul of children's services was undertaken with the oversight of the Improvement Board'. Since the first improvement notice, Ofsted has undertaken a Safeguarding and Looked After Children inspection and two unannounced inspections of the council's contact, referral and assessment arrangements for children and young people. Concerns with regards to the quality of practice in protecting children have been raised in all three inspection reports. The last unannounced inspection, undertaken in November 2011, found that some progress had made on the areas for development identified at the previous inspection, although most of the areas required further work and these were included in the improvement plan. One of these areas raised continuing concern about the quality of risk management in protecting children from harm. This inspection has also found that too many children and young people are left for too long without a robust assessment, leaving some children at risk of harm. The pace of progress to tackle some of the key issues and to ensure that child protection arrangements are secure has been too slow and significant shortfalls remain in meeting some key performance targets. For example; there are high rates of re-referrals; children and young people subject to child protection plans do not always receive statutory visits from social workers, and too many children are subject to repeat child protection plans. In some cases the decision to remove children from the initial plans that ensured their protection was premature. The vast majority of children in need known to Birmingham Children's Services do not have a child in need plan, which means their needs might not have been assessed well enough to understand what services they require. Partnership work has been ineffective in helping to tackle areas of poor quality practice that are endemic in Birmingham. For instance, the absence of a consistent representation by police at most child protection

conferences does not support effective joint planning in the protection of children.

14. Over the last three years there has been a lack of continuity of leadership. There has been delay in taking forward the objectives and actions in the improvement plan and the target for the plan to achieve its aims by September 2012 has not been achieved. Whilst some progress was noted during the unannounced inspection in 2011, this has not been sustained. Strategic oversight of the Children's Trust has failed to provide the necessary leadership and momentum required to take forward the required changes. While some progress has been made, this has often been fragmented and not underpinned by a coherent strategy or an effective performance and quality assurance framework to evaluate impact.
15. The newly appointed Director of Children's Services is a key driver in some of the recent changes in taking forward improvements to the service and in starting to work cohesively with partners. Additionally, staff and partners report increased confidence in the senior leadership team to tackle the changes required. Over the last few months, there has been a step change in momentum, with early signs of impact in some areas of practice. For example, clearer reporting mechanisms are now in place to scrutinise performance indicators both at a strategic and operational level. This is supported by a strong focus on improving practice through strengthened quality assurance arrangements across all levels of management. The current urgency and momentum to drive improvement needs to be maintained and applied consistently across all services if further progress is to be achieved to ensure that all children known to Birmingham City Council are adequately protected.

The effectiveness of the help and protection provided to children, young people, families and carers

Inadequate

16. The effectiveness of the help and protection provided to children, young people, their families and carers is inadequate. Children and young people are not sufficiently protected on their journey through life because risk is not always identified and managed well enough and there are unacceptable delays in acting upon serious concerns. The vast majority of children and young people identified as children in need do not have an assessment or plan in place to meet their needs. The absence of robust information in children's services of the definitive number of children in need means that the local authority cannot be confident that need is being identified assessed and that changes to a child's circumstances are appropriately reviewed.

17. Not all children and young people and families understand the reasons for or intentions of the help they receive. Furthermore, some children and young people who are subject to child protection plans do not receive the help they require and are sometimes excluded from some of the most significant decisions that are made about their lives. As a result, they do not participate routinely in core groups or reviews to ensure that planning and assessments fully address their needs and are effective in reducing risk. Lack of advocacy and feedback to children, young people, parents and carers reduces the effectiveness of planning because the individual needs and perspectives of those involved are often not presented fully. In addition, key agencies do not always attend core groups to ensure that accurate information is shared to inform planning, further limiting the effectiveness of work to reduce risk for children and young people.
18. Whilst some parents attend core groups, they are not fully included as they do not always have prior access to reports or advocacy. Parents are often unclear about why their children are subject to child protection procedures and what they need to do to make their children safe. Case files show a lack of understanding by parents of the long-term effect of domestic violence and mental health issues for their children and a potential consequence of this is that parents spoken to reported their reluctance to cooperate with services to provide support and protection for their children. Documentation from child protection conferences and core group meetings that is provided to parents, many with low levels of literacy, is mostly inaccessible and schools often act as advocates in helping families to understand what is happening to them. The help and protection provided is generally responsive to family diversity. Ethnicity, culture, language and religious needs are routinely recorded but issues are not always fully explored within practice and assessment. Assessments are not always provided in other languages when required and cultural issues that affect the behaviour of parents towards children are not always addressed.
19. There is a lack of clarity about procedures for locating children reported missing from education for more than 20 consecutive days. Multi-agency checks conclude that children and their families have left the country but protocols within the UK Border Agency do not allow for verification. The council are aware that the majority of these children are from communities in two distinct geographical areas. Schools and community leaders in these areas are being targeted to identify individual circumstances, but these actions are not minimising risk of harm. In contrast, there is adequate protection of vulnerable young people in alternative educational provision and for those who are elective home educated.
20. The recently restructured disabled children's service demonstrates good quality interventions that address complex family needs. For example, with a large sibling group, good consultation and planning with the wider

