Dudley Metropolitan Borough Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 11 January to 8 February 2016

Report published: 5 April 2016

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

Executive summary

There are serious and widespread failures in the services provided to children and young people who are in need of help and protection and who are looked after in Dudley. The local authority has been aware of the deficits for some time, but has not taken sufficiently swift or robust remedial action to ensure that the most vulnerable children and young people are protected. This means that senior leaders and elected members cannot be assured that children and young people are safe or being effectively protected. Further, the long period of inaction means that many services have deteriorated since the last inspection of safeguarding and children and young

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

people looked after in 2012. The majority of areas that were found to require improvement at that inspection have not been progressed.

Inspectors referred 21 cases about which there were serious concerns back to the local authority and some about which the local authority needed to take immediate action. These included children and young people not receiving adequate levels of support and protection, children and young people not seen by social workers for unacceptably long periods, poor planning for children and young people looked after returning home and delays in securing permanence.

The current senior leadership team, which was established in April 2015, identified serious and widespread weaknesses in services for children and young people in May 2015. Senior leaders are now making concerted and appropriately focused efforts to tackle a legacy of deteriorating services. However, the local authority is working from an extremely low base and required improvements will take a significant time to result in real and sustained change in the experiences of children and young people. An improvement board has recently been established by the director of children's services (DCS) to oversee the delivery of an improvement plan. However, too many children and young people have experienced drift, delay and further risk because the local authority has been too slow to decide what needs to change in a family if it is going to be safe for children and young people to remain. Weak management oversight, supervision and quality assurance processes mean that poor practice has gone unchallenged and children's and young people's needs have not been met. Additionally, elected member scrutiny is significantly underdeveloped and does not yet offer robust challenge to the local authority about the effectiveness of services for the most vulnerable children and young people in Dudley.

Assessment of the needs of children, young people and families takes too long. In too many cases, children and young people wait unacceptably long periods to be seen by a social worker. Recording of work is often of poor quality or absent. Children and young people assessed as needing statutory support often do not have a child in need plan. When children and young people are deemed to be at risk or have been subject to abuse, multi-agency core groups do not meet within appropriate timescales and do not consistently progress plans or take agreed actions to minimise risk. Neglect is a significant feature in Dudley, but there is no partnership-wide strategy to address this. Opportunities to identify neglect at an early stage and to take action are missed, and the unacceptably poor quality of chronologies contributes to this.

Planning for children and young people in care is poor. In many cases, it is not clear how their needs will be met, by whom and when. Dudley Council does not find permanent homes quickly enough for children and young people looked after. This means that many children and young people wait too long to be adopted, and some children and young people remain in care even when it is safe for them to return home.

Aspirations for children and young people looked after are too low and are not sufficiently challenging. Their achievements are not celebrated, and the corporate

parenting role is poorly developed. Educational outcomes for children and young people looked after are poor, and the educational attainment gap for children and young people in the care of Dudley has widened considerably despite a recent small improvement on that achieved by children and young people in England. Children and young people in the care of the local authority are not given enough help to attain their potential, and outcomes for these children and young people are likely to be poorer as a result.

The emotional health needs of children and young people looked after and care leavers are not being identified quickly enough, nor are prioritised by child and adolescent mental health services (CAMHS).

Poor infrastructure means that the gathering and analysis of reliable performance information remains a significant challenge to the local authority, and some key information remains inaccurate. This means that leaders and managers cannot be assured that they are effectively measuring and tracking progress.

Arrangements to manage and offer support to those children and young people at risk of being sexually exploited are improving. These include the creation of a multi-agency child sexual exploitation team to identify and monitor children and young people identified as being at risk. However, children and young people looked after who are identified as being at risk of child sexual exploitation do not have effective safety plans in place.

The recent implementation of a single point of access to accept and manage all contacts and referrals is a positive and welcome development. It has resulted in improved timeliness of appropriate initial decision making.

A good range of services supports children, young people and parents experiencing domestic abuse. Arrangements for identifying those at risk involve an appropriate range of partner agencies.

The majority of care leavers are in education, employment or training and almost all are in suitable accommodation. Support is available for young people to move to independence but needs to be more robust in content and delivery. Transition planning to adult services needs to begin earlier to ensure that the right services are in place at the right time.

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The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates five children's homes. Four were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements was in November 2011. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children and young people looked after was in November 2011. The local authority was judged to be good.

Local leadership

- The Director of Children's Services (Strategic Director for People) (DCS) has been in post since 31 March 2015.
- The DCS is also responsible for adult social care, education and health and well-being.
- The chair of the LSCB has been in post since June 2013.

Children and young people living in this area

- Approximately 67,900 children and young people under the age of 18 years live in the Dudley borough. This is 22% of the total population in the area.
- Approximately 22% of the local authority's children and young people are living in poverty.
- The proportion of children and young people entitled to free school meals:
  - in primary schools is 16.3% (the national average is 15.6%)
  - in secondary schools is 15.3% (the national average is 13.9%).
- Children and young people from minority ethnic groups' account for 17.3% of all children living in the area compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Pakistani, White and Black Caribbean, and Indian.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 13.4% (the national average is 19.4%)

[2] 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 7.8% (the national average is 15%).

Child protection in this area

- At the time of inspection, 1,313 children and young people have been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,126 at 31 March 2014.
- At the time of inspection, 339 children and young people are the subject of a child protection plan. This is an increase from 305 at 31 March 2014.
- At the time of inspection, 15 children and young people live in a privately arranged fostering placement. This is an increase from six at 31 March 2014.
- Since the last inspection, five serious incident notifications have been submitted to Ofsted, and one serious case review was ongoing at the time of the inspection.

Children and young people looked after in this area

- At the time of inspection, 708 children and young people are being looked after by the local authority (a rate of 104.7 per 10,000 children and young people). This is a reduction from 755 (111.6 per 10,000 children and young people) at 31/03/2014. Of this number:
  - 361 (or 51%) live outside the local authority area
  - 55 live in residential children's homes, of whom 62% live out of the authority area
  - none live in residential special schools
  - 414 live with foster families, of whom 54% live out of the authority area
  - 62 live with parents, of whom 29% live out of the authority area
  - one child is an unaccompanied asylum-seeking child.
- In the last 12 months:
  - there have been 39 adoptions
  - 36 children and young people became subjects of special guardianship orders
  - 217 children and young people ceased to be looked after, of whom 5.5% subsequently returned to be looked after
  - six young people ceased to be looked after and moved on to independent living
  - no young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Urgently implement quality assurance processes so that senior leaders can be assured of the quality and effectiveness of the services that children and young people receive, including feedback from children, young people and their families (Page 33, paragraph 126).

2. Ensure that all children and young people assessed as in need have a child in need plan. Improve the quality and consistency of record keeping (Page 14, paragraph 42).

3. Improve the quality of assessments and plans to ensure that they are of consistently good quality, with a clear focus on the needs, risks and strengths of the children and young people, and that outcomes, timescales and accountabilities for actions are clear (Page 13, paragraphs 33, 34).

4. Establish reliable IT systems and infrastructure to ensure support of social work practice and effective collation of performance information (Page 33, paragraph 125).

5. Ensure that initial child protection conferences and core groups are timely and used to drive child protection plans to improve outcomes for children and young people (Page 14, paragraphs 39, 40).

6. Ensure that strategy discussions and decisions are informed by the involvement of all relevant professionals, and clearly record the rationale for the decisions and agreed timescales for actions (Page 13, paragraphs 37, 38).

7. Develop suitable arrangements to share and analyse information gathered from return interviews to reduce future missing episodes for individual children and young people, and to inform partnership prevention and disruption activity (Page 15, paragraphs 45, 47, 49. Page 22, paragraph 79).

8. Ensure that social work visits to children and young people are regular and purposeful, that children and young people are seen and seen alone, and that records of visits are consistently recorded on case files (Page 12, paragraph 32. Page 19, paragraph 64).

9. Ensure that there is sufficient capacity in the emergency duty service to meet the needs of children and young people (Page 12, paragraph 30).

