

# Birmingham City Council

## Inspection of services for children in need of help and protection, children looked after and care leavers

and

## Review of the effectiveness of the local safeguarding children board<sup>1</sup>

**Inspection date: 18 March 2014 – 09 April 2014**

**Report published: 23 May 2014**

### The overall judgement is **Inadequate**

### There are widespread and serious failures that leave children and young people at risk of harm

It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

<b>1. Children who need help and protection</b>	<b>Inadequate</b>
<b>2. Children looked after and achieving permanence</b>	<b>Inadequate</b>
2.1 Adoption performance	<b>Inadequate</b>
2.2 Experiences and progress of care leavers	<b>Inadequate</b>
<b>3. Leadership, management and governance</b>	<b>Inadequate</b>

### The effectiveness of the Local Safeguarding Children Board (LSCB) is inadequate

The LSCB is not demonstrating that it has effective arrangements in place or the required skills to discharge its statutory duties.

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<sup>1</sup> Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

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## Section 1: The local authority

### Summary of key findings

#### **This local authority has serious weaknesses and is not yet good because:**

1. The most vulnerable children in Birmingham continue to be failed by the local authority. There is an insufficient focus on children who need help and protection and who need to be cared for.
2. Too many children are not seen quickly enough or properly assessed when first referred. For example, at the point of the inspection over 400 children in need cases, some of which were referred more than two months previously, had still not been robustly risk assessed or the children seen. In addition, between October 2013 and January 2014, the local authority made a decision, based on a lack of social worker capacity, to close a significant number of children in need cases without them having been risk assessed. This means that some children have not received an appropriate response or intervention to ensure their safety.
3. Long standing and historical corporate and political failures continue to impact upon the current political and professional leadership of children's services in Birmingham. In addition, inadequate strategic partnership arrangements have undermined a range of initiatives to improve services.
4. Structures, systems and processes for supporting social workers are inadequate. The legacy of poor management and practice in Birmingham children's services remain. These failures have become so entrenched that, despite recent efforts to improve management practice and outcomes, the progress being made to date is too slow and has had little or no impact. There have been too many 'false dawns' that have raised expectations but have ultimately failed to deliver adequate care and protection for vulnerable children in Birmingham.
5. Although there is a range of plans and strategies in place to improve safeguarding and care for children and young people, there has been a significant and unaccountable delay in implementation. As a consequence, help and support to the most vulnerable children and young people in Birmingham continues to be inadequate.
6. Governance arrangements are poor between the Safeguarding and Adoption Improvement Board, the Birmingham Safeguarding Children Board (BSCB) and the Health and Wellbeing Board. This inhibits the arrangements and accountability for the work of these boards.
7. The corporate parenting board is weak and, until very recently, there has been no corporate parenting strategy. This has contributed to the needs of looked after children not being met in a significant number of cases. In

addition, the absence of a Children's Strategic Partnership hampers progress in implementing, for example, an overarching multi-agency early help strategy.

8. There is a widespread lack of understanding about thresholds in and between children's social care services and their partners. This, combined with a lack of confidence in decision making, undermines any attempt to improve the quality of services. Children and young people have been left at risk of harm for too long before being protected by the care system. Timely decisions are not taken when children and young people need to be cared for by the local authority.
9. Inconsistent management oversight of social workers practice leads to a lack of focus on outcomes for children and young people. Children are sometimes left at risk of significant harm for too long without timely intervention. Some agencies fail to share information on children about whom they are concerned. Core groups do not effectively monitor the progress of children's plans to ensure that outcomes are improving and children are protected from harm.
10. The performance management system, including performance information, is ineffective. This results in a lack of focus on improving outcomes for children and young people. While a significant number of audits of practice are undertaken by managers, there is limited evidence to suggest that the impact of learning from these audits drives improvements.
11. There is a lack of strategic planning and coordination for children and young people who go missing from education, home and care or who are at risk of sexual exploitation. A significant number of children (144) are currently missing from education and are believed by the local authority to have moved abroad. As a consequence, there can be no assurances about their safety and wellbeing.
12. Independent reviewing officers (IROs) and child protection chairs do not fulfil their statutory duties adequately in improving the quality of planning and practice. The quality of assessment and planning of looked after children's cases is poor. Assessments are often out of date, are not updated following reviews and do not inform current care planning.
13. The achievement of looked after children in their education is inadequate. The attainment gap between them and all other children in Birmingham is widening in terms of the qualifications they achieve.
14. Adoption is not considered for all children who cannot return home. There is a lack of ambition and delay in pursuing adoption in some cases, for example where brothers and sisters need to live together or where children have complex needs or are disabled. There are insufficient approved local adopters to meet the needs of children waiting for adoption and there is a lack of a

range of in-house foster placements to meet the current needs of children and young people.

15. Children are often placed with 'connected persons carers' before assessments and relevant checks are completed and before cases are presented for approval at panel. This means that statutory requirements are not met, risks are not fully assessed and this can lead to children experiencing unplanned placement moves.
16. Pathway planning for care leavers is poor: it does not start early enough and too many young people leave care without a plan in place.
17. The proportion of 19-year-old care leavers who are not in education, employment or training (NEET) is significantly worse than for care leavers of this age nationally.

### **The local authority has the following strengths**

18. Some children and young people who receive help and support from the family support teams build effective relationships with workers and in many cases this is helping them to improve their lives. Some older children and families receive good support from Think Family (Troubled Families) that leads to improved outcomes.
19. Looked after children's health reviews are comprehensive and a very large majority (90%) are undertaken in a timely way. Quality assurance processes for health assessments are robust and service provision is informed by feedback from children and young people.
20. The Therapeutic Emotional Support Service (TESS) provides an effective service to looked after children and young people who do not meet the threshold for specialist Child and Adolescent Mental Health Services (CAMHS); it is accessible to all of Birmingham's looked after children, wherever they are living.
21. The number of children who are adopted is increasing. The Birmingham Improvement Team (BIT), led by the Principal Social Worker, is having a positive impact on improving practice. For example, the average timescale for court proceedings has reduced from 79 weeks to 41 weeks and, since October 2013, the average has been 21 weeks.
22. The Workforce Strategy is comprehensive and detailed. There is evidence that there has been considerable effort to respond to a ministerial letter which advised the local authority to stabilise the workforce and reduce caseloads. Some notable progress has been seen in the appointment of newly qualified social workers and experienced team managers.
23. Overall, inspectors found evidence that social workers are now committed to the children of Birmingham and they report that they enjoy working for the

authority. Staff report increased morale, reduced caseloads and smaller teams.