family, use of interim care orders and placements with family enabled social work staff to respond effectively. This work was commended by the Judge involved in the case. In addition, consultation with families through the Aiming High for Disabled Children programme and an ongoing commitment to maximise parental engagement through 'ParentViewsCount', demonstrates the positive impact of short break services for disabled children. Feedback illustrates the effectiveness of the service in meeting needs, as one family identified: 'without the short break service we would not be a family, we were at breaking point'.

21. Commissioning of early help is informed by the needs of children and families and focussed well on managing and reducing risk. Commissioned services show productive partnerships with third sector and statutory providers. However, the early help offer to vulnerable children and young people comes too late for some. There is no overarching strategy, and health agencies are not involved as key partners. This means that for some very young children intervention does not take place early enough. Insufficient numbers of the common assessment framework (CAF) are completed by community health services, potentially leaving children's centres to identify and act on risk for some children. Procedures for the completion of CAFs, both electronically and manually, do not prevent overlap and until recently a single recording system for use of the CAF has not been in place. This has confused and frustrated some families where more than one CAF runs concurrently because agencies have not communicated well and support has not been coordinated. However, overall, families show a good level of satisfaction with the help they receive.
22. Common assessments recently completed show generally good identification and management of risk and aligned multi-agency action. Assessments from other agencies are used well and medical interventions for disabled children, in particular for new-borns, are coordinated well. CAFs completed by integrated family support teams are at an appropriate level and show prompt progression to statutory services where necessary. However, a lack of a shared understanding of thresholds in step-down procedures from children's social care to integrated family support teams, affect the continuity of intervention for some children.
23. Managers and practitioners are clear about the importance of early help. However, integrated family support teams do not include health agencies, and on occasions, they fail to provide the necessary help to vulnerable children and young people and show considerable inconsistency in their work. Some teams are still struggling to establish ways of communicating with other agencies, resulting in support for families that is delayed, uncoordinated and duplicated. However, others are more effective in providing multi-agency help that minimises risk and prevents involvement with statutory services, in stark contrast, best practice has not been shared across the authority. Interventions show unacceptable variation in

the skills and expertise of staff working with families who are below the threshold for social care intervention. The view of some schools is that the service overall fails to deliver value for money because it is not reducing risk for children.

The quality of practice

Inadequate

24. The quality of practice is inadequate. A review of contacts made to children's services shows that some that met the threshold for services were not progressed to referrals for action, which left children at risk. Information sharing across the partnership is ineffective and inadequate. Although thresholds for referrals into children's services are clearly documented in BSCB procedures, referrals from partner agencies for the intervention of children's social care do not demonstrate a shared understanding of these. Too many referrals were seen where gaps in referral details resulted in serious and significant delay in decision making while further information was gathered, leaving children at potential risk. This also leads to ineffective use of time by social work managers in the integrated assessment teams, who need to enter into lengthy dialogue with other professionals to determine whether a referral to children's social care is appropriate. Partners also report unacceptable inconsistencies in decision making in the integrated assessment teams. Several examples seen by inspectors, including observation of a rapid response meeting following a child death, demonstrate how poor information sharing leads to an incomplete assessment of vulnerability within families that can leave children at potential risk of harm. Observations by inspectors, case records and reports from staff show that the police rarely attend or provide reports for child protection conferences. This is poor practice and means that a comprehensive assessment of risk is not always possible. However, some referrals seen were of a high quality, particularly those where the referral information was provided on a BSCB inter-agency form or was accompanied by a CAF, as these documents made the reason for referral clear.
25. In a significant number of cases seen, there is unacceptable delay in taking the assertive action necessary in response to child protection concerns that emerge from on-going assessments. When cases of immediate child protection concern are notified to, or identified by, children's social care, strategy discussions with the police are conducted routinely and some evidence was seen of multi-agency strategy meetings taking place. This is particularly evident in the south area of the city, where co-location of agencies in a multi-agency safeguarding hub is adding considerable value to the joint delivery of child protection processes, including a satisfactory process for screening and prioritising