10. Undertake a review of the permanence needs of all children and young people looked after, and ensure that permanence is achieved in a timely way. (Page 18, paragraph 57. Page 19, paragraphs 59, 62. Page 20, paragraphs 67,68)

11. Improve the effectiveness of the virtual school and the quality of personal education planning to ensure that children and young people looked after achieve their potential (Page 21, paragraphs 72, 73. Page 22, paragraph 76).

12. Ensure that appropriate consideration is given to implementing public law outline (PLO) processes where children and young people are at risk and timely progress in minimising risk is not being made (Page 19, paragraphs 60,62).

13. Improve the quality of care planning to ensure a focus on permanency and that plans are progressed without delay (Page 19, paragraph 63. Page 20, paragraph 66).

14. Ensure that transition planning processes between children's services and adult services are reviewed to ensure timely assessments of needs and of how the young people's needs will be met at the point of adulthood (Page 29, paragraph 113).

15. Ensure that the emotional well-being of all children and young people looked after is given priority by securing a range of services that will meet their psychological and mental health needs as soon as they are needed (Page 22, paragraph 78).

16. Revitalise the Children in Care Council to ensure that the voices of children and young people are heard and that the council understands and acts on their views and concerns (Page 23, paragraph 82).

17. Ensure that elected members effectively discharge their corporate parenting responsibilities and scrutiny functions (Page 23, paragraph 81).

18. Ensure that adoption is considered for all children and young people who may benefit from it and that sustainable processes are in place to reduce timescales and delay for children and young people (Page 23, paragraphs 84, 85. Page 24, paragraphs 88, 89).

19. Ensure that adopters receive timely support to match their needs and that post-adoption letterbox services provide timely support for children, young people, birth parents and adopters (Page 26, paragraph 100).

20. Ensure that pathway plans are reviewed rigorously by a non-case holder (Page 28, paragraph 111).

21. Ensure that entitlements for care leavers are made clear and that the care leavers' charter is reviewed so that it is unique to Dudley and created and shared with Dudley care leavers (Page 29, paragraphs 115, 116).

22. Review the robustness of arrangements for reporting and follow up on complaints to ensure that learning is not lost and that children and young people have a range of methods available to them to make complaints when they need to (Page 34, paragraph 131).

Summary for children and young people

- New leaders started to work with the council in 2015 and quickly recognised that they needed to make a lot of changes so that children and young people in Dudley are safe and well supported.
- These leaders have started to make some of those changes, but because there is still a great deal to do, Ofsted has judged the services to children and young people as still not good enough and needing to improve as soon as possible.
- The services to help children, young people and families in Dudley are not always working well together, and are not always being provided at the time when families need them. The council knows this and plans to make sure that, in future, children, young people and families get the right help at the right time.
- Some children and young people who are at risk are not helped or made safe quickly enough. Professionals need to work better together to make sure that action is taken quickly. Social work managers need to make sure that they help social workers make the right decisions at the right time to keep children and young people safe.
- When children and young people come into care, the plans for their future are not always clear. This means that some children and young people who should live with a family do not get to become part of a permanent family quickly enough. Social work managers have started to make improvements by making sure that there are clear plans for children and young people before they come into care, and that children and young people are supported to live with the right family for them as quickly as possible.
- Children and young people in care do not always do as well as they could at school. Teachers and social workers need to work more closely together to make sure that children and young people do as well as they can.
- People who work with children and young people do not always ask or listen to their views. They need to make sure that the views of children and young people are heard when they are making plans and talking to them about the future. Managers also need to make sure that the views of children and young people help to make services better.
- Care leavers are not always properly helped to get ready for adulthood and to live on their own. Most care leavers live in places that are right for them. Most but not all care leavers are in education, training or have a job, but more could be done to make sure that young people get a better start as they leave care. The vast majority of care leavers are supported by their personal advisers, but sometimes that support could be better, particularly by making sure that other services provide help when it is needed.

The experiences and progress of children who need help and protection	Inadequate

Summary

The experiences and progress of children and young people who need help and protection are inadequate. Serious and widespread failings across the main social work teams leave children and young people at risk of harm.

The local authority knows what it needs to improve and is working to ensure that structures and procedures are in place for that. However, fundamental basic social work practice remains poor in too many cases. Management oversight and supervision of staff is weak and leaves poor practice unchallenged.

At the time of the inspection, 33 children and young people did not have an allocated social worker. Some had been waiting for as long as 17, 25 or 29 days and up to three months, so were without purposeful statutory involvement to assess and meet their needs.

Social workers do not visit children and young people regularly enough, with sometimes unacceptably long periods between visits. Assessments take too long and lack a clear analysis of risk. Planning for children and young people is not outcome focused or individual to children's and young people's needs and objectives are not measurable. Not all children and young people in need have a written plan. Documents and case records are not up to date or stored systematically.

Records of strategy discussions and child protection enquiries vary too much in quality and lack detailed planning or proper consideration of roles, responsibilities and timescales for completion of actions. Initial child protection conferences are not timely enough. The service for children, young people and their families who need support and intervention out of office hours is poorly resourced. Children and young people frequently wait for unacceptably long periods for a response.

Recording of interviews carried out when children and young people return after going missing is not thorough enough. Information derived from interviews is not used adequately to analyse patterns and trends.

Poor attendance by social workers at the young person's sexual exploitation (YPSE) panel has led to significant delays in reviewing and addressing risks to children and young people. As a result, opportunities to intervene at an early enough stage are lost.

The redesign and implementation of a single point of access has improved timeliness of contacts and referrals significantly from a low base, and provides a timely and effective response to contacts and referrals.

Partner agencies do not fully understand thresholds, and this results in a high

number of inappropriate referrals. The local authority and its partners are beginning to work together to ensure better coordination and targeting of services.

Inspection findings

23. The experiences and progress of children and young people who need help and protection are inadequate. Inspectors identified 21 children and young people in need of help and protection and who were not receiving adequate levels of support and protection. These children and young people had waited too long for a robust assessment of their needs and risks to ensure protection from harm. The local authority took swift action to intervene in all cases reported to it.

24. The local authority's arrangements to receive and manage contacts and referrals from the public and partners have very recently improved. Five weeks before the inspection, there were five access points through which to refer concerns to children's social care, which increased the risk of children and young people being lost in the system. In too many cases, decisions to progress to referral were not consistent or timely. As a result, some children and young people were left too long at potential risk, and families were not always being offered help early enough.

25. The redesign and implementation of a single point of access (SPA) in December 2015 is beginning to improve significantly timeliness of decision making about contacts and referrals from a low base – from 40% within 24 hours in June 2015 to 100% in January 2016. Social workers in the SPA have a sound understanding of and consistently apply thresholds for statutory intervention. Cases were promptly transferred to a duty referral and assessment team for further assessment and intervention.

26. A programme of work is underway to deliver early-help provision through five clusters across the borough, with the aim of reducing the current duplication of early intervention services, and to provide coordinated and targeted services. An early-help strategy has been agreed, but is not yet fully implemented. Without this strategy, children, young people and families may not receive help that is appropriate for their individual needs, or that is early enough to prevent problems increasing and to reduce the high number of children and young people whose needs could be met at a lower level being referred to statutory services.

27. Performance management information is weak, with no centralised system in place to report child assessment framework (CAF) activity or to monitor progress or quality assurance of assessments under CAF. This means that the local authority is unable to target improvements to early-help services and to provide specific training to improve quality. The commitment of professionals to undertake CAF assessments and to take on the lead professional role is too variable, with a number reluctant to become fully involved. In the last six

months, only 169 CAF assessments were completed with 30% being completed by children's centres. The majority of recent assessments sampled were good although a small number required improvement, with views of children and young people not fully integrated and outcomes sought unclear.

28. Investment in prevention and early intervention services has resulted in some evidence of improved outcomes. Children's centres provide a range of relevant services to parents and children, including alcohol and substance misuse services, parenting programmes and support and advice in employment. Targeted early intervention through the family intervention team (FIT) provides effective support to families identified as part of the Troubled Families programme. Some cases seen by inspectors showed improved outcomes, for instance through delivery of Triple P parenting programmes and the management of children's and young people's behaviour. Dudley has achieved successful results with 740 families. Phase two has been launched and 170 families have been allocated to the FIT.