## What does the local authority need to improve?

### Priority and immediate action

24. Strengthen operational and senior management arrangements so that there is sufficient capacity and experience to tackle the deficiencies in the service.
25. Ensure that strategic and operational management oversight is effective, including supervision and that case file audit arrangements are robust so that workers have a full understanding of their roles and responsibilities and deliver work of a consistently high standard.
26. Improve performance management and information systems to ensure that managers at all levels have timely, relevant and accurate performance information to enable them to do their job effectively and deliver improvements.
27. Strengthen governance arrangements between the local authority and its partners, to enable effective and coherent strategic relationships to be developed with defined accountabilities and responsibilities.
28. The local authority and its partners should ensure that the range of draft plans that have been designed to support strategic and operational practice are accompanied by appropriate delivery arrangements that include training and development opportunities for staff.
29. Ensure that the delayed Early Help Strategy is implemented urgently and that partners are fully engaged in the work to achieve this.
30. The local authority and partners should re-launch the 'threshold document' *Right Service, Right Time* and ensure that partners have a full understanding of and confidence in their roles and responsibilities about what actions they must take when they have concerns about children and young people.
31. Ensure that the system to manage contacts and referrals, including domestic abuse notifications, is secure and provides the professional basis to support social workers in keeping children and young people safe and protected.
32. Senior leaders and managers need to take urgent action to ensure that all unallocated cases are appropriately risk assessed. In addition, they need to ensure that the large number of children in need cases that have been closed as part of the recent system cleansing process are reviewed and that outstanding concerns and risks to children and young people are identified and responded to appropriately.
33. Revise the function and purpose of the corporate parenting board and strategy to ensure that the needs of looked after children are paramount and that the right actions are taken to improve the quality of their lives.

**Areas for improvement:**

34. Review and strengthen assessment and care planning processes to ensure that interventions and ongoing work with children and young people are properly targeted to meet their identified needs.
35. Senior leaders and partners should develop effective, strategic multi-agency systems and practices to respond to children missing from care, home and education so that their exposure to risk can be minimised.
36. Strengthen the role, function and practice of child protection conference chairs and independent reviewing officers so that they meet their statutory responsibilities and take the necessary steps to identify and promote the quality of services that children and young people need.
37. Ensure that there is a sufficient range of placement choice, including permanency options, to meet the needs of looked after children in timely ways.
38. Strengthen the quality of education, employment and training support and provision for looked after children and care leavers to ensure that they achieve to their full potential.
39. Ensure that care leavers have good, targeted and timely pathway plans in place so that they can make a successful transition to adulthood.



## **Information about this inspection**

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of 10 of Her Majesty's Inspectors (HMI) from Ofsted.

### **The inspection team**

Lead inspector: Marie McGuinness Senior HMI

Team inspectors: Mary Candlin, Lynn Radley, Wendy Ghaffar, Paul D'Inverno, Fiona Millns, Tracey Metcalfe, Nancy Meehan, Christine Davies, Janet Frazer

## Information about this local authority area<sup>2</sup>

### Children living in this area

- Approximately 274,135 children and young people under the age of 18 years live in Birmingham. This is 25.5% of the total population in the area.
- Approximately 32% of the local authority's children aged under 16 years are living in poverty, compared with 20.6% across England.
- The proportion of children entitled to free school meals:
  - in primary schools is 34% (the national average is 19%)
  - in secondary schools is 33% (the national average is 17%).
- Children and young people from minority ethnic groups account for 60.6% of all children living in the area, compared with 29.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British (35%) and Pakistani (20%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 43% (the national average is 18%)
  - in secondary schools is 38% (the national average is 14%).

### Child protection in this area

- As at 27 March 2014, 8,188 children had been identified through assessment as being formally in need of a specialist children's service compared to 11,390 at 31 March 2013.
- As at 31 March 2014, 844 children and young people were the subject of a child protection plan compared with 1,149 at 31 March 2013.
- As at 3 April 2014, 28 children lived in a privately arranged fostering placement compared with 32 as at 31 March 2013.

### Children looked after in this area

- As at 31 March 2014, 1,826 children were being looked after by the local authority (a rate of 67 per 10,000 children) compared with 1,931 (70 per 10,000 children) at 31 March 2013.
- Of this number:
  - 740 (41%) live outside the local authority area

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<sup>2</sup> The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- 188 live in residential children’s homes, of whom 32% live out of the authority area
  - none live in residential special schools
  - 1,268 live with foster families, of whom 41% live out of the authority area
  - 102 live with parents, of whom 17% live out of the authority area
  - 13 children are unaccompanied asylum-seeking children.
- In the last 12 months:
- there have been 119 adoptions
  - 60 children became subjects of special guardianship orders
  - 748 children have ceased to be looked after, of whom 7% subsequently returned to be looked after
  - 90 children and young people have ceased to be looked after and moved on to independent living.

### **Other Ofsted inspections**

- The local authority operates 10 children’s homes: eight were judged to be good and two to be adequate in their most recent Ofsted inspections.
- The previous inspection of Birmingham’s arrangements for the protection of children was in September 2012. The local authority was judged to be inadequate.
- The inspection of safeguarding and looked after children in 2010 judged Birmingham’s safeguarding services as inadequate for overall effectiveness and capacity for improvement. For looked after children, it judged overall effectiveness and capacity for improvement to be adequate.

### **Other information about this area**

- The Director of Children’s Services has been in post since July 2013, initially in an interim capacity and, since December 2013, as the Director for People, which includes children’s services.
- The chair of the LSCB has been in post since October 2011.

## **Inspection judgements about the local authority**

### **The experiences and progress of children who need help and protection are inadequate.**

40. Children and young people in Birmingham who need help and protection still do not receive the help and support they need to be effectively safeguarded and protected. Systems and processes are neither child-centred nor fit for purpose and do not support social workers in keeping a clear focus on children in most parts of the service. Significant deficits, including poor management oversight, poor assessment of risk and lack of understanding and implementation of thresholds, lead to some children being left at continuing risk of significant harm.
41. Children and families do not always receive the help they need early enough to prevent problems from escalating. Early help services are not well targeted or consistently available across the city. The prevention and early intervention strategy is in draft, and there has been delay in its implementation.
42. The establishment of the locality based hubs – with family support teams, 'team around the family panels' (TAFs) and safeguarding teams, many of which are co-located within children's centres - is leading to more timely access to coordinated services for some families. A range of tools are used, including the graded care profile, to enable more effective identification and assessment of children suffering from neglect. In addition, champions within family support teams specifically focus on working with adults who suffer from substance misuse, domestic abuse and mental health issues. This is driving improvements in practice and leading to effective interventions with some families, which means they do not require statutory support from children's services. However, as the early help offer is not fully available across the city, some children do not benefit in the same way from the TAF processes and they are not helped by the local authority's lack of knowledge about the extent and type of need that exists across the city.
43. In those areas where early help services are not fully established, numbers of early help assessments remain relatively low and the low numbers completed by partner agencies remain an area of concern. For example, due to a historical lack of confidence in the quality and consistency of response from children's services, schools do not routinely engage in the TAF process. Instead, a large majority of schools have chosen to commission their own support services and a consequence of this is that some schools are not engaged in partnership with the local authority and other key strategic agencies. These challenges emphasise the importance and significance of the work that must be undertaken with partners before there can be any prospect of a successful launch of the recently drafted early help strategy.
44. Older children who need help and support are provided with some effective interventions. Think Family (Troubled Families) works well to provide

pathways for referral, and for a small number of young people, particularly those on the edge of care, means they remain with their families. There are currently 3,700 families within Birmingham who have been identified as meeting the criteria for Troubled Families and Think Family is providing interventions for 2,600 of them.