domestic violence notifications. Emergency duty arrangements are satisfactory, suitably resourced and link well to day time provision.

26. In the majority of cases seen, child protection plans and subsequent actions by social workers and partner agencies to protect children were of very poor quality. The actions arising from child protection plans are insufficiently child focused and are not suitably linked to improved outcomes for the child and their family. However, basic child protection planning formats are in place which give appropriate consideration to risk and protective factors and are reviewed regularly by independent reviewing officers
27. Contingency planning to step intervention up or down at the conclusion of a child protection plan is weak. Casework with children in need who have previously been the subject of child protection plans lacks a clear focus on specified outcomes. A recently introduced procedure indicates that closure of child protection plans should result in children in need plans, but this process is not yet evident in practice. Children in need cases sampled by inspectors indicate that some were being visited regularly by social workers but failed to identify any child in need plans initiated as a result of a step down from a child protection plan. Where cases are considered to require stepping up to a child protection plan or there is a need for further action, a clear framework and process is in place for convening legal planning meetings for the legal protection of children. However, in one legal planning meeting observed, the meeting was not timely with poor information provided by partners to support the assessment of risk.
28. Assessments for children who need help or protection are adequate, but vary in quality. There are significant and unacceptable delays in commencing assessments. Most assessments are focused on the needs of adults and fail to consider the impact of adults' actions on children. While children and young people are consistently seen by social workers, and seen alone where appropriate, there is insufficient evidence that children's wishes and feelings impact upon assessments or the provision of services. Assessments fail to convey the voice of the child or demonstrate what it is like to be a child in a particular family. The quality of analysis demonstrated in most assessments is basic, although assessments completed during child protection enquiries are good. Chronologies are not effectively or routinely used to inform assessments and the case chronology held on the electronic record has a very limited impact on practice.
29. Case recording is basic and at times too descriptive, with insufficient focus on purpose or the link to planned outcomes for children. The electronic recording system is used inconsistently by social workers, with some workers recording the same activity twice on the system. This poses difficulties in auditing for compliance and means that information recorded is unhelpful in understanding the child's individual story. In most case files

seen, some degree of management oversight was evident, including the basic identification of tasks to be undertaken following the allocation of assessments, and appropriate follow up in supervision. Some cases seen were of better quality and effective decision making by qualified and experienced staff resulted in plans being suitably progressed.

30. Advocacy services for children and young people and adults involved in child protection plans in Birmingham are not routinely available and this is poor practice. The lack of advocacy means that children are rarely involved in child protection processes, so their perspective or views are not included in the making or reviewing of plans. Questionnaires are not used to elicit the views of children involved in child protection processes so there is no effective, independent or supported way for children subject to child protection plans to have their voices heard.

Leadership and governance

Inadequate

31. Leadership and governance arrangements are inadequate. Since the initial improvement notice was issued in February 2009, the pace of change in making the improvements necessary has been too slow. There has been an absence of consistent leadership and strategic oversight to take forward the improvement plan. The previous Children's Trust, BSCB and scrutiny arrangements have been ineffective in meeting their duties.
32. Since his appointment five months ago, the permanent Director of Children's Services has accelerated the pace of change in driving improvements. However, achievements are from an extremely low base and in some key areas of performance, significant concerns remain in meeting performance targets. For example, there are high rates of re-referrals, statutory child protection visits not being undertaken in timescales and too many children being made subject to repeat child protection plans. Referrals received into children's social care by partner agencies are mostly of a poor quality. This means that social care staff spend additional time gathering essential information that could have been provided at source. There are too many children and young people who are defined as children in need where need has not been assessed and who do not have a plan in place to secure services sufficient to meet their needs. The overall absence of assessment, planning and risk management means that changing needs and escalating risk are potentially not identified for some children and young people. Birmingham City Council cannot be satisfied that all children receive the help and support they need at the right time.
33. Strengths and weaknesses across the service have been identified and a number of key deficits from previous inspections are now beginning to be

