

# Birmingham

## Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection dates: 12 September 2016 to 6 October 2016

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<b>Children's services in Birmingham are inadequate</b>		
<b>1. Children who need help and protection</b>		Inadequate
<b>2. Children looked after and achieving permanence</b>		Requires improvement
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Requires improvement
<b>3. Leadership, management and governance</b>		Inadequate

## Executive summary

This re-inspection has identified that serious and widespread failings in some services to help and protect children have not yet been tackled effectively. Children are not always kept safe and not enough is being done to protect them from harm.

Senior leaders and politicians have worked hard, invested considerable resources and reconfigured services to ensure that there is a strengthened focus on improvement, and this inspection has found some significant improvements in a range of services as a result. However, key areas of service provision are continuing to fail children and families, and where progress is being made further work is required to ensure that services are of good quality.

Children and families do not receive the help they need at an early enough stage. In addition, the understanding and operational support from partner agencies is poor. This results in inappropriate referrals being made to children's statutory services. The multi-agency safeguarding hub (MASH) does not identify and reduce risks to children effectively at the point of contact and referral. Inspectors had to refer back to the authority too many cases where risk had not been identified properly or acted upon.

Partnership working with other services is not well embedded, with, for example, too many instances where police do not attend strategy meetings or provide early enough information. A lack of effective multi-agency working at both operational and strategic levels is hampering the pace and extent of progress.

Children who have disabilities, and who are in need of help and protection, are not seen regularly enough by their social workers and many wait too long to have their needs reviewed. The authority does not do enough to identify those children who may be privately fostered, and for those who are identified, do not discharge their statutory responsibilities of assessment and overview effectively.

Arrangements to identify, manage and intervene where children and young people are at risk of child sexual exploitation are not consistently effective. Arrangements to link risk with children who go missing from home or care are underdeveloped, and work to reduce risk is not informed by sufficient analysis of intelligence and performance information.

Many child protection plans are not reducing risk in a timely way, with ineffective multi-agency core groups and a lack of challenge by child protection chairs to ensure that good outcomes are achieved as quickly as possible for children.

Significant progress has been made in addressing serious weaknesses in identifying and reducing the numbers of children missing education. For those children looked after, personal education plans are now often of good quality and increasing numbers of children in care attend good or better schools.

Services for children looked after have improved, and they benefit from seeing their social worker more regularly as a result of a more stable workforce. There is an

increasing and improved focus on ensuring that, where necessary, children live with a permanent alternative family as soon as possible. Adoption is considered for children who cannot return home, and they live with their new families more quickly than at the time of the last inspection. Many young people who live in permanent fostering arrangements have secure and settled placements with foster carers who receive good support from the local authority. For a minority of young people, however, it has taken too long to find a stable placement and these young people have had too many moves.

The local authority has taken robust action to ensure, following a recent child death, that the circumstances of children subject to a special guardianship order (SGO) have been reviewed to ensure their welfare. Current assessments to place young people under SGOs with carers are now of satisfactory quality.

Care planning does not always ensure that all of a child's needs are carefully considered, and there is, in some cases, ineffective challenge by independent reviewing officers of progress between reviews to ensure that plans do not drift.

Too many care leavers are not in education, employment or training, and this situation has not improved since the last inspection. The local authority has not prioritised these young people or supported them effectively to secure apprenticeships and job opportunities within the council. Care leavers benefit from good relationships with personal assistants and are well prepared and guided in preparation for independence.

The corporate parenting board now has a clear focus on issues for young people and is beginning to have an impact on improving services. The Children in Care Council is established and is listened to by the council, but more work is required to ensure that it is representative of all children in care in Birmingham.

Performance management and quality assurance systems are not closely enough aligned, and there is insufficient emphasis on the quality and impact of practice.

The council has been successful in establishing a sufficient and relatively stable workforce, including a reduction in the overall use of agency staff. Where use of agency staff remains high, as in the MASH, issues of poorer quality and inconsistent standards of practice remain.

# Contents

Executive summary	2
<b>The local authority</b>	<b>5</b>
Information about this local authority area	5
Recommendations	8
Summary for children and young people	10
The experiences and progress of children who need help and protection	11
The experiences and progress of children looked after and achieving permanence	19
Leadership, management and governance	33
<b>Information about this inspection</b>	<b>39</b>

## The local authority

### Information about this local authority area<sup>1</sup>

#### Previous Ofsted inspections

- The local authority operates five homes. Two homes were judged to be good and three were judged to require improvement in their most recent Ofsted inspections.
- The previous inspection of the local authority's safeguarding arrangements was in March 2014. The local authority was judged to be inadequate.
- The previous inspection of the local authority's services for children looked after was in March 2014. The local authority was judged to be inadequate.

#### Local leadership

- The director of children's services (DCS) has been in post since July 2013.
- The director is also responsible for adult social care, education, public health and housing strategy.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since April 2016. The previous chair of the LSCB took up the post in October 2011 and left the post in March 2016.

#### Children living in this area

- Approximately 283,900 children and young people under the age of 18 years live in Birmingham. This is 25.5% of the total population in the area (1).
- Approximately 37.1% of the local authority's children are living in poverty after housing costs – according to figures published by the End Child Poverty Coalition in October 2014.
- The proportion of children entitled to free school meals:
  - in primary schools is 28.0% (the national average (2016) is 15.2%)
  - in secondary schools is 27.4% (the national average (2016) is 14.1%).
- Children and young people from minority ethnic groups account for 60.6% of all children living in the area, compared to 25.5% in the country as a whole (2).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 43.0% (the national average (2016) is 20.1%)

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<sup>1</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.

- in secondary schools is 40.1% (the national average (2016) is 15.7%).
- Birmingham is a highly diverse city. This has a positive impact on the city, but also raises significant challenges for cohesion: 22.2% (238,300) of Birmingham residents were born outside the UK. Of these, 74,900 arrived when they were aged 0 to 15 years and 103,682 arrived in the UK between 2001 and 2011 (3). Between 2015 and 2016, Birmingham had been projected to see an increase in population of 0.9% to 1,223,000, of which 285,500 will be aged under 18 (4).

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(1) ONS 2015 mid-year population estimate

(2) ONS annual population survey January to December 2014

(3) Census 2011

(4) ONS 2014 subnational population projections

### **Child protection in this area**

- At 31 August 2016, 7,155 children had been identified through assessment as being formally in need of a specialist children's service. This is a decrease from 9,676 at 31 March 2015.
- At 31 August 2016, 854 children and young people were the subject of a child protection plan. This is a decrease from 1,028 at 31 March 2015.
- At 31 August 2016, 17 children lived in a privately arranged fostering placement. This is a reduction from 33 at 31 March 2015.
- Since the last inspection, 17 serious incident notifications have been submitted to Ofsted and eight serious case reviews have been completed or are ongoing, and there were six learning lessons reviews at the time of the inspection.

### **Children looked after in this area**

- At 31 August 2016, 1,816 children were being looked after by the local authority (a rate of 64 per 10,000 children). This is similar to 1,815 (64 per 10,000 children) at March 2015. Of this number:
  - 752 (41%) live outside the local authority area
  - 177 live in residential children's homes, of whom 45% live out of the authority area

- three live in residential special schools<sup>[1]</sup>, of whom 100% live out of the authority area
  - 1,206 live with foster families, of whom 39% live out of the authority area
  - 91 live with parents, of whom 12% live out of the authority area
  - 92 children are unaccompanied, asylum-seeking children.
- In the last 12 months:
- there have been 153 adoptions
  - 15 children became subject of special guardianship orders
  - 899 children ceased to be looked after, of whom 8% subsequently returned to be looked after
  - 18 children and young people ceased to be looked after and moved on to independent living.

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<sup>[1]</sup> These are residential special schools that look after children for 295 days or less per year.