45. When children and young people need statutory social work intervention, they do not experience good help and support from the Information and Advice Support Service (IASS). There is a lack of clarity and understanding about the threshold for referral to children's social care. The absence of qualified social workers in the IASS team means that children do not benefit from a timely response from children's services. Social work advice is not readily available to partners to help them make decisions as to whether to refer children to social care, nor to determine the right level and support for children. The quality of referrals by partner agencies to children's social care is not good enough and the significant number of inappropriate referrals to the service results in referral and advice officers having to undertake extensive work to establish the level and nature of concerns about children. This means that the IASS is unable to respond in a timely way to the persistently high level of demand.
46. On the first day of the inspection there were 137 contacts and referrals awaiting allocation to a referral and advice officer, including some that dated back to the end of February. Lack of robust management oversight means that managers do not always know which contacts have been screened and, as a consequence, there is no effective system to monitor and track this work. In addition, 1,287 police notifications of domestic abuse were awaiting joint screening by police, social care and health. However, where domestic abuse cases were judged to be so serious that a child was at risk of immediate harm, there was evidence that intervention followed without delay.
47. When children's cases need to be progressed from the IASS to safeguarding teams, arrangements to do this are not always timely or effective. Some contacts were closed when further action was required, and others were not acted on by the safeguarding teams, because safeguarding team managers overturned original IASS decisions. There is a lack of trust and confidence between managers about thresholds and the decision making process and this means that some children do not receive a service.
48. Children who are identified as being at risk of immediate harm are subject to a strategy discussion, normally involving the police and social care, to determine the course of action to be followed. These discussions are recorded, but neither the discussion nor the record benefits from information that other partners could contribute to the risk assessment process. Children experience initial child protection visits to be appropriate and timely, and visits are carried out by suitably qualified social workers.
49. The local authority recognises that the threshold for initiating child protection enquiries has been too high. They acknowledge that this has been due to a

lack of staffing capacity. Between February and November 2013, the number of child protection conferences undertaken had reduced by half compared with the previous nine months. This has meant that a significant number of children and young people have not been subject to an investigation to assess the level of risk to them nor been the subject of a child protection case conference. New measures have now been introduced to tackle this issue, and there is some early evidence that this is beginning to have an impact, with an increase in the number of child protection enquiries. Enquiries that do progress to an initial child protection conference are managed appropriately.

50. The quality of information sharing between partners and parents at child protection conferences has recently improved due to the introduction of the 'strengthening families' model. This is a national initiative to enhance the ability of families to resolve their own issues. However, this improvement is limited and problems still persist due to lack of attendance of some partners and their failure to submit written reports to conferences or to the children's parents. Consequently, parents are not always properly equipped to play a full role in the process and the decision making of child protection conferences and partners does not contribute important intelligence and information to ensure that risks are fully identified and discussed.
51. Social workers' child protection reports are not always supported by a comprehensive assessment; do not have chronologies; and lack sufficient analysis. This results in the full extent of risks to children not being understood. Only a small proportion of children attend and participate in their child protection conferences and there is a lack of access to an advocacy service. Overall, children's and young people's views are not sufficiently taken into account in child protection conferences.
52. Child protection plans are not always focused on the outcomes that need to be achieved to keep children safe. They are frequently too long, tasks are not allocated and responsibilities are not clearly defined. The format of the plan does not support social workers to do their work effectively. As a consequence, visits to children, although frequent, often lack a clear purpose or a focus on the actions identified in the child protection plan.
53. The quality of management oversight of social workers' practice is generally poor and, with some exceptions, there is a lack of focus on outcomes for children and young people. Frontline managers do not always ensure that agreed actions have been followed through in a timely way. Supervision arrangements are also poor, which means that workers are not sufficiently challenged to improve their practice. In addition, a lack of effective challenge and monitoring by child protection chairs means that a further opportunity of quality assurance is lost in promoting good practice and improvements. In cases where child protection chairs have identified and formally reported concerns about social work practice, team managers have not routinely responded with appropriate action to address the issues raised, and chairs too often fail to follow up their concerns with managers.

54. When children no longer require a child protection plan, they become subject to a child in need plan. Although there are exceptions, most of these plans are not well developed and do not set measurable progress targets nor specify contingencies should progress not be achieved. Decisions to remove children from child protection plans have not always been well considered, and professionals are too optimistic in some cases about parents' ability to maintain positive changes and therefore to be able to protect their children.
55. Most child protection core groups are held regularly, but, overall, there is a general lack of purpose and focus to meetings and core group members do not always recognise that plans are drifting or that risk is increasing for children. Consequently, children have been left for too long in situations where they have been at risk of significant harm without purposeful and timely intervention.
56. Children in need who are identified as requiring a single assessment, rather than a child protection enquiry, do not experience services being delivered promptly or effectively. In excess of 400 children in need cases, some of which were referred more than two months previously, are still awaiting a single assessment without having been risk-assessed or the children seen. Some of these cases, sampled by inspectors, identified children who were at risk of harm, and who had not received an appropriate response or intervention to ensure their safety.
57. Between October 2013 and January 2014, the local authority undertook a cleansing activity in respect of all children in need cases which resulted in a significant number of cases being closed. This activity was undertaken without the benefit of a robust risk assessment on each individual case. Inspectors found examples of decisions to close children in need cases that were based on social work capacity within teams and not children's needs. Therefore, the local authority cannot be assured that the closure of all children in need cases as part of the cleansing activity was appropriate. The local authority has provided an assurance that these cases will be reviewed.
58. Overall, the quality of single assessments is poor. Assessments are not child-focused and chronologies are not routinely used, which means that assessments do not identify historical concerns about parents and the impact of these on children's lives. As a result, they can too often contain an over-optimistic view of parents' ability to change and not enough focus on the impact of parents' behaviour on the lives of children. Children's individual needs, including culture, identity and their wishes and feelings, are not given sufficient consideration nor recorded consistently. This all contributes to a failure to identify correctly what type of support children need to improve their lives.
59. Children who are placed in private fostering arrangements do not always experience timely assessments to ensure that their safety and wellbeing are assured. The local authority acknowledges that the number of private

fostering arrangements is too low compared with the national picture and states that it is trying to tackle this under-reporting through a variety of awareness-raising activities. However, to date, progress has been limited.

60. When allegations are made against adults working with children, the response through the local authority designated officer (LADO) service is inadequate. Procedures for tracking and monitoring outcomes in approximately 70% of these cases are not robust. This means that the local authority cannot be assured that children are adequately safeguarded when an allegation against an adult in a position of responsibility has been made.
61. A lack of a strategic, coordinated response to collate and analyse information about children missing from education, home and care means that the local authority and partners are not aware of the risks to or whereabouts of all of these children. This means that responses to identify and reduce risk and harm are not well coordinated or focused. Data on children missing from home has recently begun to be collated, and return interviews are now undertaken by the Children's Society (a voluntary agency) contracted to act on the local authority's behalf.
62. A significant number of children (144) are currently missing from education and are believed by the local authority to have moved abroad, although this has not been confirmed by the UK Border Agency. There is a system to undertake checks with other agencies to identify the whereabouts of children who are missing from education, but this consists of a simple 'checking' process that is not sufficiently rigorous. At the present time, there is no robust system in place to ensure that the potential safeguarding concerns that exist in each of these children's cases are being properly addressed.
63. Systems to support agencies in identifying children and young people at risk of sexual exploitation are in place. However, there is no evidence to demonstrate that the multi-agency response is appropriately robust and that children and young people are suitably protected as a result. In some cases seen where young people have been at risk of sexual exploitation, effective action has not taken place to ensure that these children are adequately protected. In November 2013, a West Midlands Strategic Leader – Preventing Violence against Vulnerable People - was appointed on a two year secondment and is based in Birmingham City Council. The position involves developing joint work to tackle child sexual exploitation by seven local authorities, West Midlands Police, the criminal justice system and the voluntary sector.

