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Mr Peter Hay
Strategic Director for People
Council House
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Dear Mr Hay

Monitoring visit of Birmingham

This letter summarises the findings of the monitoring visit of Birmingham children's services on 1 and 2 June 2016. The visit was carried out under section 136 of the Education and Inspections Act 2006.

The visit was the third visit since the local authority was judged inadequate in May 2014. Ofsted inspections in 2010, 2012 and 2014 consistently identified serious and widespread failings in the quality of services to children and families.

Areas covered by the visit

During the course of this visit, inspectors reviewed the progress made in the area of help and protection with a particular focus on the multi-agency safeguarding hub (MASH), the application of thresholds for statutory intervention and assessment and planning processes for children in need of help and protection.

The visit considered a range of evidence, including electronic case records, supervision files and notes, observation of social workers undertaking referral and assessment duties and other information provided by staff and managers. In addition, we spoke to a range of staff including managers, social workers, other practitioners and administrative staff. The visit included a focus on safeguarding arrangements in schools, the council's response to children missing from education and those who are educated at home as well as the council's response to Prevent in schools.

Summary of findings

- Despite their acknowledgement of historical failings, senior leaders of children's social care have not made changes quickly enough. The result of this is that services to help and protect vulnerable children remain very poor.
- Senior leaders have been too slow to take required action and have only very recently started to implement the critical changes required to effectively protect and support the most vulnerable children in Birmingham.
- The quality and standard of practice and services for children remains too variable and is not consistently of a good enough standard.
- Some progress within specific areas of children's social care is evident although improvements are not sufficiently widespread, robust or embedded. Recent social work practice seen in safeguarding teams is of better quality than found during the previous inspection.
- Thresholds between early help provision and statutory intervention remain unclear and are inconsistently applied at all levels across the partnership.
- The disabled children's team does not identify or manage risks effectively and children are not seen by social workers sufficiently regularly.
- Partner agencies continue to experience challenges in getting children's services to accept referrals when they have concerns about a child's welfare or safety.
- Arrangements to identify, manage and intervene where children and young people are at risk of child sexual exploitation are not consistently effective. Birmingham City Council is failing to ensure children are always kept safe and not enough is being done to protect children from potential harm.
- Too many children with a statement of educational need or an education, health and care plan are not receiving a formal education and some of the city's most vulnerable young people are not receiving the help and support they need.
- Significant numbers of children are missing from education. Delays in establishing the whereabouts of children mean that staff are not complying with the council's own procedures and risks of children falling beneath the council's radar may increase. Links with partner agencies such as health are poor. Staff are unclear about what they need to do and the timeframes within which they must complete their work. Additionally, management oversight is not robust and staff are not held to account for deficits in practice.
- Strategic leadership of safeguarding children in schools is weak and lacks sufficient rigour. The Executive Director for Education acknowledges this and is realistic about the magnitude of the problem. However, the procedures put in place to reduce risks to children have had limited impact. The lack of strategic support from Assistant Directors has resulted in expected progress not being realised. Currently, there is no Assistant Director with specific responsibility for safeguarding children in schools and this compounds the already significant challenges.

- Individual teams that hold responsibilities for safeguarding children in schools are not working together effectively. For example, each team holds lists of children missing from education, yet this information is not shared across teams or departments. This considerable weakness means that the council cannot be assured that children are safe or whether they are at further risk.
- The local authority's evaluation of the quality of practice remains over optimistic.

Evaluation of progress

Vulnerable children who may be at risk of harm do not always receive an adequate and timely assessment of their needs. Weak manager oversight, inconsistent application of thresholds and a continuing significant shortfall in experienced social workers in the MASH, children with disabilities teams and the assessment short-term intervention teams all contribute to these serious concerns. However, the situation has improved from 18 months ago when unallocated cases were in the hundreds. There are now very few cases not allocated within seven days of contact.

Children are almost always seen and seen alone in child protection enquiries and in assessments. Very recent social work practice seen in the safeguarding teams is of better quality than found during the previous inspection, with risks assessed and reflected in plans. Numbers of agency staff remain high (22%), although have decreased recently (from 30% 12 months ago). A reconfiguration of core social work teams and family support services completed in February 2016 is leading to a more coherent delivery of services to families.