## Recommendations

1. Strengthen the management oversight, systems and processes in the MASH to ensure appropriate application of the thresholds, effective decision-making and a consistent response.
2. Ensure that local authority staff and partners, through the Local Safeguarding Children Board, understand the early help offer and are able to undertake assessments of need and offer appropriate interventions at an early enough stage to prevent escalation to statutory intervention.
3. Ensure that quality assurance and performance management processes are better used to improve weak performance, and that they and strategic improvement planning have a much stronger emphasis on impact.
4. Reduce the backlog of unassessed domestic abuse notifications and strengthen systems to ensure that children are not left in unassessed situations.
5. Ensure that key partner agencies contribute fully to child protection strategy meetings.
6. Address poor assessment and review practice in the service for children who have a disability to ensure that all children are helped and supported.
7. Improve the quality and timeliness of services to children and young people who are at risk of child sexual exploitation or who go missing. Ensure that these two service areas are aligned and that service development is informed by available intelligence and performance information.
8. Improve the quality and timeliness of core group meetings to support families in engaging with the child protection process and to ensure that progress is made.
9. Ensure that practice for children who are subject to private fostering arrangements meets statutory requirements and that all staff and partners know how to recognise a private fostering arrangement.
10. Ensure that when children have a plan to return home risks are fully considered and that the right support arrangements are in place.
11. Ensure that all children benefit from good quality care plans, including plans for permanence, and that these are actioned and reviewed effectively to prevent drift and delay for children.
12. Improve matching processes and management oversight to keep placement breakdown, particularly multiple placement breakdown, to a minimum for children.



13. Work closely with partner agencies to improve joint working at both operational and strategic levels, including in relation to female genital mutilation.
14. Ensure that issues around identity, cultural and racial needs are explored more fully in order to support effective matching during prospective adopters' assessment and by the panel.
15. Reduce the number of care leavers aged 19 to 21 not in education, employment or training.
16. Strengthen the opportunities open to care leavers through the council's own services to ensure that they receive appropriate consideration to enable them to achieve better outcomes.
17. Strengthen assessments and plans to ensure that they fully reflect and respond to all children's and young people's diverse needs.

## Summary for children and young people

- Ofsted inspected Birmingham city council children's services two years ago and found that not all children were protected and they did not get the help they needed soon enough. At this inspection, inspectors found that some improvements have been made but many things have not improved quickly enough.
- The council and its partners, such as the police and schools, need to improve how quickly they talk to each other about children and their families. It is important that they work better together, to ensure that families are not left waiting to get the help they need.
- Until quite recently, some children have had too many changes in social worker. The council is now trying to make sure that staff do not move around as often and have smaller numbers of cases so that they have more time with children and young people.
- The council is working hard to make sure that plans to protect children set out who needs to do what and by when, but they are not always getting this right.
- Inspectors found that services for children who have disabilities could be better at making sure that those young people and their families are getting the right help.
- The council has improved its services for children looked after and now most children live in safe and secure foster homes. At times, the council is not always finding the best places for children to live quickly enough, and this means some young people have to move too many times before the best place is found.
- Social workers regularly visit children looked after by Birmingham, but don't always make sure that they write down what young people say to them. When children do not see their families, they need to be able to talk to someone who is not their social worker (such as an independent visitor) and who can then speak on their behalf.
- Children do not always attend meetings to help decide what should happen in their lives. Independent reviewing officers should help them to talk about this, but they do not always talk to young people before these important meetings.
- The council has made some improvements to make sure that children are adopted quickly if they need a new permanent family. They still need to work to make sure that young people understand why they have come into care and what has happened to them since.
- Young people leaving care are well supported by the staff who work with them. However, too many young people who leave care are not in any sort of education or do not have a job. Better work needs to be done to make sure that plans for their future help them to get jobs or a better education.

<p><b>The experiences and progress of children who need help and protection</b></p>	<p><b>Inadequate</b></p>
<p><b>Summary</b></p> <p>The local authority is failing to ensure that all children are kept safe and protected. Too many children have remained as children in need when they would have benefited from the support of a child protection plan sooner.</p> <p>The quality of practice and services for children are not of a good enough standard. Thresholds between early help provision and statutory intervention remain unclear and are inconsistently applied at all levels across the partnership. Early help services are not supporting children sufficiently, and this results in too many children’s cases being referred to statutory services when this is not necessary.</p> <p>Practice in the MASH is weak and too many decisions are being made by non-qualified staff. Management oversight is not of a consistently good enough standard and the quality of information shared by partner agencies needs to improve to inform planning and decision-making effectively.</p> <p>The team working with children who have disabilities does not identify or manage risks effectively in all cases, and children are not seen by social workers sufficiently regularly.</p> <p>Arrangements to identify, manage and intervene when children and young people are at risk of child sexual exploitation are not consistently effective.</p> <p>The recent establishment of assessment and short-term intervention teams and safeguarding teams is positive. Practice in these teams is of better quality, although improvements are not sufficiently widespread, robust or embedded.</p> <p>Recent investment by leaders in more effective supervision is starting to make a positive difference to the quality of social work supervision and case direction provided by managers. Caseloads are manageable, and social workers are spending more time with children. An increased use of direct work by social workers with some children is starting to improve their outcomes.</p> <p>Recent improvements are evident in the child protection case conference process with the adoption of a well-regarded practice model, which is helping families understand what they need to do to change.</p> <p>Some children wait too long before their care is secured through legal processes, and local authority plans to improve practice have not yet had an impact.</p>	

Significant progress has been made in addressing serious weaknesses in identifying and reducing the numbers of children missing education, to ensure that there is early identification, regular review and robust follow-up of children.

### **Inspection findings**

18. Multi-agency thresholds for intervention are poorly understood by both social care staff and partner agencies. This deficit, combined with poor management oversight of practice in the MASH, results in some children's needs being inaccurately assessed and responded to. In turn this means that some children are not adequately protected. (Recommendation)
19. During this inspection, too many children have been identified as being at risk of immediate harm, and in a small number of instances urgent action has had to be taken by the local authority to safeguard them. Too often there have been missed opportunities to effect prompt change for children who have not received the right level of services at the right time, resulting in drift and delay.
20. Too many children are referred inappropriately to children's social care, because there is an absence of a coherent early help offer. There is a lack of clarity from local authority staff and partners about the purpose and function of early help, and it is often confused with targeted family support, which is delivered successfully by children's social care services. The development of the early help brokerage service, now situated at the point of access to services, has the potential to resolve disputes and to provide help and guidance about thresholds and signposting to agency partners. However, poor quality management oversight has not yet ensured that children are benefiting from early help support.
21. More needs to be done to encourage and support partners in understanding the positive impact that they could make to children by undertaking the role of lead professional. The number of common assessment frameworks (CAFs) completed has increased, although the majority are completed by local authority staff. The quality of many CAFs undertaken by partners is not good enough. Too many are incomplete, lack clear and detailed action plans, or do not include children's views. Central recording of CAFs from all agencies is in the early stages, so the total number of plans completed is not clear to the local authority or to partner agencies. (Recommendation)
22. There is now a single point of access for contacts and referrals. Unqualified referral officers receive all contacts, as well as making all follow-up enquiries and telephone calls to professionals. Professional oversight is poor and this results in key information often being missed, as these staff are unclear about what is expected of them. The number of contacts is increasing, but many do not lead to a referral. Decisions are being made on the basis of incomplete

information and there is an over-reliance on unqualified workers to signpost and process contacts. This results in missed opportunities to correctly identify needs and ensure that there is the right response.

23. The day-to-day management oversight of cases in MASH is inconsistent, with managers often changing decisions made by other managers. This in turn leads to staff confusion and a lack of clarity about the application of thresholds. The absence of an effective electronic performance management information system, combined with incomplete enquiries, are significant factors in a failure to identify risks and ensure that appropriate action is taken to help and protect children. Added to this, the workforce in the MASH is over-reliant on agency staff. As a result, the inevitably high turnover in social work staff means that new protocols and policies are not consistently understood or applied.
24. Consent by families, both for early help and statutory services, is always sought and the discussions with professionals and families are recorded in great detail. In some cases, the rationale to overrule consent is not recorded, and this lack of management recording undermines the care and attention that is being taken when families are first referred.
25. The number of domestic abuse referrals per month is high, at over 3,000, with 401 referrals in a backlog at the time of the inspection, awaiting triage. This backlog, while gradually reducing, still means that children wait too long before an assessment of need or risk is undertaken. Consequently, children who have been involved in, or have witnessed, domestic incidents, may not be adequately supported and protected soon enough. The use of various risk assessment tools in the domestic abuse triage process between police and children's social care does not efficiently identify levels of risk to children. However, when children need an immediate and urgent response, prompt decision-making is effective. (Recommendation)
26. Multi-agency partners who are based in the MASH are not yet being used effectively to gather information. Agencies are co-located but do not yet work well together and more needs to be done to improve respect and understanding for each other's roles and their shared roles in the MASH. Only a third of referrals are responded to in a timely way. Unnecessary multi-agency discussions, in cases assessed as of medium risk, result in children and families experiencing delays in the provision of services they need.
27. When children are assessed to be at risk of significant harm, strategy meetings are generally timely, but not all children who require them have one. Strategy meetings are not routinely attended by all key agencies including, in some instances, the police. This means that decisions to initiate child protection investigations are made without a full picture of the child's life experience and family history. This deficit also relates to children whose cases are already open to statutory services. Inspectors identified a small number of enquiries that should have led to a child protection conference but did not. In

these cases, insufficient or no action was taken to reduce risks for those children. Strategy meetings and child protection enquiries vary significantly in the detail and quality of recording. Some seen lacked relevant information from partners and it was difficult to understand why some decisions were taken based on the information gathered. This compromises opportunities to understand risks to children and young people. (Recommendation)