### **The experiences and progress of children looked after and achieving permanence is inadequate**

64. Children and young people have been left at risk of harm for too long before being protected by the care system and when it is recognised that they need to be looked after, they do not benefit from timely decision making. Poor case



management has resulted in drift and delay for some children and young people and until recently there has been limited use of the Public Law Outline (PLO) process. The absence of a strategic plan for looked after children has resulted in a lack of corporate awareness of the particular needs of this vulnerable group.

65. Children and young people who enter the care system do not generally experience good quality needs assessment and case planning. In the large majority of cases, assessments are out of date, are not updated following reviews and do not inform current care plans. Care plans lack detail and do not focus sufficiently on the needs and long-term welfare of children and young people. In a small number of cases, better standards of practice were seen, with good case work, and improved assessment and care planning that resulted in positive outcomes for children and young people. This was due to timely work and the diligence of individual staff demonstrating an appropriate focus on the needs of children.
66. Children and young people are beginning to benefit from an improvement in the timeliness of court proceedings that lead to decisions being made about their future. In all cases initiated since October 2013, government targets of 26 weeks for the conclusion of proceedings are being met and the quality of assessments is improving. This has been in part due to the influence of the principal social worker and the head of legal services working effectively together to specify expectations of performance, and to monitor more closely case progress of the dedicated court teams. However, the local authority is still dealing with a substantial backlog of cases, so the average length of time for proceedings in 2013–14 is still 46 weeks.
67. Not all children and young people in Birmingham who need to be looked after benefit from early, fully informed and detailed consideration of the right permanence option for them. As a result, some children experience delay in achieving permanence. In some cases, good use has been made of Special Guardianship Orders (SGOs) to avoid children needing to be looked after in public care. However, where a child is placed with a foster carer who wishes to secure permanence for them through an SGO, the current policy leads to them being financially disadvantaged. In some cases, carers have attempted to circumvent this by making private law applications for residence orders and seeking judicial directions, for example to provide funding or provision of equipment. This is unacceptable practice and impacts adversely on children and young people and their carers. The local authority has acknowledged this and has plans to urgently review policies to address the matter.
68. The local authority does not meet statutory requirements when it is considering whether to place children and young people with family members, friends and others who are 'connected' to them. Children are often placed with connected persons carers before assessments and relevant checks are completed and before cases are presented for approval at panel. This means

that risks are not fully assessed and results in some children having to make unplanned and avoidable moves to alternative placements.

69. Most children and young people who become looked after in Birmingham live in foster care placements. Of the 1,822 children and young people looked after at the end of February 2014, 1,265 were placed in foster families. However, there is an insufficient range of suitable in-house foster placements to meet the current needs of children and young people. Children and young people have regular, planned and appropriate contact with their families, although arrangements are not always recorded fully in care plans; this means that there is no clear record of observed risks to inform ongoing assessment. Families are supported well by social workers to stay in touch with their children. However, a high proportion of children and young people in Birmingham have experienced too many changes in social workers, which has resulted in a lack of continuity of practice and delay in progressing their future plans. Statutory visiting is timely, and children and young people are seen alone by their social workers and consulted about their wishes and feelings. However, visits are not consistently purposeful and do not link to the progression of the care plan.
70. Foster carers engage well with their supporting social workers. Recent improvements to the annual review process, with a good focus on the work that carers have carried out with children and young people, have been well received. Good support is also available from the well-established Birmingham Foster Care Association (BFCA), which offers buddies, a telephone helpline and a resource centre. However, a lack of investment in training has meant that foster carers are often unable to access places on courses they need to attend. The local authority has recognised this shortfall and new funding for training for carers has been identified for next year.
71. When there is a plan for children to return to live in their families, this is not well supported by careful, considered planning to ensure that they are protected and risks are minimised. However, in some areas of the city, inspectors did see a small number of good assessments of risks, including the use of written agreements.
72. The quality of management oversight of social workers' practice is inconsistent and fails to focus on outcomes for children and young people. Supervision of staff does not sufficiently explore or challenge assessments, planning decisions, the quality of practice, the timeliness of work or the impact on children and young people. This is exacerbated by the poor work of independent reviewing officers (IROs), who do not fulfil their statutory duties adequately, including visiting and consulting children and young people outside the statutory review process. Despite efforts to improve the IRO service over the last 12 months, which includes reducing caseloads from 140 to 85, poor practice within social work teams is still not consistently brought to the attention of managers and concerns are not routinely followed up. This often results in further unacceptable delay for children and young people.

73. The local authority now has 10 residential homes, having recently voluntarily closed two establishments that had been judged to be providing an inadequate level of service to children and young people. The young people who were displaced as a result of these closures experienced a poor service, typified by a lack of sensitive planning and the identification and the availability of appropriate placements. Significantly, in eight cases, emergency placement decisions were based on resource considerations rather than on the needs of the young person. This resulted in young people being placed prematurely in semi-independent hostels and residential provision without being appropriately prepared. Outcomes for these young people are poor, which results in an escalation in missing episodes, placing some at risk of both child sexual exploitation and increasing offending behaviour.
74. The quality of the remaining children's homes is currently judged to be at least adequate or better following their most recent Ofsted inspections. The care experienced by children with disabilities in five of the homes is good. However, Ofsted has issued compliance notices on a small number of homes that provide care for young people with emotional and behavioural problems, and this has resulted in those homes improving their standards and providing a satisfactory level of care.
75. For children and young people who are placed out of area, their experiences of the support they receive are generally poor. However, those children with complex needs whose cases were tracked received a good service within commissioned specialist provision. This was characterised by timely and responsive education and health services based on effective placement planning between the local authority and the provider.
76. Looked after children and young people experience good support for their health needs. Health reviews are timely and comprehensive and health needs are well considered in statutory reviews, with appropriate action plans developed. Children and young people have had the opportunity to provide feedback on the quality of their reviews, which has informed positive changes to the way in which services are provided. An audit of 100 case files by the designated looked after children nurse in 2013 showed significant positive improvement in wellbeing for a large minority of looked after children in care.
77. Looked after children and young people, including those living out of area, are encouraged to complete a strengths and difficulties questionnaire about their wellbeing; this also informs their health plans. However, the experience of children and young people with emotional and behavioural difficulties was more variable, with some being unaware of the content of their plans and not having appropriate education and health services to support them. Where emotional support needs are identified for children living out of area, the local authority's Therapeutic Emotional Support Service (TESS) ensures that appropriate referrals for Child and Adolescent Mental Health Services (CAMHS) are made. However, despite a clear procedure established for services delivered by local providers to be re-charged to the Birmingham Clinical

Commissioning Groups (CCGs), some children living out of area experience unacceptable delays in accessing specialist CAMHS.