addressed. In some cases, swift decisions are made regarding children who need immediate help and protection and these children are usually seen quickly, with good joint work taking place between children's services and the police. A draft joint strategic needs assessment provides an overview of the population and of the health and well-being needs of children and young people, but there is no clear focus on child protection needs, or of gaps in services to ensure that there is an effective offer of help to children and families. A lack of coherence and connectivity between the joint strategic needs assessment, the Children and Young People's Plan and the BSCB Business Plan, means that the level of services and actions required to meet the needs of children and young people are not fully identified.

34. Governance arrangements and accountabilities are now in place between the BSCB, the Director of Children's Services (DCS), the Chief Executive, the Leader of the Council and the Cabinet Member for Children's Services. The Leader of the Council has established a task force which has already met and there is renewed commitment across the council to improving children's services. Weekly meetings take place between the DCS and the Cabinet Member, where performance indicators are discussed, including scrutiny of the improvement plan.
35. While there has been a wealth of performance information available, there has been an insufficient grip and understanding of performance management and quality assurance, with poor tracking, monitoring and delivery of actions emanating from plans, including a lack of connection between the improvement notice and actions in the improvement plan. Clearer processes and systems have recently been put in place for the collation and reporting of performance information against national and local indicators, underpinned by an effective performance assurance framework. There remains a wide variation in performance across the social work teams and evidence of impact of the newly strengthened arrangements on improved performance is limited. The introduction of a performance board and clinics led by the senior management team is developing a performance culture at all levels that is showing some signs of impact in taking forward plans and driving up standards. The council has very recently put in place quality assurance arrangements for managers in the auditing of cases and aspects of practice. Evaluation of these by inspectors found some were comprehensive and supported by clear outcomes and learning points. However, in a number of audits there was inconsistency between the overall judgement reached in the audit and weaknesses identified in practice. Despite the improved performance management processes, not all managers have sufficient understanding of acceptable practice.
36. Since the appointment of the independent chair of the BSCB almost one year ago, there has been a positive change in the governance arrangements and membership, including a review of sub-groups. A

renewed commitment from partners to the work of the Board and to the delivery of the council's strategic priorities is slowly beginning to demonstrate improvement necessary in the functioning of the BSCB. However, prior to this, statutory duties to oversee the core business of the Board were not met. A new strategic and business plan is in place to drive forward the board's work. These plans are supported by a new safeguarding performance dashboard but this is too recent to show evidence of impact. The Board acknowledges that significant work remains in producing key data across the partnership and in evidencing the effectiveness and impact of the work of sub-groups. The BSCB has made insufficient progress in safeguarding children and young people from sexual exploitation. While a sub-group is in place, with some inter-agency working, this is not coordinated and each agency does not have an identified lead. The BSCB recognises that challenges remain in addressing progress against priorities set. Consultation with young people is not embedded and the need to adopt a more strategic approach to their engagement is recognised.

37. A workforce development group with responsibility for taking forward the new directorate workforce priority was set up in May 2012. In the absence of a coherent overarching strategic plan and, until recently, robust strategic leadership, progress and review against the workforce priorities for 2011-14, have not been fully coordinated with the result that a number of key actions have not been achieved. The role of partners in delivering against the priorities is unclear. Notwithstanding this, the council has made some notable progress, including a reduction in the case loads of front line staff, although this has not yet consistently impacted on the quality of social work practice. The council's partnership with the University of Birmingham continues to work to drive up standards in social work practice and the council has also recently introduced a leadership and development programme for front line managers, but this is too new to evidence impact. The council remains ambitious to reduce reliance on the use of agency staff across front line services, including social workers and team managers. However, high numbers of agency staff remain and an effective recruitment and retention strategy is not in place.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Inadequate
The effectiveness of the help and protection provided to children, young people, families and carers	Inadequate
The quality of practice	Inadequate

Leadership and governance	Inadequate
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