28. The service and response to children provided by the out-of-hours emergency duty team is poor. The local authority does not quality-assure or oversee decisions made by the emergency duty service and communication with daytime services is too limited. As a result, senior managers cannot be confident that the response to children who need help outside of normal working hours is always timely, effective or safe. In a small number of cases, young people did not receive a sufficiently timely service, including provision of accommodation that was in line with statutory guidance.
29. Assessments of need for children often do not provide a full analysis of risk and clear recommendations. The local authority has introduced new operating principles, and social workers have received training in undertaking assessments. However, most assessments still lack historical context, and this deficit means that assessments are often based on a limited understanding of the child's lived experience. Some assessments seen do not explicitly explore the emotional impact on children of long-term neglect. Managers who authorise completed assessments do not always challenge the quality of them and this does not support required improvements to practice effectively.
30. There are continued serious shortfalls in assessments and planning for children who have disabilities. Too many children receive an inconsistent response when help and protection are needed. Children in need of this service do not have their cases reviewed regularly enough: 481 children have not had their plan reviewed within required timescales and some children have not been visited by children's services in over two years. Too many children who have disabilities are dealt with by the early help service, where the necessary expertise is not available. (Recommendation)
31. Social workers and managers are not yet using authoritative action when situations have changed and new risks have emerged or known risks have escalated for children subject to children in need plans. This means that there are missed opportunities to intervene to safeguard children through child protection proceedings or court care proceedings. A lack of understanding of the complexity of using a relationship-based social work model with families is, in some cases, leading to delays in responding to risks and an over-optimistic view of children's circumstances.
32. Some children have had to wait too long before appropriate action is taken to secure their care through legal processes. The local authority is aware of the current weaknesses in pre-proceedings work and has recently been seeking to address this.

33. Increasingly, the public law outline is being used with good effect to ensure that care is only used when this is in the best interests of children. This is particularly evident in planning arrangements for young children and babies. When letters are written to families to advise them of the intention to enter pre-proceedings, the large majority of these clearly identify concerns and what families need to do to reduce professionals' concerns.
34. Consideration of children's individual and diverse needs within assessments and plans is not consistently of a good enough standard. Stronger assessments recognise the impact and importance of identity to children and young people, and are central to planning for them. Weaker assessments lack detailed exploration and understanding of the impact of religion and culture in families, and this does not help in identifying the right services for children. (Recommendation)
35. Child in need plans and child protection plans do not demonstrate a focus on outcomes based on actions and timescales to achieve change. Recent work has been completed to improve the quality of plans, but this is not yet demonstrating an impact. Many child protection plans are not updated following core group meetings and have unrealistic expectations of parents' ability to change and to protect their children. Core-group activity is very inconsistent in quality and timeliness, and this does not ensure that progress to ensure that children and young people are protected is being monitored, reviewed and measured. (Recommendation)
36. The establishment of the assessment and short-term intervention teams (ASTI) and safeguarding teams is starting to demonstrate improvements in practice. The frequency of management oversight and decision-making is improving. There is a stronger 'grip' on cases in this part of the service. Caseloads are now manageable and children are now more able to build trusting and positive relationships with social workers. Children are almost always seen, and seen alone, in child protection enquiries and in assessments. A strong focus on relationship-based and solution-focused practice means that children and families are starting to understand professional concerns, and parents are increasingly understanding of what needs to change. However, disguised compliance is not always recognised and this means that too much emphasis can be placed upon families' ability to improve outcomes for children, without evidence of sustainable change.
37. Support to families is further enhanced through work by family support workers, who work with families delivering a range of direct work and interventions alongside social workers. Feedback from families indicates that this is a much-valued service that is making a positive and lasting difference to children and families.
38. Child protection chairs are not challenging drift effectively in the progress of plans through use of a formal escalation process. Informal challenges do not always result in a swift management response. As a result, many children in

need of help and protection experience delays in achieving change, and are stepped down to children in need plans inappropriately, or remain on protection plans with no improvement to their outcomes.

39. The quality of child protection case conferences is starting to improve through the use of a recognised and well-regarded model of practice: 91% of families and professionals now report that they understand why they are in conference and they understand what they need to do to change their family situation, and this is positive performance. However, children's views are not consistently heard through the child protection planning and review process. Children do not have sufficient advocacy support to attend child protection meetings to enable them to contribute meaningfully to decisions.
40. At the time of the inspection, local authority performance data reports that 29% of children remain on a child protection plan for three months or less, which is slightly below the 31% recorded in 2014–15, but still five points higher than comparators. In cases seen, the majority of these children were removed prematurely, before risk was reduced, with no positive change sustained. The local authority has not yet successfully addressed delays in securing lasting safety and stability for these children, with a high percentage of children (21.7%) becoming subject to repeat child protection plans at the time of the inspection.
41. Services for children missing from home or care are poor. Return home interviews are only being completed for a minority of children who go missing, with some young people not being offered an interview. Of those undertaken, two thirds take over 72 hours to complete and they are not then consistently copied across to children's electronic case files. The information gathered from children is not collated or used well to evaluate the reasons why they go missing or to inform their care planning. As a result, children do not always receive the help that they need, and there is no evidence that episodes of going missing are reducing. (Recommendation)
42. Those children and young people identified as being at risk of child sexual exploitation are referred to the multi-agency child sexual exploitation (MASE) meeting. Inspectors identified delays of up to five months from a case recommendation to escalate a child's case to MASE, and delays of up to six months for children's cases to be reviewed at MASE. As a result of this inspection, all of these children's cases have now been scheduled to be considered at MASE. However, these significant delays mean that children at risk have not received a multi-agency response to their needs and there have been missed opportunities to gather critical intelligence about trends, patterns and perpetrators. (Recommendation)
43. The experiences of children discussed at a MASE meeting provide a clear source of intelligence. However, opportunities for maximising the benefit that this meeting offers are missed. There is an absence of specific or timely actions to improve planning for individual children. Thresholds to access



targeted child sexual exploitation services are not applied consistently, which means that services are not always directed at those children who are most at risk. As a consequence the targeted family support on offer is not yet reducing risk effectively. The local authority is not adequately addressing the underlying causes of children who are at risk of child sexual exploitation and, despite a revision of child sexual exploitation procedures, practice is not improving.

44. Significant progress has been made in addressing serious weaknesses in identifying and reducing the numbers of children missing education. Additional capacity has enabled a thorough review of data systems, processes and procedures, which has prompted a raft of changes to make sure that accurate information is collected so that action can be taken. The system has been cleansed and is now regularly updated and reviewed. The data-set is now robust, with 109 young people at the time of the inspection currently missing. All current referrals for children missing education are retained for 12 months until the child's whereabouts are known, and only at that point are names withdrawn from the data-set.
45. Schools' representatives, including headteachers, confirm that they are confident that the council has a much better grasp on safeguarding children in schools as a result of significant improvements having been made. Elective home education (EHE) data is now also secure, a significant improvement realised since June 2016. Relatively high numbers (894) are closely monitored and now carefully analysed to identify any trends, concerns and issues arising from local areas, schools and communities. Schools are aware of their duties and complete the appropriate referral forms for children they identify as being at risk. Children they identify as being subject to a CAF, child protection and children in need plans are now alerted to the authority through the referral process. Managers and local schools are working closely with representative EHE families to improve and increase provision for this cohort of children and, more specifically, to raise awareness and concerns regarding safeguarding issues.
46. Effective arrangements are in place when planning for high-risk adults who are due to be released from prison through multi-agency public protection arrangements (MAPPA) and the youth MAPPA. Cross boundary arrangements are in place and these are well supported through regional procedures. MAPPA monitors agency attendance, and social care are now contributing to and attending all MAPPA. Prior to January 2016 this was not the case.
47. Despite a 34% increase in referral of high-risk victims to the multi-agency risk assessment conference (MARAC) since 2014–15, a range of partners, such as adult mental health and housing, still do not contribute routinely. This reduces the effectiveness of MARAC. While there are a range of support services focusing on groups such as mothers, children and male victims, there are no perpetrator programmes available. This is a significant gap and further limits the effectiveness of responses to reduce risk.