78. Young people receive good support from a wide range of health and voluntary sector services when they experience problems in their lives relating to drug misuse. Good examples included drug workers providing targeted programmes to engage with young people in residential settings. In cases seen during the inspection, young people about to leave care benefited from appropriate counselling from Barnardo's 'SPACE' project for complex issues around drug and alcohol misuse.
79. Looked after children do not achieve well in education and the attainment gap between them and other children in Birmingham is widening in terms of the qualifications they achieve. On entry to primary school they are not well prepared for education, with their achievement and progress being lower than that of children in care nationally at the end of Key Stage 1. Support from the virtual school team, such as the Letterbox Club literacy scheme, has helped to improve some children's writing, and those children now do better than others nationally at the end of Key Stage 2 in English and mathematics. Progress from Key Stage 2 to Key Stage 4 has deteriorated over the last three years and is now slower than in both statistical neighbour authorities and for looked after children nationally.
80. The proportion of looked after children achieving one qualification or five GCSEs graded A to G in 2013 was higher than for looked after children nationally. A very small minority (13% – 17 young people out of 135) achieved five or more good GCSEs (A\* to C including English and mathematics) in the last year, which is a significantly smaller proportion than for looked after children nationally and for others in their age group in Birmingham. The attainment gap is growing (47.3 percentage points) and is significantly greater than statistical neighbour authorities (28.4) and four points greater than the England average (43.3). When they are ready to leave school, young people's achievement is low compared with looked after young people nationally.
81. The Virtual School team, Looked After Children Educational Support (LACES), works in partnership with schools to make sure that every child in care has a school place. However, there is a lack of concerted corporate ambition and a quarter of looked after children (478) are not in good or better schools. The quality of personal education plans (PEPs) is poor, typified by a lack of challenging targets or details of any additional support that should be identified to improve children's progress through the use of pupil premium funds.
82. When looked after young people require alternative educational provision, this is of good quality. The City of Birmingham School (the pupil referral unit for Birmingham) supports looked after children by providing a unified service of strategic advice, behaviour support to pupils and settings and a pupil referral

service in 11 units dispersed around the city. Home tuition and bespoke programmes also ensure that looked after children have their full entitlement of 25 hours of education when they are not in school. The rate of fixed term exclusions for looked after children generally is higher, at 13%, than the national average of 11.8%. However, this is partly explained by the local authority's determination to avoid permanently excluding looked after children and numbers of permanent exclusions are very low.

83. Looked after children and young people are provided with appropriate advocacy services through the rights and participation service, who attend reviews and meetings. Independent visitors are commissioned through the National Youth Advocacy Service (NYAS). The advocacy service also supports children and young people through the complaints process. Timeliness in responses to complaints made by looked after children and young people has historically been poor and inconsistent. Recent improvements are being seen through the introduction of monthly performance meetings, with clear management oversight, but this practice is not embedded. The website for looked after children is under-developed, which means that there is no easily accessible way to share information and ensure that all looked after children understand their rights.
84. The Children in Care Council (CiCC) has recently recruited some enthusiastic new members, who are in the process of receiving induction into their role. Until recently, there has been limited impact due to the ineffectiveness of the corporate parenting board, but notwithstanding this, the care leaver's grant has recently been increased to the government guideline of £2,000 and young people are now involved in the recruitment and training of newly qualified social workers. CiCC members are keen to see further developments, especially in how social workers and IROs work and support them. For example, young people said that some social workers do not always listen to what children and young people say. Furthermore, in their statutory reviews, children feel that they are being talked about and not consulted or involved, and that their opinions are not considered as important. Members of the CiCC told inspectors that some professionals in schools and social care do not pay due attention to the feelings of children about being looked after. This means that in school they can feel discriminated against and embarrassed when their care status is revealed publicly to their peers. Where young people have disclosed bullying to carers, in most cases school staff have acted appropriately.

### **The graded judgement for adoption performance is inadequate**

85. When a decision has been made that children and young people cannot return home, adoption is not always considered as a viable permanent alternative. This reflects a lack of ambition on behalf of children who need a new family.
86. Children and young people experience delay at all stages of the adoption process. In too many cases where adoption plans are made, the plans are

changed as a result of unsuccessful family finding. This, in turn, results in further delay for some children and young people. Although these delays are recognised by IROs, they are not followed up by the implementation of decisive recommendations for action.

87. The adoption service is not always aware of children who need adoptive parents early enough to support prompt and robust family finding activity. There is confusion among practitioners as to when a referral should be made to the family finding team. As a result, the system has been reviewed and teams have undergone a recent restructure to improve the focus on active and creative family finding. A recent recruitment campaign using TV advertising has been undertaken and there are plans to develop the use of DVDs and to improve tracking systems to support early, targeted family finding. These changes are still very recent and it is too early to evidence any impact. Although there is no 'fostering to adopt' scheme in place, some children benefit from being adopted by their foster carers. Plans to formalise the scheme are currently being developed.
88. Until very recently, the quality of child permanence reports (CPRs) has been mostly poor, typified by incomplete and sometimes incorrect information. Full and accurate records of the reasons why children need to be adopted are frequently missing, and these deficiencies are not identified through normal line management processes. In some cases, this leads to delays in decision making. Training on completion of these reports has now been provided, but so far there is only limited impact on improvements.
89. The Department for Education adoption scorecard for 2010-13 shows that it took 877 days more time for children in Birmingham to be placed with their adoptive parents than the national performance of 650 days. This figure has now reduced to 708 days. This progress has been achieved due to the knowledge and commitment of the adoption team managers and the early implementation of plans to address identified barriers to progress.
90. The number of children who are adopted is also increasing. Figures provided by the local authority show that 17% of children who left care during 2013-14 were adopted. The most recent figure (56% for March 2014) demonstrates significantly improved performance for children being placed for adoption within 21 months of coming into the local authority's care. Although this figure exceeds statistical neighbour authorities, it remains slightly below the national average. Until recently, 21 children remained subject to freeing orders. Plans made in conjunction with the courts and Cafcass are in place to address this, and have resulted in the orders being rescinded for three children, while work remains ongoing to ensure that progress is made in the remaining cases. While acknowledging that this action should have been taken earlier, the local authority and partners (courts and Cafcass) have plans to complete this task shortly.

91. There are insufficient approved local adopters to meet the needs of children waiting for adoption; currently, 145 children with plans for adoption are waiting to be matched with adoptive families. In 2013-14, 62 adoptive families have been approved, which is fewer than the 67 approved in the previous year. A further 30 prospective adopters have completed the assessment process but have not yet been to panel for approval, which continues to create delay for children and young people who need to be adopted. Some adopters have experienced delay in their assessment due to a lack of social worker capacity to provide sufficient training courses last year. However, prospective adopters who have received training speak highly of the courses that are provided, commenting that they were thought-provoking, gave them increased understanding of the range of reasons children need adoptive parents and were helpful in preparing them to adopt.
92. Adoption panel minutes are of a good quality, with detailed recording of discussions that take place. They accurately reflect where challenges have been made by panel members, for example in relation to the quality of CPRs or a failure to properly assess whether a father could care for his child. However, the panel has not produced an annual report this year, which is a statutory requirement, and panel members do not meet with the adoption decision maker to share their concerns. This is a missed opportunity to provide the local authority with valuable feedback on the quality of the work seen by the panel.
93. Consideration is given to meeting children's needs arising from their ethnicity, culture, religion or disability. Inspectors saw a good example of a young child with a life-limiting condition being matched with an adoptive parent and other examples of children being matched with adoptive parents who can meet their complex needs. When children are preparing to move from foster placements to their adoptive families, foster carers are thoughtful in preparing children and supporting introductions. Examples were seen by inspectors of foster carers using stories and photographs to prepare children for their move. However, in too many cases, formal life story work is not completed in a timely way in line with requirements.
94. A range of good adoption support services are available to adopters, both before and after the adoption order is made. Adoptive parents have access to a helpline that provides advice and signposts them to services. Inspectors saw good examples of bespoke packages of post-adoption support for individual children, including those placed outside Birmingham. Birth parents are supported by a service commissioned by the authority.