In too many cases, decisions to progress initial contacts to referrals are not consistent or timely. For example, 83 contacts were waiting to be allocated to a referral and advice officer to make a decision about whether they should progress to a referral or be closed or signposted to other agencies. These cases had been triaged by a social worker but this still means children and families wait too long for a decision to be made about what help they will receive. Managers in the MASH do not routinely sign off contact decisions made by unqualified referral and advice officers and there is no system in place to monitor and track this decision-making. This is a significant weakness and inspectors found cases passed to family support services without sufficient consideration of risk, need or the history of the case. In other cases, decisions to take no further action were based on too little information.

When children are thought to be at risk of significant harm, strategy discussions are generally timely but not all children who require them have one. Strategy discussions convened in the MASH appropriately include a range of partner agencies and are well informed and purposeful. However, emerging child protection concerns in open cases do not always benefit from a sufficiently prompt response and so children may be left at risk of harm for too long. The quality and recording of strategy discussions and child protection enquiries vary too much in detail and quality. This compromises opportunities to understand risks to children and young people.

Assessments are overly descriptive and lack a thorough analysis of risk. However, those that are more recent clearly identify the difficulties that families are experiencing. The voice and experiences of children are increasingly evident in case recording and are beginning to form an integral part of assessment and planning. However, consideration of what life is truly like for children growing up in families who are experiencing mental health, domestic abuse, alcohol or drug problems is not sufficiently analysed to improve outcomes. Child protection and child in need plans too often lack specific and measurable goals and contingency plans. This leads to unfocused intervention and makes progress hard to evidence.

Current arrangements for responding to disabled children lack rigour in the management of escalating risk and this means that children may be left at risk of harm for too long. Some children wait too long, for either their needs or risks to be recognised or managed effectively. For example, despite a disabled child with an injury disclosing a physical assault, child protection procedures were not instigated. A number of children with complex needs have been without an allocated social worker and one child subject to looked after children arrangements had been without an allocated social worker for five weeks. Social workers do not see disabled children regularly enough, children in need plans are either absent or are not up to date.

Over 50 children with a statement of special educational need or education and health care plan are not receiving full-time education. For example, a child has not received any formal education since December 2013. Some of these children have never been visited by council officers. This means that the council cannot be assured that these children are safe. Council staff are aware that safeguarding checks need to be carried out, yet this has not happened.

Staff are too slow in checking the whereabouts of children missing from education and this means opportunities to trace them in a timely way are missed. Children who remain missing are removed from the council's records once checks have been completed. From September 2015 to January 2016, the council removed 253 children from their list of missing children without locating their whereabouts.

Vulnerable children who have been excluded from education do not have their needs catered for well enough. Many do not have a school place and the council do not routinely check the safety of all of these children. Of significant concern is that, for some of these children, no checks are made to assure that they are appropriately safeguarded while they are out of school. As a result of the required policies and procedures not being in place, staff are not clear about who should do what and when action needs to be taken.

Insufficiently robust checks are made on children whose parents have elected for them to be educated at home. Home visits by council staff do not include a sufficient or rigorous consideration of safeguarding but instead focus on the delivery of subjects and examinations.

Links between Birmingham City Council and independent schools are weak. There is very little evidence of information passed to the council from any of the independent schools in the city.

Almost all schools have received 'Prevent' training from Birmingham City Council and a range of support is provided for headteachers in schools where there are issues of potential radicalisation. All schools in Birmingham now receive a visit from the Birmingham Education Partnership. However, headteacher questionnaires were less positive about the city's strategy to support schools.

Historically, issues relating to the governance of schools have been a significant concern for the council. Progress has been made and appropriate procedures are now in place to evaluate the suitability of potential school governors for maintained schools. However, checks to assess the suitability of governors in academies, free schools and independent schools have not been routinely carried out. This equates to one third of all Birmingham schools and so a considerable challenge remains.

The arrangements for the identification, management and intervention for children and young people who are at risk of child sexual exploitation are not consistently effective. The quality of analysis and information gathering within risk assessments is variable and not all are sufficiently rigorous in identifying all risks posed. As a result, plans are often weak and do not routinely identify the named individuals who will complete particular actions, or incorporate timescales. When children go missing, return home interviews are not always offered or undertaken and findings are not used to prepare and plan for interventions to reduce risk.

Caseloads in most of the social work teams are reducing. The quality of social work supervision is not yet good enough but its frequency is improving. Most supervision records are brief with little evidence of reflective discussion, challenge or rationale for decisions made. Frontline managers do not yet have a consistent or realistic appreciation of what good practice looks like and much work is required to help them achieve this.

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

Yours sincerely

Linda Steele

Her Majesty's Inspector

The letter is copied to the Department for Education [at SocialCare.INSPECTION-IMPROVEMENT@education.gsi.gov.uk]