48. Homeless young people who are 16 and 17 years old receive a good quality joint response from social care and housing services through the integrated youth hub. Social work assessments lead to young people being offered section 20 accommodation appropriately, with seven young people becoming looked after during the last six months. The remaining 26 homeless young people have all benefited from a range of accommodation providers and appropriate child in need support plans.
49. The council is not identifying children who are privately fostered effectively. When children are living with private foster carers, the local authority does not discharge its statutory responsibilities. Children are not visited in line with requirements, and assessments of potential private foster carers do not always include an analysis of suitability of living arrangements for children. Further, statutory checks relating to the carer's household are often incomplete. As a result, the local authority cannot be sure that privately fostered children are being cared for safely. (Recommendation)
50. The local authority's response to cases referred to it by the police through Operation Limelight, identifying young people as potentially at risk from female genital mutilation, was poor and failed to ensure that necessary multi-agency checks and risk assessments had been completed. There was insufficient planning by both the local authority and police to ensure that a coordinated response to concerns and actions was taken, and this was not compliant with Local Safeguarding Children Board procedures. (Recommendation)
51. The management of allegations through the work of the designated officer is improving and is now effective. The outcomes of investigations are based on a full range of information, and decision-making is appropriate. Good work on engaging with faith organisations is undertaken alongside a charity and is supported by community safety partnership funding, this includes a helpful guide document for all faiths. Further improvements are yet to be made in establishing the role and responsibilities of the designated officer across agencies and the implementation of an audit programme to drive up the quality and effectiveness of practice.

<p><b>The experiences and progress of children looked after and achieving permanence</b></p>	<p><b>Requires improvement</b></p>
<p><b>Summary</b></p> <p>The local authority has improved services for children looked after since the last inspection. This is the result of successfully delivering a substantial work programme to review and improve practice. Key achievements include joint working with the courts and the Children and Family Court Advisory and Support Service (Cafcass) to ensure that children gain legal security swiftly through reducing court timescales, as well as the review and development of services that deliver good quality assessments and support for special guardians and connected persons caring for children. However, the large majority of children still receive services that require improvement.</p> <p>Appropriate decisions are made for children to become looked after, although some children are looked after in an emergency rather than as a planned move.</p> <p>The education of children looked after is positive, with attendance, attainment and progress being supported effectively by a well-led virtual school. An increasing range of after-school activities are enabling children to become more self-confident.</p> <p>Risks for children who frequently go missing, and risks from gangs or sexual exploitation, are considered and reduced through robust plans. Children looked after do not always receive or are offered return home interviews after they have been missing, so risks associated with these individual episodes are not known. Some children and care leavers have experienced a delay in receiving mental health services.</p> <p>Most children live in stable placements. However, some children have experienced numerous placement breakdowns due to a lack of robust matching processes. Care planning is an area of weakness for the local authority. This means that some children experience delay in receiving services to meet their needs and improve their outcomes.</p> <p>Children are engaged in decisions about their lives and social workers visit them regularly. Adoption is considered for children who cannot return home and they live with their new families more quickly than at the time of the last inspection. Children, including those placed for adoption, are not consistently helped to understand their care histories through direct work and life story work.</p> <p>Care leavers enjoy positive relationships with their personal advisers, are aware of their entitlements and high numbers stay in regular contact with the service. The timeliness and quality of pathway plans, however, are inconsistent and too many care leavers are not in education, employment or training.</p>	

## Inspection findings

52. Appropriate decisions are made to accommodate children, and no children who had been brought into care unnecessarily were identified during this inspection. For some children, decisions to accommodate them are not based on clear, effective and comprehensive risk-based assessments. This means that they are taken into care in an emergency as risks escalate, rather than having a planned move into accommodation.
53. Assessments and plans for children who have a plan to return home require improvement to ensure that risks are fully considered and that the right support arrangements are in place. When children and families require additional support to make a return home successful, there is an effective edge of care service that undertakes proactive work to support these moves. This team also works positively with children and families at risk of family breakdown, and at the point of a child becoming accommodated.  
(Recommendation)
54. Applications to court are based on a detailed analysis of issues and children's needs, and contain appropriate recommendations. A small number of court statements lack clarity about placement options. The district judge and Cafcass report that they have seen an improvement in the quality and timeliness of documents submitted to court, and improved decision-making regarding thresholds for children in the past year. The timeliness of court processes is improving. In 2015–16, the average was 37 weeks for care applications, and from April to July 2016 this had reduced to 27 weeks.
55. Children regularly see their social workers and almost all see them alone. The current provision of independent visitors is not sufficient to meet the needs of children looked after. The local authority offers an appropriate issues-based advocacy service for children, including those placed out of authority. An information pack has not been developed to share with children when they become looked after, so the local authority cannot have confidence that all children know how to complain. When there is concern that a child looked after is being bullied, professionals and foster carers work effectively to reduce this risk.
56. Return home interviews are not routinely offered and completed with all children looked after following each missing episode. This means that risks associated with a particular missing episode, the reasons why children went missing or where they were, is not always known. There have been delays in appropriately identifying and responding to risk, particularly the risk of child sexual exploitation, for a small number of children looked after. However, for most children looked after, risks associated with offending, going missing or being at risk of child sexual exploitation are being addressed. This includes exploration of missing episodes for those children who regularly go missing, use of strategy discussions and referral to MASE meetings to reduce risk. For

some children who have been at high risk of child sexual exploitation or gang-related crime, placements have been sought outside the child's immediate community to provide specialist care, resulting in a reduction of risk. Effective specialist provision for children looked after who are at risk of child sexual exploitation includes two full-time and one part-time nurse who provide education and awareness-raising, and who can coordinate health information to inform MASE meetings. (Recommendation)

57. Children cannot easily access timely support to improve their emotional well-being and mental health. There have been delays in access to the local authority's therapeutic and emotional support service (TESS) service to prevent placement breakdown and in access to a service from Forward Thinking Birmingham (FTB), which is the local child and adolescent mental health service (CAMHS), to assess and meet mental health needs. The local authority has been working, via TESS, to engage effectively with FTB, and joint screening meetings will now be held to consider new referrals.
58. Educational outcomes for children who are looked after have improved marginally since the last inspection. In 2014–2015 at key stage 1, children performed better in reading than statistical neighbours and nationally, and achieved in line with comparators in writing and mathematics. At key stage 2, attainment in grammar, writing and reading improved, with children performing better than the national average, while attainment in mathematics declined. At key stage 4, of 130 pupils eligible to take exams, a small cohort of 22 (17%) achieved five or more A\*–Cs, including English and mathematics, which was better than the national average of 14%. However, gaps in attainment at each key stage between children looked after and all children in Birmingham remain too wide.
59. The number of children attending good or better schools has increased to 67%. Looked after children educational support (LACES) workers focus their attention on increasing support, if it is assessed as necessary, for children in schools judged to be less than good. Attendance has improved and is high in both primary and secondary schools. The new welfare call system has been introduced to regularly monitor and support the attendance of children attending alternative provision and when living out of area. No child looked after has been permanently excluded, and the virtual school works well with schools to address potential fixed-term exclusions.
60. For those children who struggle to sustain a place in mainstream education, a range of alternative provision is used. Currently, 35 children who are looked after attend provision for up to and including 25 hours. The LACES team closely monitors the attendance and progress of children at this provision. The quality of placements is also regularly reviewed and all provision within the city is subject to monitoring visits. Only two out of the city providers were judged to be less than good and quality assurance visits have been scheduled to take place this term.