29. Since December 2015, an early-help manager, based in the SPA, has been offering advice and support on whether early-help support can meet the needs of families, and supports the CAF. This is beginning to ensure that children and young people who have identified needs but who do not meet thresholds for a statutory service are signposted to the appropriate level of service within early help. Case sampling by inspectors demonstrated appropriate application of thresholds.

30. The service for children, young people and their families who need support and intervention out of office hours is insufficiently resourced. As a result, children and young people do not receive a good enough service. Inspectors saw cases where children and young people who needed urgent intervention and accommodation had remained in the care of police overnight due to the insufficient capacity of the out-of-hours service. This is unacceptable and is likely to be a worrying experience for children and young people.

31. Some children's and young people's cases have remained open to children's social care for longer than necessary when they could have been stepped down to early-help services or closed. Children in need panels established in August 2015 to review all children and young people in receipt of statutory services identified that 377 cases out of 773 reviewed to date do not require a social worker to be involved. In a very small minority of cases, the decision to step down was premature as needs were not fully assessed and met. The local authority has not undertaken any monitoring to track re-referrals of these specific cases, and this is a missed opportunity to improve practice.

32. In some cases, children and young people experience unacceptable delays in social workers visiting them. In the worst cases seen, the delay was five months. In too many cases, it is not clear whether children and young people are seen or spoken to alone because recording in case files is absent or poor. At the time of the inspection, 33 children and young people did not have an

allocated social worker. Some had been waiting for 17, 25 or 29 days and for as long as three months. In a number of cases, case records of child protection statutory visits are blank. During the inspection, the local authority reviewed all children and young people subject to child protection plans to assure themselves that visits are being completed. Statutory visiting to children and young people subject to child protection plans within the prescribed two weekly timescale of the local authority is an improving picture, from 37% of visits required in June 2015 to 78% in December 2015. However, the quality of the recording is in many cases poor, with general conversations about day-to-day activities rather than purposeful visiting to progress plans.

33. Overall, assessments take too long and are not in line with the potential risk and needs of the child or young person. Some take many months to complete. In December 2015, 38% of single assessments took longer than 45 days and just 3% were completed in 10 days. Support to children, young people and families during the assessment period is often inconsistent, resulting in children and young people waiting too long for services. Managers at the time of the inspection had a backlog (103) of assessments that required decisions to authorise further work, delaying subsequent planning and transfer of cases. Management oversight of assessments is weak and relates mainly to next-step processes rather than providing a review of the quality of the assessment and the resulting plan.

34. Some assessments are not comprehensive. The majority lack sufficient analysis of risk, and risk is often implied rather than explicitly articulated. The individual needs of children and young people are not always clear, as records are copied across groups of brothers and sisters. Neither are the diverse needs of children and young people arising from their culture, religion or ethnicity sufficiently well detailed. As a result, the specific needs of individual children and young people are not considered.

35. A small number of assessments seen during the inspection were of good quality. The Family Adolescent Support Team (FAST) mostly completed these, which included good parenting assessments that clearly identified risk and provided a good level of analysis, leading to appropriate actions to help and protect children and young people.

36. The local authority has adopted Signs of Safety as a model of social work practice. However, the model is used inconsistently by practitioners and is not embedded as a way of assessing risk and determining progress in minimising risk. This is a missed opportunity to ensure better practice. Direct work tools are not used consistently with children and young people. In examples of better work seen, specific tools are used to ascertain the wishes of children and young people, the voice of the child or young person is clear, assessments are child focused and the experience of the child or young person is effectively assessed. In addition, the FAST and Respect services provide good quality support to children, young people and families.

37. Not all children and young people benefit from well-informed and purposeful strategy discussions. For these children and young people, risks had not been properly considered, recognised or clearly defined. The vast majority of strategy discussions are telephone conversations between police and a social care manager, and do not involve other agencies. Not involving agencies such as health and education in this important process limits the range of information available and reduces the ability of those who are present to make robust decisions about next steps.

38. Records of strategy discussions and child protection enquiries vary too much in quality. The vast majority lack detailed planning or proper consideration of roles, responsibilities and timescales for completion of actions. A number of social workers had difficulties finding these records on case files. Poor recording prevents managers and newly allocated social workers from fully understanding the risks and needs of children and young people. It also means that important information about patterns of behaviour or previous concerns are not consistently available to inform decision making.

39. Timeliness of child protection conferences is improving, with 72% (year to date) held within 15 working days of the strategy discussion. However, 28% of children and young people are potentially experiencing delay between having risks identified and multi-agency consideration of plans to protect them. The quality of social work reports prepared for conferences is variable and in some cases not shared with parents, carers and the child protection chair prior to the conference. As a result, children, young people, parents, partner agencies and child protection chairs may not know what is to be discussed or recommended. This limits their ability to understand fully any concerns and to influence outcomes.

40. Core group meetings are not held regularly enough, with only 49% in time in December 2015 down from 67% in October 2015. Progress against plans and minutes of meetings are not always recorded. As a result, core groups do not sufficiently develop the child protection plan or measure progress. This significantly reduces their effectiveness in protecting or improving the lives and safety of children and young people.

41. The local authority does not ensure that children and young people routinely attend child protection conferences. Independent advocates are available to children and young people involved in child protection processes, but the take-up of advocacy support is low.

42. In the vast majority of children in need cases seen by inspectors, children and young people did not have a child in need plan. The local authority was unable to give inspectors an accurate figure of the number of children and young people who had a plan due to a legacy of poor data quality. The overall quality of children in need and child protection plans is weak. The majority lack a clear focus on outcomes and timescales, and in some cases overly focus on the needs of adults or brothers and sisters rather than the subject child or young

person. In other cases, they reflect an over-optimistic view of family engagement. Contingency planning is not sufficiently robust and timescales for alternative courses of action are not always evident.

43. At the time of the inspection, 340 children and young people were the subject of child protection plans. Neglect was a risk factor in 137 (40%) of these plans, emotional abuse in 149 (43%), physical abuse in 46 (13.5%) and sexual abuse in eight (2%). The local authority is aware that 62% of new admissions to care during 2014/15 were for reasons of abuse and neglect, compared to 56% nationally. However, the local authority does not have an inclusive strategy for addressing neglect. Without this strategy, neglect is not given a sufficiently high profile across all agencies, which means that some children and young people may be left at potential risk for too long.

44. Chronologies are not present in the majority of cases. As a result, important information is not immediately available to social workers and managers to inform decision making, assessments and plans. The lack of chronologies is a particular weakness in cases of neglect. This is a missed opportunity to identify patterns and behaviours and to ensure that robust action is taken to safeguard children and young people.

45. Recent arrangements to identify and monitor children and young people at risk of sexual exploitation are increasingly supporting children and young people, and in some cases reducing risks. A multi-agency child sexual exploitation team set up in September 2015 screens all referrals for children and young people identified as at risk of sexual exploitation, and holds multi-agency sexual exploitation (MASE) meetings. However, the quality of information sharing is poor. Social workers in the SPA do not have access to the recording system used by the child sexual exploitation team or the Missing You team. This means that, for new referrals, social workers and managers do not always know whether children and young people are already known to be at risk of child sexual exploitation or have previously had episodes of being missing. This limits their ability to ensure that children and young people are protected and receive the right help.

46. At the time of the inspection, 18 children and young people were assessed to be at high risk of child sexual exploitation, and seven were considered to be at medium risk. The YPSE panel, which is chaired by the police, reviews all children and young people known to be at high and medium risk. However, poor attendance by social workers at this meeting has led to significant delays in reviewing and addressing risks to children and young people. As a result, opportunities to intervene at an early enough stage are lost. A multi-agency audit in July 2015 concluded that children and young people continue to be at risk and acknowledged numerous missed opportunities to protect children and young people.