**The graded judgement for the experiences and progress of care leavers is inadequate**

95. Young people report their experience of preparation to leave care as being 'too rushed' and the inspection evidence supports this view. Pathway planning is generally poor and does not start early enough, and too many young people

leave care without a viable plan in place. This view was also expressed in a recent authority-led survey of the views of children in care and care leavers. Although some steps are said to have been taken in response, the impact on the quality of pathway planning is yet to be seen.

96. The 'staying put' policy, under which care leavers can remain with their foster families beyond the age of 18 years, is not fully developed. This can affect the stability of their placement and can mean that some young people move into independence before they are ready to do so.
97. Leaving care advisors build positive personal relationships with young people, but the absence of purposeful assessment and pathway plans means that their work too often lacks focus. Plans fail to underpin the actions that need to be taken to support young people in making the transition towards independence.
98. Young care leavers who do well at school and are ambitious are supported very well to access and pursue further and higher education and training for employment. The Looked After Children's Education Service (LACES) tracks young people with the potential to achieve GCSE, A level or level 3 vocational qualifications, and supports aspirations with college taster days. However, those less ambitious young people are not supported well enough to stay in school or college or to take up employment. The proportion of 19-year-old care leavers who are not in education, employment or training (NEET) is significantly worse – at 46% at the end of 2013 – than for care leavers of this age nationally (34%). Vulnerable groups, such as care leavers who become parents, are not offered the support that they need to remain engaged with education, employment or training and often drop out without robust follow up.
99. There are some small, successful work placement schemes in place such as the partnership with Marriott Hotels, which gave eight care leavers the chance to work in Germany for two weeks. Additionally, nine care leavers have been well matched to apprenticeships in the area. However, too few young people engage and benefit to make any difference to the proportion who are not in education, employment or training. Apprenticeships and work placements in the local authority and with partners are all under-developed at present, and plans to improve the universal and specific offers are at a draft stage only. The current situation reflects the long-standing failure of corporate parenting.
100. A wide range of housing options are available to care leavers, so that most needs are met after initial assessment and support programmes have been completed. Most young people experience one or more interim moves before settling in safe and sustainable housing. The range of support in housing schemes for care leavers with low and medium need for support is good, and it is adequate for those with greater needs: 96% are in suitable accommodation.



101. The knowledge that care leavers have about their entitlement to services depends on the amount of contact they have with an advisor, and the knowledge of that practitioner. The care leaving team, which is newly formed, is building its expertise, but at this stage knowledge gaps remain that have not yet been filled by training. For example, they still have a lack of knowledge about the legal rights of unaccompanied asylum seekers. Care leavers are under-represented in the CiCC and a care leavers' forum is not yet in place.
102. Care leavers have access to a range of health-related support and advice services. The leaving care team is active in directing and encouraging care leavers to access services, such as the drug and alcohol misuse service, smoking cessation, sexual health advice and counselling. There is an effective and timely Care Leaver Mental Health Service. This comprises two members of staff who provide screening of all care leavers and the offer of outreach services. They are able to respond immediately to young people in need, and either refer them to an appropriate service or provide a brief intervention themselves. The dedicated looked after children health service has recently appointed a care leavers' nurse, who ensures that young people have access to their full health history in preparation for their transition to independence.

## **Leadership, management and governance are inadequate**

103. The local authority has failed to adequately drive improvements to safeguard and care for children and young people in Birmingham; practice remains poor and children are not protected or cared for effectively. Serious and widespread failures have not been tackled quickly enough to make the service safe. The child protection inspection in September 2012 found the service to be inadequate, and the significant concerns identified then remain across the whole of the service, including services for children who are looked after. Too much drift and delay in dealing with child protection concerns means that children are not promptly identified when they need to be cared for by the local authority.
104. In 2010, the looked after children service was judged to be adequate, but services have deteriorated and the service is now inadequate. The local authority does not discharge its corporate parenting responsibilities effectively. The corporate parenting board is weak and, until very recently, there has been no strategy in place. This has meant that the needs of looked after children have not been sufficiently focused on. Following the last inspection in 2012, the local authority experienced significant organisational turmoil, and services further deteriorated in quality. Senior management arrangements changed, with new appointments of an Interim Director of Children's Services in July 2013, and a Chief Executive in December 2013, who took up post in March 2014.
105. In July 2013, the Department for Education reported the service to be in a 'fragile and unsafe state'. The Parliamentary Under Secretary of State for Children and Families, Edward Timpson, wrote to the Leader of the Council with four key instructions:
- to stabilise the workforce
  - to improve frontline practice
  - to establish an operational structure that staff understand
  - to put in place a vision and plan for sustained improvements.
106. Since this time, the Director of Children's Services has been focused on the key issues highlighted. In December 2013, the Interim Director for Children's Services was appointed as the Director for People, which includes responsibility for adults' and children's services. A 'test of assurance' to evaluate the possible impact of combining these functions has not yet taken place.
107. There is evidence of some increased corporate and political ownership of the risks in children's services. The provision of an additional £9.6 million into the service, when there has been significant cutbacks in all other services in the local authority, has supported the intention to improve the workforce and provide some much needed stability. Middle management arrangements have

been strengthened, with the re-introduction of Heads of Service. During the inspection, staff reported increased morale, reduced caseloads and smaller teams. There are also some improvements to the adoption service, with waiting times for adoption reducing significantly and, in some parts of the city, improved early help arrangements.

108. Notwithstanding the improvements noted above, much remains to be done before services for children and young people are made safe. Senior managers can clearly articulate what is required to tackle the failings across the service, but there is limited evidence that this has yet translated into coherent action or plans with a demonstrable impact on improving services. The draft Children's Social Care Improvement Plan is very new and not yet fully informed by clear actions, milestones and responsibilities.
109. A range of plans and strategies are in draft, and there has been significant delay in the implementation of a number of these. For example, the early help strategy was identified as a priority for change in the previous child protection inspection undertaken in 2012. The inspection report highlighted the need to implement an overarching strategy that secures partnerships between agencies to allow vulnerable children to receive help earlier. To date, this strategy remains in draft and partners have not yet reached a shared definition of early help. Progress has also been affected by partnerships failing to establish the extent of unidentified need in the city.
110. The local authority's efforts to improve the Information and Advice Support Service (IASS) have been ineffective, and the service remains not fit for purpose. The proposal to replace the IASS with a multi-agency safeguarding hub (MASH), without addressing some of the fundamental challenges that affect almost all aspects of the contact and referral system, means that it is unlikely that any replacement would have significant prospects for success. Partners fail to take responsibility for their actions in respect of child protection and this is reflected in the poor quality of referrals and the lack of consistent and sustained contributions to joint working. These difficulties undermine any attempt to improve the quality of services to children and young people.
111. A range of commissioned services is available to support families and vulnerable children, and some individual services are effective, such as the St Basil's project, which works successfully with children and young people who are considered to be on the edge of care. This service helps to keep some children and families together, avoiding the need for children and young people to be accommodated by the local authority. However, the overall impact of commissioned services is diminished by the absence of an integrated strategic approach to commissioning, which would allow children and young people's needs to be more easily met and resources to be used more efficiently. Commissioning capacity has been increased since the current Director has taken up post, and the new draft joint strategic commissioning strategy has been developed to improve performance in this area. However,

the local authority is fully aware that the absence of reliable child level data is a major risk to the effectiveness of this strategy.