61. The vast majority of personal education plans are now completed within appropriate timescales and those sampled were generally of good quality. A small number require improvement because target setting was too simplistic and not appropriately linked to individual needs. Three well-attended reward events have taken place this year for children to celebrate their achievements, attendance and involvement in enrichment and extra-curricular activities.
62. Most children are enabled to have meaningful contact with their family. This includes foster carers supporting some complex contact arrangements to ensure that children are able to maintain their important family relationships. There is limited evidence of social workers proactively considering children's social needs or friendships, or their ability to make friends. Many children engage in a range of leisure activities, from girl guides to gymnastics and regular swimming. A range of additional programmes, across the virtual school and schools in Birmingham, have developed this year to encourage children looked after to develop wider interests in learning, both during and after school.
63. Some children who have complex needs and behavioural issues, including children as young as seven years, have experienced multiple placement breakdowns. This is due to weaknesses in matching processes and insufficiently detailed placement request forms. For a small number of children, the impact of these breakdowns continues to affect their well-being. Most children, however, live in stable placements that have been well matched by the local authority. Following good quality assessments, most children live with their brothers and sisters when this is in their best interests. The local authority has appropriately reviewed the placements of four children who are living in children's homes which have been judged to be inadequate. (Recommendation)
64. The large majority of children's care plans require improvement to ensure that the child's full range of needs and risks are considered, and to ensure that actions are sufficiently clear and time-bound to enable effective monitoring. Adherence to and follow-through of care plans is an area of weakness, with the lack of a sense of urgency leading to drift. This includes delay in accessing appropriate services for children, and is particularly evident for children in their junior and secondary years. (Recommendation)
65. Children benefit from regular review of their care plans, but only just under half of children aged 4 to 18 years old attended their review in person in 2015–16. Not all children are engaged effectively by their independent reviewing officer (IRO) between reviews and prior to their next review meeting. The IRO team is seeking to improve children's attendance at review meetings and to ensure that their participation in these important meetings becomes more meaningful. Review meetings are appropriately challenging for professionals when drift has become evident against the plan. However, there is little evidence within children's case records that IROs are challenging drift effectively in progressing care plans between reviews. The IRO service has

undergone much development since the previous inspection, including reducing caseloads to the current manageable average of 68 children per full-time IRO.

66. When children are placed out of the local authority area, priority is given to securing a suitable placement, with education services identified as soon as possible. This includes appropriate use of both therapeutic and secure accommodation to meet needs and reduce risks for some children. Health colleagues do not currently sit on the external placements panel, which means that children's health needs are not always met at the time placements are made. For the majority of children, the health team negotiates appropriate health support effectively with the host area once the child is in placement, including for emotional and mental health.
67. Support and care planning for the 94 unaccompanied asylum-seeking children who are looked after by the local authority require improvement. At the time of this inspection not all of these young people had fully completed care and pathway plans. The local authority has placed more experienced staff in this area, but it is too early to have had an impact on improving practice.
68. The majority of children who have disabilities and who are in care are making tangible progress and are positively engaged with by their social workers. Management oversight and direction is clear, and planning for permanency is being taken forward for these children. When practice is less than good, this is due to lack of appropriate engagement by social workers with the child and family.
69. Timeliness to achieve permanence for children is variable, and for some children is poor. For those children experiencing delays, this is due to lack of swift action for access to appropriate services and assessments in identifying appropriate permanent placement options. Practice from the start of 2016 shows that planning for permanence is becoming stronger. Children with an early plan for permanence, particularly babies and younger children where relevant parallel planning has been identified, are receiving proactive and timely interventions by social workers against their plans. Many social workers have received training from the local judge regarding best practice when reaching decisions for children. Delays in proceedings are being kept to a minimum through joint work between the courts, social workers and Cafcass.
70. The local authority took practical and decisive action to review and improve the welfare of children living with special guardians and connected persons following the death of a child in 2015. Detailed reviews of children who were subject to proceedings for special guardianship orders, and those who had been placed with special guardians over the preceding two years, was undertaken. Appropriate follow-up action was taken when relevant to promote individual children's welfare. The local authority has added substantial resources to develop the assessment and support service for SGOs and connected persons to ensure that these placements are timely, safe and

supported for children. SGO and connected persons assessments are now of a good quality. Furthermore, the local authority is in the process of identifying and contacting all special guardians to explain its offer of support.

71. During 2015, the fostering team undertook a review of in-house foster care provision, which resulted in a reduction of 116 placements, some of which had never been used for children. There has been a significant improvement in the recruitment of foster carers following this review, although further improvement is still required to increase options for children. Current recruitment is appropriately targeted to increase the availability of placements for children who can be difficult to place, such as teenagers. The new designated out-of-hours carers are supporting continuity for children (including siblings placed together) who are placed in an emergency. Previously, very short-term placements were being used.
72. Assessments for foster carers are thorough, include relevant checks and are appropriately challenging if concerns are identified. The large majority of foster carers spoken to by inspectors were very positive about the support they receive from their supervising social workers, describing them as 'amazing' and 'second to none'. Carers all have up-to-date, signed, delegated authority to make appropriate decisions regarding their care of the children placed with them, and they receive information about the children in a timely way. Carers spoke positively about the potential for children to develop more enduring and open relationships with their social workers now that the workforce is more stable.
73. The local authority has commissioned an effective service to support children aged 10 to 16 years who are moving from residential care to foster placements. Children are central in planning for these moves and are supported by inspirational mentors with a background of care themselves. Therapeutic support is also provided to support these moves, with this gradually decreasing over time according to the child's needs.
74. Life story work is not routinely undertaken with all children who are being long-term fostered to ensure that they understand their identity, life and care histories. Where this important work is undertaken, it requires improvement to ensure that information is sufficiently child-focused and that it is likely to be of help, both now and in the future. The large majority of children are enabled to establish positive relationships with those who are caring for them through being placed in stable placements with skilled carers. Current recording systems would make it challenging for a child accessing their records in the future to gain a clear oversight of their care histories or experiences.  
(Recommendation)
75. The Children in Care Council (CiCC) is made up of a small but active group of 13 children looked after and two care leavers. Members of the CiCC are working effectively with the local authority to improve services for children looked after. Key successes have been, implementation of the MOMO mobile



telephone application, enabling improved communication between children, their social worker and IRO, and a full review of pocket money rates.

76. For some children, consideration of diversity is limited to noting the child's identity and diversity, without then developing this into a detailed plan to meet these needs. For most children, though, needs arising from ethnicity, religion and identity are considered well, with appropriate plans in place to meet these. This includes appropriate consideration during matching for placements.

<p><b>The graded judgement for adoption performance is that it requires improvement</b></p>
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77. Steady progress over the last 15 months, under a new manager, has improved the adoption service by increasing staffing, expanding family-finding teams and establishing a post-adoption service. A clear improvement plan identifies the areas requiring urgent attention, such as improving the timeliness of, and monitoring the progress of, adoption plans. However, recent improvements to the service, such as the permanence advice clinic, are not yet sufficiently embedded to evidence the desired impact.
78. Adoption is considered for all children who cannot return home at the second child looked after review. Nevertheless, the absence of the adoption manager's early involvement at legal and care planning meetings means that the service is not alerted at a sufficiently early stage about children who may need an adoptive family, and, as a result, adoption planning and family-finding does not start as soon as it could.
79. Monthly tracking meetings are now in place to monitor the progress of decisions about children ready for adoption through to care proceedings. Despite recent involvement by the adoption manager, it is still too early to see if there has been any impact in ensuring that plans are progressed without delays and that placement options are continually monitored.
80. Timeliness, as measured by the national adoption scorecard, demonstrates progress in closing gaps to target thresholds. Recent figures for 2016 relating to the average time it takes from a child entering care and moving to their adoptive placement show the gap reducing between 2012 and 2015 to 200 days. However, performance for the average time between a placement order being granted and a match with an adoptive family, while reducing and now at 263 days, still misses the government target of 121 days. Some good examples of improved timeliness were identified, such as adoptive families being identified for three children within 180 days.
81. The authority acknowledges the challenges of meeting nationally set adoption timescales and understands why their performance is not yet meeting these.

In particular, delays relate to the time taken to identify suitable families to meet the needs of harder to place children. Delays are mitigated by the council's tenacity in identifying adoptive families for children with complex health and disability needs. A good example is that of five brothers and sisters, where it has taken 2,000 days to secure the right adoptive family. More positively, these children benefited from living in stable and secure foster homes while they waited.