47. Information on the local profile of child sexual exploitation, missing children and young people, children and young people missing education, and perpetrators

is regularly discussed at YPSE panel meetings. However, information from return interviews and information about children and young people at risk of sexual exploitation and children and young people missing education are not yet brought together to create a comprehensive picture to inform planning, prevention and disruption activity. Awareness raising has taken place with education settings, transport providers and licensed premises around the possible warning signs to look out for with children and young people who may be at risk of sexual exploitation. The local authority licensing team has been successful in using their powers to revoke licenses.

48. The arrangements for responding to the needs of children and young people who go missing have been recently strengthened. The head of safeguarding chairs the newly formed children missing operational panel, which tracks and cross-references all children and young people missing from home, care and education. The panel also identifies those at risk of child sexual exploitation. However, the strategy for missing children and young people is in draft and the panel is in its infancy. Therefore, it is too early for it to have had any impact on current children's and young people's experiences.

49. The Missing You team offers all children and young people return interviews following missing episodes. However, interviews are not always timely (65% within 72 hours in December 2015), and records of interviews are not good enough, with a significant number of cases seen in which children and young people had not been successfully engaged. Information from interviews is not readily available or shared with the child's or young person's social worker or relevant professionals. As a result, important information is not available to inform future safety planning to reduce risk.

50. A specialist team works with children and young people who have disability. Risks to children who have disability are identified and addressed appropriately and are assessed, investigated and escalated in a timely way by social workers in the children with disabilities team. Transition arrangements between children's and adult services for children and young people who have disability start too late, with the majority not assessed until they are 17 years old.

51. A range of services is in place to support children, young people and their parents experiencing domestic abuse. All police notifications are initially discussed and screened by the multi-agency domestic abuse referral team (DART) using a risk matrix. When children and young people are screened as high risk, they are promptly referred to the SPA. The multi-agency risk assessment conference (MARAC) considers children and young people living in households where domestic abuse is a risk. Minutes seen by inspectors showed appropriate involvement of relevant agencies with actions and reviews followed up.

52. The system for managing allegations against adults working with children and young people has recently improved from a low base. An experienced interim designated officer is now in post. However, the service remains without an

adequate database, and this affects how progress is tracked and monitored. The local authority recognises that records have not always included rationales for decisions made or recorded outcomes.

53. There is a draft (2013) but operational joint protocol for the assessment and provision for homeless 16- to 17-year-olds, agreed by the housing department and children' services. However, managers and staff are not fully aware of its existence. In order to reduce the risk of homelessness, mediation is available through the housing youth hub to support children and young people to remain with their families. When this is not successful or appropriate, a referral for assessment and intervention is made to the SPA, which has recently strengthened the pathway for homeless 16- to 17-year-olds.

54. The local authority has processes in place for identifying and tracking children and young people missing education and elective home education (EHE) and maintains up-to-date records. Effective action is in place to locate children and young people who have not taken up their school places or who are no longer accessing education. A range of checks are completed to establish the whereabouts of children and young people. These include contact with schools, home visits and checks with other agencies. Currently, 47 children and young people are known to be in the borough waiting to be placed in education provision. Nine children and young people are on a reduced timetable, a very small number are considered to be missing from education and 197 are being educated at home.

55. Dudley is a Tier 2 Prevent priority area and has a full-time Prevent coordinator. A Prevent plan is delivered and monitored by members of Dudley Prevent Delivery Group (DPDG). Ongoing monthly workshops providing raising awareness (WRAP) training for frontline staff has significantly increased the number of referrals received about children and young people who may be vulnerable to radicalisation, although there has been none where further escalation was required. The Channel panel meets monthly and is chaired by a senior officer. Prevent ambassadors from secondary schools have been trained to deliver low level Prevent sessions to Year 7 pupils within schools.

The experiences and progress of children looked after and achieving permanence	**Inadequate**

Summary

Services for children and young people looked after in Dudley are inadequate. Too many children and young people remain in care when they could and should be cared for through alternative arrangements. There is drift and delay in securing permanent arrangements to return children and young people home or to permanent placements outside the family. The local authority is not working effectively with the

judiciary and the Children and Family Court Advisory and Support Service (Cafcass) to ensure that children and young people are subject to appropriate orders and achieving permanent arrangements in a timely way. This means that many children and young people do not know what plans are being made for their future.

Assessments are not good enough. They are not updated to reflect the changing needs or circumstances of children and young people. The vast majority of children and young people returning home do not benefit from an assessment and support plans to maximise their potential for successful rehabilitation. Too many care plans lack clear targets and timescales. It is not clear how needs will be met, by whom or when. There is drift and delay in care planning, which results in too many children and young people remaining in short-term placements and not being considered for adoption early enough.

Social workers see children and young people on their own and take time to make sure that they understand their wishes and feelings. However, 35% of visits do not take place within the prescribed timescales of the local authority.

Independent reviewing officers' (IRO) oversight of plans, including the need to secure timely permanence, is not rigorous and lacks sufficient or effective challenge to poor practice. The local authority does not have enough foster carers available to provide placement choice.

The virtual school has been ineffective in supporting the educational needs of children and young people looked after and educational outcomes for children and young people looked after are very poor. The emotional and mental health needs of children and young people looked after are not being met. Arrangements with CAMHS do not prioritise children and young people looked after.

When children and young people go missing from care, return interviews are not of a good enough quality and not used to inform planning and intervention. Safety planning is not sufficiently used to reduce the risk of child sexual exploitation.

The majority of care leavers are in education, employment or training, and almost all are in suitable accommodation. However, for some care leavers with complex needs, support services and transitional arrangements are insufficiently developed to ensure that all their needs are met.

Corporate parenting in Dudley is ineffective and new arrangements are yet to make an impact. The collective voice of children and young people looked after through the Children in Care Council (CICC) has not been heard or prioritised by the authority and partners.

Inspection findings

56. The local authority has not ensured that all children and young people who need to be looked after are in secure placements and are in permanent arrangements as quickly as possible. Planning for children's and young people's

futures is poor. Transition arrangements with adult services begin too late to ensure proper and timely consideration of future needs. Children and young people in care of the local authority do not achieve sufficiently well in education, and the attainment gap continues to widen with potentially poor outcomes as a result. There is a lack of emotional support for this most vulnerable group, and burgeoning mental health issues are poorly supported by mental health services, for which children and young people in care of the local authority are not a priority. The local authority as a whole has not properly considered all the needs of children and young people looked after as a good corporate parent.

57. At the time of this inspection, 708 children and young people are looked after by Dudley council. At a rate of 105 children and young people looked after per 10,000 population, this is a much higher proportion than in similar local authorities and almost double the England average. A recent review of the thresholds for bringing children and young people into care has resulted in only a 4% reduction from 740 children and young people looked after since 31 March 2015. The local authority has started to review the children and young people looked after cohort in an effort to reduce these numbers further and has a clear understanding of deficits in practice resulting in high numbers in care. This work is recent. The local authority is not yet able to be sure that all these children and young people have the right plans, including permanent arrangements for their care, and that these plans are progressed in timescales appropriate for them.

58. Inspectors did not see any children or young people entering care who should not have done so. However, a small number of children and young people should have become looked after more swiftly, and some children and young people were discharged from care when the risks or reasons for accommodation had not been fully addressed. The responsibility for decisions about when children and young people should become looked after or discharged from care has recently been reviewed and is now made at an appropriately senior level. The local authority is beginning to focus its attention on the high number of children and young people placed at home on care orders (63) and on those children and young people subject to care orders and who would benefit from alternative orders such as special guardianship.

59. The judiciary and Cafcass have recently raised concerns about delays in securing legal permanence for children and young people, and the poor quality of care planning and decision making. The recent (October 2015) introduction of a legal gateway meeting has enabled a review of the arrangements of 77 children and young people looked after by the local authority to be undertaken. 17 were identified as being looked after under section 20 of the Children Act 1989 for too long when legal meetings or proceedings should have been instigated earlier to secure their care status and to further permanent arrangements.