112. In summer 2013, the Children's Strategic Partnership was disbanded and the lack of a replacement hinders the work of partners to work together to ensure that safeguarding of children is effective. The Birmingham University INLOGOV report completed in 2013, which was focused on partnership work, highlighted failings in the quality of work, particularly between Children's Services, the Police and Education.<sup>3</sup> Partners contributed to this review and continue to engage in 'think tank' sessions to take work forward. However, partnership issues continue to pose significant risks to multi-agency working. For example, the absence of a Birmingham Safeguarding Children Board (BSCB) education sub-committee to coordinate the work of the school sector on safeguarding issues affects the BSCB's ability to improve the quality of joint work between schools and children's services. The Birmingham Education Partnership has been set up by the Local Authority and schools to establish collective leadership of schools and learning in Birmingham. In addition, it will deal with historical and long-standing problems of confidence in the quality of the social care response to reported concerns about children, and there is some early evidence of a new desire to strengthen fractured relationships.
113. Since July 2013, governance arrangements between the Leader of the Council, the Lead Member, the Chief Executive and the Director of People have been re-confirmed and are understood by each party. Their focus during this time has been dominated by a local government review, a partnership review and the government-commissioned Le Grand review.<sup>4</sup> A draft improvement plan has now been produced in response to the Le Grand review, but it is too early to see evidence of impact. The Director of People continues to meet weekly with the Lead Member, who now has a clear grasp of the issues and risks in children's services. Cross-party scrutiny arrangements are also in place, although the chair of scrutiny acknowledges that they are not as effective as they should be. They have, however, raised concerns about the poor quality of performance information they receive that has prevented them from carrying out their responsibilities. Governance arrangements between the Safeguarding and Adoption Improvement Board, the BSCB and the Health and Wellbeing Board are not yet fully established, which inhibits arrangements and accountability for the work of these boards.
114. Operational performance management, quality assurance and supervision arrangements are weak. The lack of an effective performance management

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<sup>3</sup> The Institute of Local Government Studies at the University of Birmingham (INLOGOV) was asked by Birmingham City Council (BCC) to undertake an independent peer review of the ways in which the Council and its partners work together to protect and to improve the lives of children in Birmingham.

<sup>4</sup> Report to the Secretary of State for Education and the Minister for Children and Families on ways forward for Children's Social Care Services in Birmingham by Professor Julian Le Grand.

system, including poor performance information, is evident throughout most of the service and does not support the drive for improvements to be made. Management oversight of social care practice is poor, with too many children and young people continuing to be left at risk of harm. This is further hampered by the poor quality of data, including, for example, a lack of robust information on assessments and supervision arrangements. While a significant number of audits of practice are undertaken by managers, there is limited evidence to suggest that the impact of learning from these audits drives improvements. These difficulties have also been identified by two of the external reviews, and the need to address them has been seen as fundamental to securing quality practice. This has not yet been achieved.

115. There is a lack of understanding and effective communication between frontline management and senior managers. While senior managers can clearly articulate what they are seeking to achieve, it is evident that they are not fully conversant with the detail of the pressures facing operational staff. For example, senior managers were unaware that the unallocated cases, currently in excess of 400, had not been risk-assessed appropriately, as they had been assured by frontline managers that they had been. In addition, during the inspection, it was agreed that children in need cases had been 'removed' from the system and closed without a robust risk assessment, resulting in some children not receiving services that they need.
116. The Workforce Strategy is comprehensive and detailed. There is a clear plan to reduce reliance on agency social workers and a recruitment and retention group has been established to oversee this process. There is evidence that there has been considerable effort to respond to the Minister's letter of September 2013 - to stabilise the workforce and reduce caseloads - with some notable progress seen, particularly in the appointment of newly qualified social workers and experienced team managers. However, a number of frontline positions remain vacant and long-term sickness absence and vacancy rates, while improving, remain high and continue to pose a significant risk to securing and retaining permanent experienced staff. This is an ongoing challenge in spite of the efforts made, and poses a threat to achieving and sustaining progress.
117. The Birmingham Improvement Team (BIT), led by the Principal Social Worker, is having an impact on improving practice in some areas. There has been demonstrable improvement in the average timescale for court proceedings, from 79 weeks to 41 weeks; since October 2013, court proceedings now take an average of 21 weeks, which has been noted by Cafcass. In the past 10 months, the team has made a good contribution to driving some improvements through training and, in particular, through challenging poor practice within safeguarding teams and supporting workers at all levels to improve frontline practice. However, evidence of this remains limited and children in need services have not yet benefited from the influence and support of the Principal Social Worker and the progression team, which is a missed opportunity.

118. The local authority has committed £2 million to improvement work and has a clear social worker pathway to support continuous professional development. A notable achievement is the contribution to the training and development of team managers and social workers within the newly established court teams across the city through targeted practice improvement reflection groups. All newly appointed team managers have benefited from induction training and 1,000 staff have received training on the Public Law Outline (PLO) to drive up standards. A range of new initiatives is being developed to drive improvement in practice, such as the recent investment in the training for the introduction of the *Safeguarding assessment and analysis framework* and the 'In My Shoes' model of direct work with children.
119. Overall, inspectors found evidence that social workers are committed to the children of Birmingham and they report that they enjoy working for the local authority. Some team managers and social workers report that recent improvements in the management of the service have resulted in them deciding to continue to work for Birmingham City Council. In some cases, feedback from parents and children showed that social workers had made a real and positive difference to their lives. However, in some teams, caseloads remain high and staff report a backlog of work that causes delays in children being seen. The magnitude of the problems that continue to face the local authority can only mean that progress is fragile and that children will continue to remain highly vulnerable until services can be consistently improved to an acceptable standard.

## What the inspection judgements mean: the local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people, and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place. However, the authority is not yet delivering good protection, help and care for children, young people and families.

An **inadequate** local authority provides services where there are widespread or serious failures that result in or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

## **Section 2: The effectiveness of the Local Safeguarding Children Board**

### **The effectiveness of the LSCB is inadequate**

#### **Priority actions**

120. The BSCB to ensure that each partner agency urgently develops and can demonstrate stronger and more effective accountability within its organisation for their roles and responsibilities in safeguarding children and young people in Birmingham particularly at middle and frontline manager levels.
121. Strengthen governance arrangements between the BSCB and the Health and Wellbeing Board and ensure that these arrangements routinely include a record of impact and effectiveness.
122. Ensure that partners urgently agree a definition of early help and drive the implementation of the Early Help Strategy, so that partners are fully engaged in the work to achieve and deliver this.
123. BSCB to ensure that single and multi-agency audits are undertaken, analysed and evaluated and that findings are used to help to improve standards of practice in all agencies.
124. The BSCB to work with partners urgently to develop and implement systems and processes to ensure that they fully comply with safeguarding audit requirements. Progress towards compliance, with a requirement to complete these audits, must be routinely tested and reported regularly to BSCB.
125. Develop and implement a comprehensive programme of multi-agency child protection training (levels 1, 2 and 3), with clear arrangements for evaluation of impact to inform future training needs.