82. Numbers of children placed for adoption have steadily increased, from 120 in 2014–15 to 140 children in 2015–16 and, so far in 2016–17, 57 children. Currently there are 32 children with a placement order going through the matching process, including seven brother and sister groups. A further 44 children have a decision for adoption but legal proceedings are not yet concluded.
83. There have been two pre-order adoption disruptions in the last three years. This indicates that, in most cases, matching ensures that children live in safe, permanent homes. Matching practice is effective, considers the strengths of adopters, their capacity to meet the needs of children with complex needs and the level of support they will need. As a result, children and their adoptive families receive the right support.
84. In the last 12 months, 34 plans for adoption have been changed and the rationale for these includes courts not granting a placement order and the authority reversing the decision. For some children, permanence has been achieved through special guardianship arrangements or a successful return home. Although it is positive that the children have had stability with their foster carers, there have been delays of over two years for a small number of children in making the decision to change the plan in order to achieve permanence. In these cases, consideration of adoption with the existing foster carers was not timely. In 2015–16 the authority actively reviewed all cases of children waiting too long and have now secured permanence for the majority through long-term foster care.
85. There are no formal arrangements for concurrent planning, but twin-track planning for some children has been effective in reducing delays. The limited progress in securing 'foster to adoption' carers and continuing low numbers, one in 2014–15 up to four in 2015–2016, means that there are missed opportunities to secure permanence and avoid unnecessary delays for some children. The authority acknowledge this challenge and is ensuring that this option is explored with prospective adopters.
86. A range of options are pursued for family-finding, including activity days and collaborations with local adoption agencies and access to national adoption links. The authority has been successful in finding families for harder to place children. For example, in 2015–16, 49 children from Black and minority backgrounds, and 24 brother and sister groups of two, and two brother and sister groups of three, were placed. While the district judge has commended

the quality of assessments of whether brothers and sisters should stay together or be separated, the arrangements for contact between the children is not always clearly identified. Establishing the accuracy of adoption data about the number and progress of children who have disabilities and the number of older children who have been adopted is problematic.

87. The adoption panel has appropriate processes in place to consider recommendations for approval and matching. Suitably senior agency decision-makers are now making timely decisions and plans are under way for more regular meetings with the panel chairs. More effective quality assurance by the panel informs areas for development, such as improving the quality of child placement reports (CPRs) and as a consequence additional training was provided to staff. CPRs now demonstrate improvement and provide appropriate information about the child's journey, their experience and the rationale for adoption. Children's wishes are taken into account where possible. One young person expressed their strong desire to no longer be 'associated' with being a child looked after and made this clear to the social worker, as they wanted to be adopted by their long-term foster carer, and this positive outcome was achieved.
88. The adoption panel could better explore children's identity, especially when a child of mixed parentage is considered for placement with white adopters, or adopters of a culturally mixed background. It is not consistently clear how adopters will address identity issues as children grow up and become more culturally and racially aware. While social workers say that they do scrutinise prospective adopters' attitudes to diversity, the prospective adopters' reports also show the same limitations in this important area. (Recommendation)
89. Life story work is not consistently completed at the right time. For example, the life story work for six children was incomplete, and one child has been waiting since 2015 for this important work. While one adopter praised the timeliness and positive impact of life story work and the book for their child, another said that they have been waiting for this to commence. The quality of life story work and life story books is variable. Some life story books are excellent, focusing on the child's journey, capturing their history and ongoing experiences in a helpful, sensitive manner. Others are less child-friendly, with too much use of jargon and lacking personal information to help young people make sense of their history.
90. Children are prepared well for the transition from foster care to their adoptive family. Effective support plans identify direct work to support children. For example, pictorial imagery is used effectively to help children to recognise and identify the people in their lives.
91. No delay was found from the point of enquiry to the prospective adopter initial visit, but the quality of the initial visit assessments was variable. Unclear recording limits the understanding of the information provided by the prospective adopter. One adopter described the adopter preparation,

assessment and training as 'excellent and exacting' and that it provided confirmation of whether adoption was the right choice for them. Adopters were clear that the training prepared them well for the challenges associated with adoption. In 2014–15, 45 adopters were approved. This increased in 2015–16 to 70. At the time of the inspection, 25 adopters were at stage 1 and 20 were at stage 2 of the recruitment process. It is encouraging that the authority has 16 approved Muslim adopters, with seven currently awaiting placement.

92. The post-adoption support team helps adopters and children before and after adoption, including access to the team's clinical psychologist. Appropriate individual and group support is available through a commissioned adoption agency. The offer of therapeutic parenting training assists adopters with their new roles and attachments with children. A good example is the positive impact on an adoptive child of six years, after difficulties in engagement at school emerged. The support plan included one-to-one support in school and counselling for both the child and the adopters and access to a clinical psychologist via the adoption support fund. The adopter reported that the support had helped her child to, 'begin to make sense of his situation and environment.'
93. An increasing number of adoptive families received effective support, including support from Adoption Support UK, 47 families are accessing the adoption support fund, counselling is offered to birth families and adopted adults received birth records counselling and access to records. Letterbox contact is available with 1,193 such arrangements.

**The graded judgement about the experience and progress of care leavers is that it requires improvement**

94. Considerable work has taken place since the last inspection to improve practice. Young people say that they feel well supported by their aftercare advisers and show confidence in seeking advice and support when they need to. Personal safety and keeping safe are key themes which are regularly discussed with care leavers, and when interventions are required they are duly recorded. Risks are carefully assessed, and particularly so when moving towards independence and in the allocation of housing. When necessary, management oversight is timely and decisive.
95. Training has been implemented to strengthen relationship-focused work and some good examples were seen where this is beginning to have a positive impact on young people's lives. The local authority is in touch with 97% of care leavers, which is better than the England average of 88% in 2015–16. Of 469 care leavers (19 to 21 year-olds) only 14 no longer have contact with the service. Aftercare advisers are experienced and use their skills and

relationships effectively to support them and keep them engaged. Caseloads are becoming more manageable, and the local authority has identified a need for a newly established team to lead and support work with unaccompanied asylum seekers and care leavers who have special educational needs and/or disabilities to increase the capacity and strength of the service.

96. The quality and timeliness of pathway plans are not consistently good. There is still much work to do to ensure greater consistency of practice across all the care leaving teams. In some instances, plans were not completed to timescales and action planning was cursory. New electronic pathway plans have been recently introduced, with a much stronger focus on the voice of young people. Oversight and quality monitoring are more rigorous, which ensures that in the majority of cases plans are thorough and the views and wishes of care leavers are well documented. As a result, planning in the best examples was well-defined with a stronger focus on outcomes. However, some care leavers have expressed concerns that the new style of plan is overly personal rather than focusing on more practical issues. Some advisers also expressed concerns that the plans were taking longer and this was causing some delays in completion.
97. Joint transition planning between the 16 to 18 social work teams and the 18+ service is inconsistent and for some young people happens at too late a stage. Planning for transition began for some individuals in their mid-17th year, giving them little time to explore concerns about, for example, readiness for independence and accommodation options. Transition planning for children looked after who have special educational needs and/or disabilities is more effective and well targeted in ensuring that appropriate housing solutions and specialist services are commissioned in a timely way.
98. Overall, there is good attention to medical and health issues for care leavers. They know how to access the right services when they need them and there is support to arrange local registration with a doctor, dentist and optician. Specialist health services are available in a variety of locations around the city, including sexual health and drug and alcohol services. When living out of the area, aftercare advisers help care leavers to locate and access relevant services when necessary. Designated nurses provide support to those care leavers who have special educational needs and/or disabilities in completing new forms for disability and personal independence payments.
99. A bespoke service for children and young people who are looked after, the therapeutic emotional support service, receives many referrals and is providing a reliable and immediate service for those care leavers needing emotional support and guidance. However, waiting times for the newly configured child and adult mental health service, Forward Thinking Birmingham, are at times excessive because children looked after and care leavers do not currently receive prioritised treatment. It was unclear from case records whether care leavers had received information about their health histories prior to leaving care. Aftercare advisers were equally unsure. A

review is to be implemented to improve this practice and ensure that information has been appropriately passed on to each care leaver.