60. Use of the PLO has been ineffective in identifying what needs to happen to secure change to ensure the welfare of children and young people. A recent review of the PLO process has included training for social workers and the introduction of a review panel. This has seen a 97% rise in cases subject to pre-proceedings, many of which have been subject to unnecessary drift and delay in entering the pre-proceedings stage. This means that children and young people have been at risk and waited too long for action to be taken to change their circumstances.

61. Family group meetings have recently been reintroduced to help to support children and young people remaining in their families and to improve assessments prior to care proceedings. However, the local authority does not yet fully understand if these meetings are effective or achieving what they were intended to achieve.

62. During the course of this inspection, inspectors saw a number of cases in which drift and delay in permanence planning and absence of parallel planning had created delay and uncertainty for children and young people. The increase in numbers of proceedings and the necessary change from solicitors writing court reports to social workers doing so have led to both a decline in report quality and court criticism of compliance with the PLO. At the time of the inspection, 33 out of 92 cases in care proceedings were beyond the 26-week timescale. The average length of care proceedings in 2014–15 was 30 weeks, which is the England average and better than statistical neighbours at 31 weeks. However, local authority data indicates that this performance is likely to worsen over coming months given current delays.

63. When the care plan is for children and young people to return home, the vast majority of children and young people returning home do not benefit from an up-to-date assessment and support plan. This does not maximise the potential for successful rehabilitation. However, the number of children and young people returning to care is low, with 12 children and young people coming back into care for a second or subsequent time in the last year.

64. A recent senior management decision has been made to increase visiting frequency for all children and young people looked after to a minimum of four weekly to ensure that visits are completed. This new arrangement means that social workers do not have the time to visit children and young people who are less settled and in need of increased levels of support. The local authority's own data demonstrate that 35% of children and young people looked after do not see their social workers as often as is prescribed by the local authority. When children and young people are seen, social workers see them on their own and take time to make sure that they understand their wishes and feelings.

65. Most children and young people looked after know their rights and entitlements and are advised on how to access an advocate. During 2014–15, 51 children and young people were supported by an advocate. However, outcomes are not evaluated, so the impact of this support has yet to be understood. The take-up

from the commissioned independent visitor service is increasing: 41 children and young people looked after had an independent visitor in December 2015.

66. In the majority of cases, assessments are completed when children and young people become looked after. However, assessments are not routinely updated to reflect changing circumstances and needs. Overall, assessments lack an analysis of long-term needs and the child's or young person's voice through direct work was not evident in all assessments seen. As a result, children's and young people's care plans are not routinely informed by up-to-date holistic assessments. Reports for reviews do include current information about the child or young person, but these are not sharply focused on progress against the care plan. Too many care plans lack clear targets and timescales. In these cases, it is not clear how needs will be met, by whom and when.

67. The local authority's data report that all children and young people looked after have had a review of their plan within timescales. However, the quality of the IROs' oversight of plans, including the need to secure timely permanence plans, is not rigorous and too many children and young people have been subject to drift and delay. Formal escalation relating to lack of progress, absence of care plans and poor standards of practice has only recently started. A lack of capacity in the IRO service has affected the IROs' ability to speak to children and young people before their reviews. This means that IROs are not driving improvements to ensure that children and young people receive a timely and appropriate service.

68. The local authority has failed to secure the permanent status of many placements leaving children and young people potentially vulnerable. Many of these children and young people have remained in the same placement for two years or more (72%). However, 14 long-term foster placements have been disrupted during the past year and, although the learning was used to inform future matching for the children and young people involved, it has not been used for wider practice and service development. Children and young people have been placed with short-term carers and have remained with them, some for several years. Work is now underway to establish the numbers of children and young people who can be matched, and to review the approval status of foster carers. The local authority has offered assurance that children and young people will be matched permanently to independent fostering placements if this is in their best interests.

69. The local authority does not have enough foster carers and relies heavily on commissioned fostering. At the time of this inspection, the local authority had only recruited five foster carers during 2014–15, with a further 16 mainstream assessments in progress. The draft sufficiency statement highlights the need to increase in-house fostering provision as a priority, because there is an over-reliance on purchased provision, including placements for infants. The chief officer has recently started to approve and scrutinise requests for all out-of-borough placements in an effort to improve management oversight.

70. Those foster carers who are recruited report that they are trained and supported well. Carers receive regular supervision and training and routinely contribute to children's and young people's reviews. Delegated authority is not in place for all children and young people, and this limits fosters carers' ability to support children's and young people's hobbies, activities and interests. Where there are no in-house permanent fostering placements available, Dudley's new Access to Resources panel approves the purchase of a placement from the independent sector.

71. Progress has been made in children and young people achieving permanence through special guardianship orders (SGOs). In 2014–15, 11% (25) children left care through SGOs, which is an improvement from 7% in 2013–14. Special guardians receive timely assessments and good plans are put in place, supported by the specialist post-order support worker. However, some children and young people in stable long-term foster placements would benefit from a more systematic consideration of their foster carers applying for an SGO to enable them to leave local authority care.

72. The virtual school has been ineffective in supporting the educational needs of children and young people looked after. There has recently been more scrutiny of the quality of personal education plans (PEPs) and use of the pupil premium. However, in examples seen, the pupil premium is not being used effectively to support progress. PEPs are not specific enough about attainment and targets and continue to lack sufficient management oversight. Aspirations for children and young people looked after are not challenging enough and predicted exam results are overly optimistic, which demonstrates a lack of focus on the needs of individual children and young people. Five children and young people looked after were permanently excluded in 2014–15. The local authority reports that, at the point of inspection, nine young people attended alternative provision for between ten and 17 hours a week. Children and young people looked after who are taught in Dudley are making less progress than children and young people looked after taught in out-of-borough schools.

73. The majority of PEPs require improvement. There are some examples of effective target setting with specific goals and appropriate support in place to help children and young people reach their potential. However, in most cases, targets and timescales are not clear. This makes measuring progress difficult. While many plans contain detailed information about the child or young person, this information is not used effectively to identify key issues and actions required to support educational progress. The voice of the child or young person is not consistently captured in PEPs, and not all PEPs identify how the pupil premium should be used.

74. Educational outcomes for children and young people looked after are not good enough. There are 478 school-aged children and young people looked after, 53% of whom are taught in the borough. The percentage of good or outstanding secondary schools that children and young people looked after

attend has risen from 45% to 60%. While this is an improvement, it is still not good enough.

75. Attainment for children looked after at Key Stage 1 is below the national average in reading, writing and mathematics. The gap in the attainment of children looked after remains wide at 19 percentage points lower in reading, 25 percentage points lower in writing and 21 percentage points lower in mathematics. While all children looked after at Key Stage 2 are making at least expected progress, the gap for attainment of Level 4 in reading, writing and mathematics has closed from 30% in 2014 to 24% in 2015.

76. Key Stage 4 outcomes are poor and have continued to decline in the past three years. The attainment gap for young people in the care of Dudley continues to widen from that achieved by young people generally across England, from 31 percentage points in 2012 to 46 percentage points in 2014. The proportion of young people looked after by Dudley gaining five GCSEs grades A* to C, including English and mathematics, has also deteriorated over the last four years, from 28% in 2012 to 12% in 2015. Young people looked after by this local authority are not sufficiently helped to attain their potential and outcomes for these young people are likely to be poorer as a result.

77. During quarter 3 (2015/16), 80% of children and young people had their initial health assessments completed within timescales. This is below the England average of 90% and below the local authority target of 95%. Performance has not improved since 2013–14. The local authority has started to work closely with health partners to improve this figure. Review health assessments, dental checks and immunisations are taking place in a timely way, and performance in this area is above the England average.

78. The emotional health needs of children and young people looked after are not being sufficiently identified and met. Strengths and difficulties questionnaires do not systematically inform health assessments and are not completed until children and young people have been looked after for 12 months. This means that children and young people are not screened to support their immediate health needs. This is compounded by the lack of a fast-track service to CAMHS for children and young people looked after. A children and young people looked after psychology service run by the local authority is in place but long-standing vacancies and a lack of focus on the work that needs to be undertaken by the service means that children and young people are not benefiting from this service.