#### **Areas for improvement**

126. The BSCB to improve the degree to which partners at the Board use their role to properly influence their own strategic and corporate governance, and to ensure the Board's work is integrated into their own strategic, operational and business as well as workforce development.
127. The BSCB to ensure that a range of mechanisms, platforms and processes are in place to support schools to own and fully engage with their statutory responsibilities for safeguarding children and young people.
128. The BSCB to provide robust challenge and scrutiny to ensure that the arrangements between schools and their partners, especially the local authority, are secure and progress on these arrangements should be reported routinely to the safeguarding board.



129. Work with partners to develop good quality collection and collation of data on missing children so that partners have a full understanding of the risks to these children and can identify what actions they need to take to minimise these risks. Scrutiny of challenge to this data and related performance must be included in the routine work of the BSCB.
130. Improve the attendance of partners at sub-groups and assure that sub-groups are resourced appropriately to undertake the tasks and actions that are required, and that they maximise learning from their work.
131. Ensure that learning from serious case reviews is used effectively to inform practice and that audits begin to demonstrate that learning is having an impact on improving practice across partner agencies.

### **Key strengths and weaknesses of the LSCB**

132. Effective partnership working is not yet developed and remains a significant challenge for the Board. Frontline practice has not demonstrated significant improvements in response to the Board's influence. Attendance by partners at child protection conferences remains unacceptably low, which results in some agencies failing to contribute to identifying risks and protecting children.
133. As yet, an overarching early help strategy has not been agreed or implemented, which was a recommendation of the Ofsted child protection inspection in 2012. BSCB cannot be assured that early help is targeting the right children early enough or that services are effective. Partners have not yet reached a shared definition of early help in Birmingham or accurately assessed the extent of unidentified need in the city. This results in a partnership that does not take full or collective responsibility for strategically designing and driving effective early help for children and their families.
134. Despite strategic engagement to develop the new threshold model of *Right Service Right Time*, shared understanding and ownership of the model amongst practitioners is poor. Some partners report being insufficiently prepared to use the model and that a multi-agency change management programme has not been put in place to support the implementation of this important initiative. Compliance by agency operational staff with new policies and procedures is poor. Much work remains to be done by BSCB to fully utilise training that will raise the standard of frontline practice and management to an acceptable level. There is limited evidence of partners holding each other to account at operational level, although general practitioner practices now have named safeguarding champions in place as a result of the BSCB's encouragement for them to become more involved in child protection work.
135. BSCB does not receive data on children missing from home, care or education and receives insufficient data on child sexual exploitation. This is a deficit of significant magnitude, not least because it shows that the local authority and partners do not collect, collate and analyse this information in a systematic

way. As result, partners cannot be assured of the whereabouts or safety of these young people. The child sexual exploitation strategy agreed by the Board in January 2014, has not yet been implemented and this delay means that agencies are not yet working together effectively to provide the appropriate level of safeguarding support to children and young people who are risk of/or are suffering sexual exploitation.

136. Formal arrangements are in place for the Chair of the LSCB to have regular, recorded meetings with the Chief Executive, Director of People, Lead Member and Chair of the Health and Wellbeing Board. The BSCB annual report is shared with the Health and Wellbeing Board and is also reported to the Children's Safeguarding and Adoption Monitoring Board. However, in practice, there is little evidence to demonstrate how these strategic bodies hold each other to account or if these arrangements are effective.
137. The BSCB annual report is detailed and comprehensive and highlights both strengths and weaknesses. Progress to secure strategic agreement around joint priorities, sharing risks and coordinating services is set out clearly. The BSCB strategic plan 2014-17 has three appropriate priorities:
  - voice of the child
  - early help
  - safe systems.
138. These and the associated actions, although devised independently, align with the city's most significant challenges in protecting children. However, the PREVENT agenda and the needs of looked after children are not sufficiently reflected in either the annual report or the business plan and this is an omission.
139. Much work has been done to engage schools, which are now represented on the Board. There is also now a Birmingham Education Partnership, which has a significant number of schools engaged. Despite this, many schools neither fully understand nor accept their own safeguarding responsibilities or understand the difference in statutory roles and responsibilities between the Board and the local authority. This results in some school staff lacking the knowledge and experience needed to provide effective safeguards to children and young people. The strategic plan for 2014-17, details the reinstatement of a schools safeguarding sub-group which is much needed as only 63% of approximately 437 settings responded to a Section 175 Education Act audit, which was commissioned to assess safeguarding standards in educational establishments. Low compliance was reported in five key areas, including training about diversity and training for governors in child protection and safeguarding.
140. An established BSCB sub structure exists, but some key groups are not sufficiently effective. The serious case review sub-group is poorly attended

and their practice is process-driven rather than focusing on maximising learning from each case. Some agencies have not adequately supported members to participate and it remains challenging to resource sub-groups with effective business support. A current review of sub-group governance aims to improve these arrangements.

141. Serious case reviews are initiated where necessary and in line with statutory guidance, the progress of reviews and the completion of subsequent recommendations are appropriately monitored and reported to the Board. Reviews are published and accessible events to disseminate learning are arranged. A formalised learning and improvement framework is not currently in place, so opportunities to identify improvements for practice are not comprehensive or sufficiently effective. The impact of learning from serious case reviews is not evident in frontline practice. Eight cases have been notified to Ofsted and the Department for Education this year. One review was published, three serious case reviews are ongoing and another is subject to early scoping. A recent court case has led to a review being re-commissioned in light of new evidence.
142. Multi-agency and single agency audits undertaken by BSCB are not effective and do not demonstrate impact in improving standards of practice. Furthermore, auditors were not sufficiently independent or robust and audit findings simply reinforced what was already known. The audit programme for the next year, which will use revised and more qualitative audit tools, is appropriately focused on 'the voice of the child'.
143. The present BSCB multi-agency data set is not of sufficient quality to enable robust scrutiny of multi-agency performance and to drive improvement. Performance information is vast in quantity but poor in quality and data reliability remains questionable. A functional and interactive performance scorecard system has been commissioned and will be implemented this year. A recent West Midlands wide Protocol setting out the principles and practice standards governing child protection processes has been developed, led by BSCB, and subject to any final changes after consultation will be agreed and implemented in the early Summer. This protocol is designed to improve attendance at child protection case conferences.
144. Training is available to all partners and take up is generally good from most agencies (94%). However, attendance rates for social workers and police officers are low and, in light of the authority's significant challenges with practice, this is inappropriate. In 2013, two major programmes accompanied the launch of the implementation of the 'Strengthening Families' model of child protection conferencing and Right Services Right Time threshold document. Multi-agency child protection training at levels 1 and 2 is delivered by individual agencies with their own agency content and curriculum and a consequence of this is that there are no common standards or multi-agency curriculum. This approach also means that the advantages of training staff on a multi-agency basis is lost.

## What the inspection judgements mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Its evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An **inadequate** LSCB does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and it fails to identify where improvements can be made.

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