100. Care leavers are aware of their entitlement to services and they receive good support to access information about, for example, legal rights, benefits and financial help they can receive. Good examples were seen of aftercare advisers helping care leavers to apply for duplicate birth certificates and passports. In job centres across the city, welfare rights 'champions' work closely with the 18+ service, and help care leavers to navigate the benefits system and seek employment.
101. Most 16 to 18 year-old care leavers are in education, employment or training and there has been a gradual reduction in the not in education, employment or training (NEET) cohort to 13% (53 of 406). The virtual school headteacher has developed a number of strong partnerships across higher and further education, training and business sectors to increase the range of opportunities to prepare care leavers for more positive pathways. The corporate parenting board's mentoring programme, for children looked after and care leavers in the city and out of area, is a positive development. Over 200 mentors have been recruited and offer a range of one-to-one learning support as well as help with job search, interviewing techniques and writing curricula vitae.
102. Currently 54% of care leavers known to the 18+ service are in education, employment or training, and of this group 15% (101) are in higher education. Of real concern, however, is the stubbornly high percentage of young people who are NEET. At 46%, higher than the national average of 40%, this has not reduced significantly since the last inspection. Progress has been too slow. Significant barriers continue to block progress, particularly for those in care who have not fared well in English and mathematics while at school. For example, a care leaver who had successfully completed an entry-level childcare programme at college could not move on to the level 1 course because she did not have functional skills qualifications. (Recommendation)
103. More focused work is in progress within the council and with training and employment partners to improve opportunities for care leavers. Although it is too early to see significant impact, new pathways are beginning to emerge across the city, including joint funding with another local authority of £50 million for a youth employment initiative targeting vulnerable young people, including care leavers. An effective partnership has developed between the virtual school and the 18+ service with the University Hospitals Trust to open up opportunities for care leavers in work experience and training in the public health sector, and 11 care leavers have also recently started a pre-apprenticeship programme with a construction company, and full apprenticeships will be offered to those who complete the programme successfully. To date, however, very few opportunities have been offered by the council that prioritise care leavers for placements, and this is a significant gap. (Recommendation)

104. The 'staying put' policy has been revised since the last inspection, with improved attention to ensuring more gradual transition from care to adulthood. Take-up has more than doubled, from 35 in 2014, with currently 77 care leavers choosing to extend their fostering arrangements on their 18th birthday. A higher proportion of young people are choosing to stay in care until their 18th birthday, at 73% against 68% nationally.
105. Good work is undertaken to make sure that the right accommodation is available and appropriate for care leavers. The care leavers' accommodation and support framework provides a helpful pathway in identifying the range of options available to them. All provision must meet 'the Birmingham standard', a commissioning validation tool, to ensure that quality standards are met. Approximately 94% of care leavers were in suitable supported and independent accommodation on 31 August 2016, which has improved over the year. Placement stability was good. Multi-occupancy accommodation was used only when it had been assessed as suitable for the young person. Risk and protective factors regarding a young person's safety and well-being are prioritised in the placement process, whether they are being housed in Birmingham or out of area. A number of examples were seen where care leavers had been appropriately rehoused out of Birmingham for their safety and protection.
106. For care leavers who have special educational needs and/or disabilities, support is targeted well through the council's provision of appropriate housing and commissioning of specialist services. The small cohort (13) of care leavers in custody receive regular visits by their aftercare advisers and preparation for leaving is prioritised. In some instances, this work had been undermined by inaccurate or short-notice information about actual release dates from the custodial placement, leaving very little notice for the 18+ service to make sure that the right accommodation in the right location was available.
107. Aftercare advisers and care leavers have been involved in monitoring and assessing the suitability and quality of accommodation, as well as testing the support arrangements offered by a range of council and private housing providers. Bespoke packages of support towards independence are in place and floating tenancy arrangements are made for those new to tenancies or who might need extra help in becoming independent. Emergency accommodation is sufficient and well-regulated to meet requirements should placements break down or if needs are unmet. The Youth Hub, a nationally recognised service established by St Basil's voluntary organisation, is an important and well-used facility to address emergency placements as well as the housing and homelessness needs of young people living and arriving in the city. A key partner with the council, it also provides staff training and accredited life skills programmes supporting care leavers in their move towards independent living.
108. Two well-attended rewards evenings were held this summer for care leavers. Academic achievement and participation in training and activities to develop

their confidence and skills were celebrated. The newly established care leavers' forum has begun to engage in broad policy discussions with senior officers and the corporate parenting board on a range of issues. Building on the success of the active CiCC, numbers attending are low and work to extend its representation is identified by the service as an important priority for the group.



<b>Leadership, management and governance</b>	<b>Inadequate</b>
<p><b>Summary</b></p> <p>The local authority has a history of providing poor services to children and their families. Some services continue to have serious and widespread failings that have not been tackled effectively. Against this background, strategic leaders have an increasingly effective focus on improvement and have invested in services to support this. This has been helped by stronger and more joined-up leadership at a council-wide level from both political and strategic leaders. Because of this, some important steps forward have been taken within the last year, including a sharper focus on frontline practice. A well-considered approach to workforce development has been successful in ensuring that there is a sufficient and relatively stable workforce. Services for children looked after, care leavers and those who could benefit from adoption, which were graded inadequate by Ofsted’s last inspection, have improved. Some improvements are very new or yet to have a full impact in ensuring better outcomes, and significant barriers to further improvement remain. Despite this, those improvements that have been achieved, and an increase in the pace of improvement, provide a foundation for further progress.</p> <p>Frontline management oversight and decision-making, particularly of unqualified staff within the MASH, is not consistently effective in ensuring that risk is identified, or that interventions are matched to the levels of children’s needs and risks.</p> <p>Strategic planning to address child sexual exploitation is weak, with planning for improvement at an early stage. There is a lack of focus on understanding the impact of services in reducing risk, including understanding the links between children missing and continuing risk.</p> <p>Service development for children in need of help and protection is not sufficiently informed by analysis of intelligence and performance information or by a strong enough focus on understanding the impact that services are having on reducing risk.</p> <p>Performance management, strategic improvement planning and quality assurance processes are not consistently used to identify and improve performance and lack a focus on impact. The local authority has an unclear and sometimes over-optimistic picture of the progress it is making. Multi-agency working at both strategic and operational levels is not consistently effective. It is not well joined-up, lacking clarity and coherence. This has limited the pace and extent of progress, particularly when services are provided in partnership with other agencies. While most local authority-led early help work is at least adequate, and some is good, the majority of that led by partner agencies is very poor. Although yet to have a significant impact on improving frontline services to children, the establishment of the children’s strategic leaders’ forum and the early help and safeguarding</p>	

partnership have been important in beginning the process of creating a shared strategic approach.

## Inspection findings

109. This inspection has found that some services continue to have serious and widespread failings that have not been tackled effectively. These are primarily for children and young people in need of help and protection but the failings have an impact across all services. Against this background, strategic leaders have an increasingly effective focus on improvement and have invested in services to support this. The appointment of the Executive Director of Children's Services (EDCS) has led to a sharper focus on frontline services. This has been supported by stronger and more joined-up leadership at a council-wide level from both political and strategic leaders. Because of this, some important steps forward have been taken within the last year. Services for children looked after, care leavers and those who could benefit from adoption, which were graded inadequate by Ofsted's last inspection, are now improved. Some of these improvements are very new or yet to have had an impact, and significant barriers to further improvement remain. Such barriers include an electronic case recording system that does not best support good social work practice and partnership working that is frequently poor. Despite this, those improvements that have been achieved and an increase in the pace of improvement provide a foundation for further progress.
110. Managers in the MASH are not overseeing the work of unqualified referral and advice officers consistently enough or well enough to ensure that they make the right judgements, nor are their own decisions consistently right when evaluating risk. This means that children do not always receive the right services, or receive them quickly enough, and in some cases children have been left at continuing risk of significant harm. This lack of effective management oversight has also meant that many children who have disabilities, and who are in need of help and protection, have not been seen regularly, nor have they had plans to support their welfare reviewed. Although this service has recently been brought under children's safeguarding line management, much work remains to be done to ensure that it is fit for purpose. (Recommendation)
111. Work to tackle child sexual exploitation is inconsistent and much is poor. Strategic planning to tackle child sexual exploitation is not good. It lacks sufficient connection to work to protect children and young people who may be at risk as a result of going missing, and lacks a strong enough focus on understanding the impact of services in reducing risk. Work to reduce risk is not sufficiently advanced, and neither it nor wider service development is informed by sufficient analysis of intelligence and performance information. For example, delays in holding MASE meetings have only recently been reduced to approximately four weeks, and the practice of providing much quicker 'emergency slots' to discuss the cases of children whose situations are

urgent was only introduced four weeks before the start of the inspection.  
(Recommendation)