79. Senior managers identify when children and young people looked after go missing and who may be at risk of child sexual exploitation or criminal behaviour through the YPSE panel. Foster carers and residential staff follow procedures for reporting children and young people looked after missing and for seeking to locate them appropriately. Thirty-six children and young people were missing from care in the last 12 months, of whom 11 children were missing 167 times. Return interviews for children and young people who go

missing lack required detail, such as how long they have been missing. A lack of persistence in understanding the reasons for missing episodes is evident. Key documents are often missing from children's and young people's files, and care plans are not updated to include a safety plan. This lack of supervision and management oversight does not support improved outcomes for children and young people who go missing from care. In December 2015, 12 children and young people looked after were identified as being at risk of or subject to child sexual exploitation. None of these children or young people had a safety plan in place.

80. In 2014–15, 25 children and young people looked after (4%) were identified as having a substance misuse issue, with 15 of those (60%) receiving an intervention and 10 (40%) refusing support. This is better than the England average. A close working relationship between youth offending services and the 14 plus team helps to ensure appropriate preventive work and support for children and young people when they are remanded into care. In 2014–15, 4% of children and young people looked after were convicted and cautioned compared with 7% in statistical neighbouring authorities and the England average of 6%.

81. Corporate parenting in Dudley is ineffective. The corporate parenting forum did not meet from January to September 2015. The forum was refreshed in October 2015. This development, along with a draft corporate parenting strategy, has introduced a renewed focus. However, the work of the forum is not yet making a positive difference to the lives of children and young people looked after.

82. The profile of the CICC is weak. A recent awards evening for children and young people looked after was poorly attended by children, young people and adults, and lacked support from the local authority. This has resulted in some children and young people in care saying that they do not feel valued by the local authority. Very recent support from the interim chief officer has secured funding for the council, a review of the pledge to children and young people looked after and a new website to support a more effective CICC. These recent changes are positive but they are not yet ensuring a strong platform for children and young people to be heard.

83. A small number of children and young people looked after of minority ethnic origin have not had their needs that arise from their diverse backgrounds assessed well or planned for, indicating a lack of awareness among social workers of the distinctive needs of these children and young people. Foster carers receive training on how to protect children and young people from bullying, homophobia and discrimination.

The graded judgement for adoption performance is that it is inadequate

84. Adoption has not been considered for all children and young people in the care of Dudley council until very recently. Children and young people do not benefit from the security of permanent arrangements through adoption quickly enough. A legacy of inconsistent practice combined with weak management oversight of care planning and decision making for children and young people is now beginning to be addressed. However, for a number of children and young people, this has meant that opportunities to secure permanent placements through adoption have been missed or significantly delayed. The local authority acknowledges that any recent progress in performance will not be evident in 2013–16 scorecard data.

85. A recently commissioned diagnostic report of the adoption service identified that 93 children under five years of age became looked after in Dudley in 2012–13. Fifty-seven (61%) were still in care or had returned to care in 2014–15. This means that a high proportion of children under five continued to be looked after two years after first entering care and had not been permanently placed. Of these, six had adoption plans but were yet to be adopted. Only two children aged over five were placed for adoption in the period 2012–15, and both were aged six years. This indicates significant delays in finding permanent solutions for children and a much-reduced likelihood of older children being adopted.

86. Children and young people experience significant and unacceptable delays in the time it takes for them to live with their adoptive families. The average time it takes between a child or young person entering care and moving in with their adoptive family is longer in Dudley, at 741 days, compared with the three-year average and the national scorecard target of 547 days. Very recent remedial work by the authority to improve adoption planning has resulted in some improvement. However, too many children and young people over a lengthy period have endured too many long delays in securing permanence through adoption. The local authority's own data for the first three quarters of 2015–16 record timescales of 589 days. This remains above both the national target and performance of statistical neighbours.

87. In 2011–14, the local authority took on average 280 days between a placement order being made and children and young people being matched with adoptive families. Current local authority data show that over the first nine months of 2015–16 this had fallen to 269 days, which is still higher than the national target by 52 days and statistical neighbours by 48 days.

88. In March 2015, 32 children and young people with placement orders made between April 2012 and March 2015 were still waiting for adoptive placements. In the cases of six of these children or young people, managers had made decisions to change their adoption plans to alternative permanence options, but their orders had yet to be revoked by October 2015. This demonstrates a

significant lack of urgency in permanence planning. Three children or young people were identified as having waited for more than three years for an adoptive placement. This lengthy delay places the likelihood of a successful permanence outcome at unnecessary risk. Currently, 10 children and young people have plans to discharge their placement orders, but these orders have not been discharged yet, including a child whose adoption was disrupted in December 2014. This substantial delay in progressing this child's care plan demonstrates poor management oversight and prolonged uncertainty for the child.

89. Only 37% of children and young people (2011–14) moved to live with their adoptive family within recommended timescales. This represents poor performance, considerably below the national average of 51%. These delays mean that children and young people are not moving into and benefitting from permanent placements with an adoptive family quickly enough. Too many children and young people wait too long to have a permanent alternative family identified for them, with only 39% of children and young people waiting 18 months or less.

90. Fostering to adopt is not yet an option for children and young people in Dudley. This is a missed opportunity. Managers have failed to develop or implement a policy to progress this practice. The adoption service has only very recently begun to raise this concept of securing permanence for children or young people with prospective adopters, which demonstrates poor awareness of developments in adoption practice.

91. Until very recently (November 2015), managers had no effective or overarching oversight of those children or young people who need an adoptive or alternative permanent family. A weekly panel that acts as a legal planning gateway is a positive development, but while demonstrating some very early improvement on prevention of delays for some children and young people, it is too soon to assess its impact fully. Another benefit of the panel is that the adoption team now receives early information about children and young people to inform matching to adopters, but again it is too early to demonstrate impact.

92. Dudley does not have enough prospective adopters to meet demand. The local authority approved 45 households as adopters in the period 2012–15 compared with 113 placement orders made in the same period. The local authority purchases access to adopters approved by other agencies to ensure that greater choice is available. However, the negative impact of this is that these resources are not then available to invest in developing their own pool of adopters or other priority areas. The adoption service routinely uses the West Midlands Adoption in the Black Country consortium and the national adoption register to find families for children and young people who are waiting to be placed. Developments for a regional adoption agency are in the very early stages of planning and so offer no improvement to the circumstances of children and young people overall yet.

93. The adoption team has a marketing and recruitment worker and is actively involved in the training and assessment of carers on the Adoption Black County Partnership. The positive benefits of this include immediate access to an innovative initial online training programme, followed by three days group training for prospective adopters.

94. Prospective adopters currently wait 282 days between registration and approval (2014–15), 48 days longer than the England average. Despite improvements in timescales for adopters having a child or young person matched, the average number of days between registration and match for new matches exceeds the England average by 19 days at 401 days.

95. Preparation and assessment for adopters is thorough if not timely. Prospective adopters reports (PARs) show that detailed preparation work is completed to help them understand children's and young people's needs and what will be expected of them. Adopters spoken to said that they felt well informed about the individual needs of children and young people. Life story work is progressed with children and young people who need it, and later life letters are appropriately detailed. Adopters spoken to were given a life storybook and memory box for their child or young person, ensuring that those children and young people are supported to understand their life history and have information about their birth families.

96. For those children and young people who are adopted, Dudley does well in placing brothers and sisters together, with 20 children and young people placed in such groups out of a total of 40 children and young people adopted in 2014–15 (Adoption Leadership Board data 2014-15).

97. The adoption team actively promotes and approves adopters from diverse backgrounds and cultures. Children's and young people's permanence reports (CPRs) seen are thorough and contain sufficient detail of the child's or young person's personality, identity and diverse needs to support planning and decisions about matching to suitable adoptive families.