112. Services for children missing from home or care are poor, particularly so for those missing from home. Return home interviews (RHIs) are only being completed for a minority of children who go missing. Of these, two thirds take over 72 hours to complete and they are not then consistently copied into children's electronic case files. Children's plans are not routinely informed by RHIs, nor are themes from RHIs used to inform service planning. This work is not well aligned with work to counter child sexual exploitation. Planning for improvement is at an early stage.
113. Performance management systems and meetings are not being used to tackle significant deficits in some important areas of practice, such as child sexual exploitation, protecting children who go missing and those who live in homes where there is domestic abuse. The effective use of such systems to understand and improve performance is also hampered by ongoing challenges with data quality. More broadly, the electronic case recording system does not best support high quality work with children and families. Performance management and quality assurance systems are not closely enough aligned and there is insufficient emphasis on the quality and impact of practice. With the exception of an audit of assessments carried out by the three principal social workers (PSWs), thematic audits are not being used to identify or help improve poor practice. Although the use of practice evaluation forms has become progressively more embedded during 2016, findings have not been well used to identify or tackle areas of poor practice, such as inconsistent threshold decision-making in the MASH. Feedback from children and their families is increasingly being gathered, which is a positive improvement, but this is at a relatively early stage and is not used alongside performance and audit information to help understand the impact of practice.  
(Recommendation)
114. Despite these limitations, performance management and quality assurance systems have undergone significant development during 2016. The structure of performance meetings, from the senior management 'quartet' at a strategic level, through city- and area-level meetings, provides a sound framework for considering performance. It provides senior managers with a line of sight to the frontline and gives frontline and middle managers a framework to understand and improve some areas of performance. The performance evaluation service and PSWs are increasingly well integrated into this structure. This is beginning to have an impact in some areas of practice. Improvements have been achieved in the timeliness of assessments and initial child protection case conferences. This means that children are more likely to have their needs assessed and to receive appropriate and timely services.
115. Since the last inspection, improvement planning has largely focused on the right things, but has paid too much attention to simply checking whether agreed actions have happened and too little to whether those actions

achieved improvements in practice and in children's outcomes. This has sometimes led to an over-optimistic assessment of progress, and means that the local authority cannot always be clear that desired improvements in the quality of practice and in outcomes for children have been achieved. For example, if overview and scrutiny reports on progress in tackling child sexual exploitation or monitoring of the implementation of the MASH had a stronger focus on quality and impact, deficits in practice which were identified by inspectors may have been picked up earlier. Although further work is required to shape a functional framework for early help services, the current arrangement of the Children's advice and support service, ASTI, safeguarding, children looked after and leaving care teams provides a coherent framework for the delivery of statutory services.

116. Multi-agency working at a strategic level is not consistently effective. It is not well joined-up, lacking clarity and coherence. Birmingham's joint strategic needs analysis contains a number of gaps in important information, for example about children living in homes where domestic abuse or parental mental ill-health are a feature. A July 2016 partial update still contains gaps and is too recent to have had an impact on improving services. This incomplete package of information, not linked to any shared multi-agency set of priorities, clear commissioning or monitoring plan, makes it more difficult for agencies to work together effectively to improve outcomes for children, to hold each other to account for delivery or to understand what difference they are making. Despite these gaps, the local authority has provided leadership to partner agencies, by driving the establishment of the children's strategic leaders' forum and the early help and safeguarding partnership. Although yet to have a significant impact on improving frontline services, these groups have been important in beginning the process of creating a shared strategic approach, for example through the recent adoption by agencies of the early help outcomes framework. (Recommendation)
117. Partner agencies have not been successfully engaged in providing early help work. Of over 4,500 children and young people receiving early help services at the time of the inspection, 2,882 were being supported by the local authority's own family support services and 752 by the youth offending service, compared to only 1,046 being supported through CAFs with partner agencies taking the role of lead professional. While most local authority-led early help work is at least adequate and some is good, the overwhelming majority of examples seen by inspectors where work was led by partner agencies is very poor. Weak tracking and evaluation systems, and no current electronic CAF recording system, make it difficult to drive improvement through performance management. The duplication of CAFs alongside child in need or child protection plans for some children is particularly confusing. (Recommendation)
118. The creation of the commissioning centre of excellence has been an important advance in establishing an effective approach to commissioning. However, the quality of commissioning remains inconsistent and there is much more work to do to embed the centre's approach. While early years services have been

mapped against need and recommissioned, a similar process for early help and targeted services is yet to be completed. Contract management does not always ensure that commissioned services consistently deliver against contract specifications and children's needs, as seen with the poor completion rate and timeliness of RHIs. In an improving, but still inconsistent, commissioning landscape, there are a number of examples of good practice. These include: an improved approach to recruiting agency staff via a master-provider contract and agreed regional price-cap, leading to better value for money and an improved ability to transfer capable agency staff to permanent contracts; an improved 0 to 25 CAMHS service, including reduced waiting times and a rapid response team helping to avoid hospitalisation; and a recently established young people-specific sexual health service for which young people were involved in the specification and tender processes.

119. The corporate parenting board has been working with the CiCC to establish and refine its work plan. Clear governance arrangements now oversee the board and its work effectively. Although the board has achieved some improvements, it is still at an early stage of considering the full range of issues for children looked after. For example, the board has not considered the IRO annual report and, although it secured a number of refurbished laptops for children looked after, did not know how many children looked after had access to a computer or laptop at the time of the inspection. It has, however, established itself as a key driver in improving services for children looked after and has ensured that nearly all councillors have had training about their corporate parenting responsibilities.
120. Data and management information have been used effectively to underpin planned activity in a recently published sufficiency strategy. Although the strategy lacks specificity about current or projected numbers of children looked after, it is a well-considered document that provides a structure and evidence base for planning to meet need. Good use is made of results-based contracting and a mixed economy of providers and partner agencies.
121. A well-considered approach to workforce development has been successful in establishing a sufficient and increasingly stable workforce. The percentage of permanent, as against agency, staff has improved and both vacancy rates and staff turnover have reduced. Focused advertising, 'golden hellos', retention payments and 'no-penalty' conversion of agency staff have been elements of this approach. Additional investment has supported improved staffing levels, and this has helped to ensure that staff have manageable caseloads. Children are now more likely to be able to build a relationship with a social worker who does not change and has the time to visit regularly. The support and progression package for social workers in their assessed and supported first year in employment is strong, and social workers generally speak positively of the support and development opportunities they receive. Almost all social workers receive regular supervision and this is continuing to improve. Between 1 April and 30 June 2016, 86% of social workers received supervision at least monthly. The impact of systemic supervision training received by team

managers can be seen in improved reflection and learning in more recent supervision records.

122. Evaluation of the impact of training in improving practice is underdeveloped. Workers are asked to complete an electronic evaluation form between five and 30 days after attending training. This is too soon to show if it is improving practice, and has a completion rate of only 26%. The training 'offer' has recently been matched against the core competencies expected of staff, as outlined in a practice framework, but has not been matched against areas of poor practice identified through audit or performance management. This means that the volume and focus of training is not well aligned with areas of performance most in need of improvement.
123. The chief social worker (CSW) and PSWs are being progressively well used. The CSW meets regularly with the chief executive, DCS and EDCS, and the PSWs are well integrated into area management structures. This approach is beginning to have a positive impact. An audit of single assessments, carried out earlier in the year, led to a revision of the assessment template and this has supported recent improvements in practice. However, their role is at a relatively early stage, with much still to do, such as the roll-out to all staff of evidence-based tools, the creation of a stronger link between the PSWs' oversight of practice and the learning and development 'offer' and further work to improve planning.
124. Work to counter the risks to young people from radicalisation is in place and there are some examples of good practice and well-targeted work reducing risk for young people. This is true at an individual level, where the 'Prevent' duty is well joined-up with mainstream safeguarding work, and at a strategic level, where the local counter-terrorism profile drives awareness training in schools and other settings, as well as targeted interventions with vulnerable communities and groups.

## **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.

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### **The inspection team**

Lead inspector: Peter McEntee

Deputy lead inspector: Dominic Stevens

Team inspectors: Jenny Turnross, Tracey Metcalfe, Jansy Kelly, Janet Fraser, Alison Smale, Tara Geere, Stella Butler, Lolly Rascagneres, Christy Wannop, Fiona Millns

Shadow inspectors: John Roughton

Senior data analysts: Stewart Hartshorne, Judith Swindell

Quality assurance manager: Lynn Radley

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Manchester  
M1 2WD  
T: 0300 123 4234  
Textphone: 0161 618 8524  
E: [enquiries@ofsted.gov.uk](mailto:enquiries@ofsted.gov.uk)  
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