98. Adopters do not consistently receive quick and effective support when they need it. Some assessments for adoption support take as long as three months to complete and this is unacceptable. Decisions for specialist therapeutic support and access to the Adoption Support Fund are authorised by an access to resource panel. Current arrangements are cumbersome and do not facilitate timely provision of support services. For example, adoption team workers not only have to identify support services to meet need, but are then required to obtain three costings of service provision before presenting to the panel for a decision. Currently, managers are planning that all requests for adoption support are dealt with by the SPA. The potential risk with this is that there is further delay in responding to adopters' needs effectively.

99. Management oversight and challenge within the adoption support service is weak. Adoption support plans seen are too variable in quality and some do not

have clear timescales to achieve their aims. Managers currently have no method to evaluate whether adoption support is helping families. There is currently no method of measuring whether adoption support is helping families over time, and there is no easily accessible process for commissioning specialist support. All of these factors contribute to delay for families accessing support and do not contribute to improving the circumstances of adopted children and young people. Adopters spoken to are aware of their entitlements and the current range of support provided by the adoption service.

100. Recruitment of staff to the adoption service is problematic and results in reduced effectiveness in service delivery. A specialist adoption worker post has been vacant since May 2015, and this is negatively affecting the capacity and progress of the adoption team. Managers have also agreed to an additional permanent post to support the post-adoption letterbox service, but this too is vacant. As a direct result, important letterbox work in maintaining indirect contacts and post-adoption agreements between birth family relatives, adopters and adopted children and young people is delayed for the two thirds of the 743 letterbox members who are active. This means that children, young people and birth families do not receive and progress information about people who are important to them.

101. The adoption panel has made some recent improvements but remains under-developed and is not functioning at a good standard. The chair of the adoption panel is suitably qualified and has extensive experience of adoption services. Panel membership consists of a diverse ethnic group with a mix of adoptive carers and independent members. However, the panel has only recently identified the need to increase local authority representation to ensure that it has sufficient social workers available to meet statutory regulations. At the time of inspection, recruitment was taking place to address this shortfall. The chair reports that the panel receives documents in a timely way because they are no longer reliant on paper copies of documents and reports. For the voice of children and young people to be heard, the panel is reliant on social workers representing the children's and young people's views and on assessments. These are not always clearly articulated.

102. The role of the agency decision maker (ADM) is underdeveloped due to a legacy of poor leadership and management within the authority. The current ADM makes timely decisions in accordance with regulations and has begun a programme of improvement since taking over the role in August 2015. This includes the development of a performance management framework, a clear action plan for monitoring timescales for children and young people needing adoption and a review of ADM procedures. However, since the local authority has only just begun to establish monitoring of processes to achieve permanent solutions, it is too early to evidence positive impact. The ADM acknowledges the deficits in permanent solution planning in the authority and the importance for children and young people of timely decisions and actions to ensure that they live with permanent families. The ADM has responsibility for social work

practice across children's services and is aware that it would be good practice to ensure that arrangements are put in place for more independent oversight.

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

103. The local authority recognises that there has been a loss of the required focus on care leavers and drift in related policy development and implementation in recent years. To rectify this, it has recently appointed an experienced interim team manager to oversee the care leavers' service and to implement the New Belongings project to ensure that care leavers have an improved quality of service in their journey to adulthood. This initiative is in its infancy but is beginning to show positive improvements in the care leavers' service. So far, the project has delivered five council apprenticeships that are ring-fenced to care leavers. It has also begun reviews of supported accommodation provision and a review of the financial policy for care leavers.

104. Personal advisers as part of the 14-plus looked after children's team provide effective support to 177 care leavers. In addition, there are a further 123 16- and 17-year-olds looked after who are eligible by age for care leaving services. Personal advisers have manageable caseloads and are able to spend time with young people allocated to them. However, the arrangements mean that young people are not allocated a personal adviser until they are 17.5 years old. This is too late and does not ensure an early enough focus to support effective transitions to independence or adult services for many young people.

105. Personal advisers know their young people well and are in contact with the vast majority (92%) of care leavers. Personal advisers' contact and visit young people regularly. A small minority of young people would benefit from contact that is more robust, but evidence was seen of tenacious work in engaging those who are harder to reach. Care leavers spoken to by inspectors are positive about the support that they receive from their personal advisers.

106. The vast majority of care leavers (93%) live in suitable and appropriate accommodation. Care leavers have access to a variety of accommodation including commissioned training flats, supported lodgings, semi-supported and independent accommodation. Further work is being done by the local authority to ensure that all accommodation is regularly reviewed to ensure its quality. Care leavers' housing needs are prioritised across the council and care leavers are given a priority Band B access to social housing. Most care leavers told inspectors that they feel safe where they are living and are satisfied with their accommodation. The local authority does not use bed and breakfast accommodation, and no young people are living in homes of multiple occupancy at the time of the inspection.

107. Young people are encouraged to live with their foster carers for as long as they wish. At the time of the inspection, 31 (17%) young people remained with their foster carers under staying put arrangements.

108. Young people are encouraged to keep in touch with support workers. A dedicated weekly drop in is well attended by care leavers and ensures that they have access to personal advisers, a Connexions adviser, and the designated nurse for care leavers to access advice and support on sexual health. Of the 177 care leavers, seven are parents and have access to support from a monthly support group for parents and access to the family nurse partnership.

109. Strong partnerships and good support from a Connexions worker has ensured that a high proportion of care leavers move into education, employment or training (EET). Those in further and higher education are supported appropriately through bursaries. There has been a significant improvement in the number of care leavers entering university, which now exceeds the national target of 7%. Fifteen care leavers went to university in 2015 and eight care leavers are in apprenticeships with private providers with a further five ring-fenced apprenticeships recently agreed for care leavers within the local authority

110. A good range of support is available to care leavers to help them into education, employment and training (EET). Care leavers are encouraged to take part in programmes such as the Prince's Trust and Duke of Edinburgh's Award. Twelve care leavers have accessed support from Talent Match run by Dudley College, which provides mentoring for young people and supports young people back into EET. Links with local colleges and training providers have enabled a range of opportunities. According to the most recent local authority data, at January 2016, 64.7% of 16- to 21-year-olds are recorded as in EET, including 74.6% of 19-year-olds. The proportion of 16- to 17-year-old care leavers in some form of EET is high, at over 90%.

111. The quality of pathway plans is too variable and requires improvement. Weaker plans do not address key issues for young people, such as mental health or substance misuse, or consider contingency planning. The majority of plans seen are more effective, clearly reflect the views of care leavers, and give appropriate attention to independence skills, education, training and employment. Pathway reviews are carried out by personal advisers but do not benefit from independent scrutiny, challenge or quality assurance to ensure that young people are making progress. Although young people attend their pathway planning meetings, information from relevant agencies is often gathered by phone rather than by inviting them to attend, thereby missing an opportunity for more meaningful interaction with young people.

112. Young people are not always thoroughly prepared for the acquisition of independent living skills. This means that, for some, opportunities for successful outcomes are more limited than they otherwise would be. Care leavers are in many cases relying on personal advisers to prepare them for independence.

Young people themselves identified this shortfall in a recent survey, and current planning by the local authority includes a greater focus on specific skill sets such as cooking and finance.

113. Transition planning and arrangements to move from children's services to adult services are not effective and start too late to ensure that young people have the support that they require from adult services. Some young people have not received an assessment from adult services until after their 18th birthday. This means that some young people may not be in the right placement or accommodation or receiving the services that they most need. As a result, some young people experience anxieties and uncertainties at a critical period in their lives.

114. The information provided to care leavers about their health histories is largely limited to details about their birth and immunisations. This potentially leaves young people unaware of important personal health information in adulthood. Care leavers do not have timely and effective access to CAMHS and therapeutic services. The large majority of care leavers are registered with a doctor and most are registered with a dentist. Where a young person is a risk of child sexual exploitation, a risk assessment is completed and appropriately referred to the child sexual exploitation team and the YPSE panel or the adult safeguarding multi-agency panel.

115. A care-leaving booklet is available for young people when they leave care and sets out the rights and entitlements of care leavers, education support and the financial offer. The booklet offers a housing pledge, which states that the local authority will make sure that care leavers' homes are safe and that support is provided along with the option of staying put. However, information on financial support is not up to date and has caused some confusion about financial entitlements for care leavers. The local authority has reviewed its financial support to care leavers and now intends to increase it to the government recommended allowance. Care leavers need to be informed about this change as soon as possible.

116. The local authority has not yet worked with young people to produce a charter unique to care leavers in Dudley. Currently, care leavers do not meet as a separate forum from the CICC to discuss matters that are important to them. This means that the specific views of care leavers, including their concerns, are not being heard as well as they should be by the authority.

Leadership, management and governance	Inadequate

Summary

Senior leaders and managers have not ensured that children and young people receive effective services that help and protect them. They cannot be assured that children and young people are safe. Further, the planning for their care when they become looked after is very poor. Deficits are long standing and have been known to the local authority for some time. Despite this, it has not acted with sufficient urgency to improve matters. As a result, many services have deteriorated.

The current senior leadership team is now providing strong leadership and strategic vision in setting about rectifying these deficits. It has a sound understanding of the deficits and has been systematic in its planning to establish the strategic foundations on which to prioritise and drive forward the wide-ranging improvements required.

Partnership working has not provided the necessary challenge and support to the local authority to tackle weaknesses. The recently established improvement board and the Dudley Children and Young People's Alliance are very early steps in the partnership's commitment to work together collaboratively to improve services to children and young people in Dudley. These forums provide appropriate governance arrangements but do not yet link effectively with other strategic activity across the partnership. Many existing strategies are under review, not in place or currently being developed, which impedes multi-agency working.

Elected members' involvement as corporate parents is inadequate, and their scrutiny is significantly underdeveloped. Recent political support to senior leaders and additional financial investment is beginning to make a difference.

Local authority and joint commissioning arrangements are ineffective and are not supported by robust performance monitoring arrangements. This means that it is not possible to evaluate the impact of services provided to children and young people, to analyse the shortfalls and to take action to meet gaps.

Poor senior and frontline management oversight, inaccurate performance information and weak quality assurance arrangements have all contributed to the inconsistent and poor-quality services provided to children and young people. New arrangements are now in place but are yet to have impact. The instability of team managers hampers progress.

The views of children, young people and their families do not fully inform service developments within children's social care, and this is a significant omission.

Arrangements to support children and young people at risk of or who have suffered child sexual exploitation are in place but would be better supported through more

effective information sharing.

Inspection findings

117. Inspectors have found significant failings that are widespread across many of the key areas inspected under this framework. Leaders cannot be assured that children and young people are safe or that planning for those that are in the care of the local authority is effective. Many current deficits are long standing and have been known to the local authority for some time. Significant areas for development identified at previous inspections have not been progressed. Services provided for the help and protection of children and young people are inadequate and do not ensure that risks are effectively identified and reduced. Services for children and young people looked after by the local authority, previously judged to be adequate, have deteriorated significantly and are now inadequate.

118. The current senior leadership team is providing strong leadership and strategic vision in setting about rectifying these long-standing deficits. Concerted efforts are being made by leaders to tackle and arrest a legacy of deteriorating services. The local authority self-assessment is an accurate and honest appraisal of the services it provides to vulnerable children and young people. Leaders have a comprehensive understanding of the extent of the change programme required. This is supported by a thorough, appropriately prioritised and well-sequenced improvement plan. The local authority is working from a very low base, and improvements will take time to result in real and sustained change in the experiences of children and young people.

119. An improvement board, recently established in September 2015, brings together local authority and partnership senior leaders to oversee temporarily the delivery of the local authority improvement plan. An independent chair appropriately facilitates board members to discuss openly strategic barriers to progressing effective multi-agency working. While still in the early stages and yet to have impact, improvement board members have taken individual sponsorship responsibilities for key strands of the improvement plan and recognise the urgency required to drive forward improvements.

120. The local authority and partners acknowledge that previous arrangements, including the LSCB, have not provided effective focus on shared strategic priorities for the protection and care of children and young people in Dudley. Partnership governance and monitoring arrangements to ensure the delivery of existing strategies and development of others have been weak or absent. In September 2015, the Dudley Children and Young People's Alliance replaced and refreshed the previous Children and Young People's Trust arrangements. Its governance arrangements with the improvement board are clear. However, alignment to the health and well-being board and the LSCB are yet to be clearly defined or understood. In addition, there is much more to do to ensure that frontline practitioners and managers across agencies work collaboratively to plan for and reduce risk to children and young people.

121. Many local authority and multi-agency priority strategies are only just being written, are in draft or are under review despite long-standing concerns about the functioning of services. As a result, effective arrangements are not in place to respond to a broad range of children's and young people's needs. These include early-help provision, tackling neglect, joint commissioning arrangements and many aspects of children and young people looked after provision. In December 2015, the Dudley Children and Young People's Alliance did launch the CAMHS Transformation Plan 2015–2020. This provides very early indications of effective work at a strategic level to develop a coherent multi-agency strategy and plan. It is informed by a needs analysis and draws on some engagement activity with children and young people. However, the plan is in its very early stages of implementation. This still leaves children and young people without suitable pathways or access to services when they need them. For example, suitable arrangements for young people to transition to adult services or for children and young people who have experienced sexual exploitation to access therapeutic services are not yet in place.

122. Commissioning arrangements are ineffective. Work began in October 2015 to review existing contracts, procurement and commissioning arrangements. Many of the current arrangements are long established and, while there is a range of services, they are often fragmented or duplicated. Many are not yet outcome focused so it is not known whether they are providing the right services to the right children and young people at the right time. Much work is still to progress and the delivery plan has only just begun. However, effective project-management arrangements are now in place to drive forward urgently the development of an integrated commissioning strategy. The joint strategic needs analysis (JSNA) provides a broad range of general population analysis. However, it is not sufficiently focused on the specific needs of vulnerable children and young people.

123. The local authority and its partners have been more effective in prioritising and developing a response to child sexual exploitation in Dudley. A wide range of awareness-raising activity has taken place within the local community. In September 2015, a specific multi-agency team to respond to the needs of children at greatest risk of child sexual exploitation was launched. These arrangements are providing an increasingly effective response. However, information sharing and decision making arrangements are not yet embedded across the partnership and reduce the effectiveness of the response to children and young people.

124. Many aspects of political leadership are weak. Corporate parents have failed to discharge their responsibilities to children and young people looked after and care leavers. In addition, scrutiny by elected members is significantly underdeveloped despite the very recent efforts of officers to arrange support via the Local Government Association. Scrutiny does not offer robust challenge to the council about the effectiveness of services for the most vulnerable children and young people in Dudley. However, senior leaders have been given the full support of the lead member for children and the council leader. To this

end, £1.25 million additional funding provided during 2015–16 has contributed to kick-starting priority improvements. This funding has allowed for the increase in foster carer allowances to make recruitment more competitive within the local market. It also provides the funding for additional posts to drive forward the improvement plans. For example, the funding of a court progression manager has provided significant and much-needed focus to reducing drift for children and young people subject to public law proceedings.

125. The gathering and analysis of reliable performance information remains a significant challenge to the local authority. Proactive steps have been taken to enable better collation of information with very recent changes to IT systems in December 2015. However, the local authority still has areas where some key information remains inaccurate or is manually collected and is not providing real-time information. This weakens the local authority's capacity to analyse and respond to dips in performance. Staff compliance to minimum practice standards, measured through performance information, is improving, but the local authority is not yet in a place to be assured about the quality of practice or the service that children and young people receive. Difficulties with some IT systems mean that social workers are diverting their time from direct contact with children, young people and families.

126. The local authority quality assurance framework, agreed in December 2015, draws together a wide range of appropriate activities to examine the quality of practice. These include routine auditing, thematic audits, practice observations, engagement of children, young people, parents and professionals, complaints information, performance data, supervision and feedback from the safeguarding and review service. However, at this stage, this plan is aspirational and delivery is not due to begin until at least March 2016. Until this time, the local authority has very limited assurance of the quality of services that children and young people receive. Audits undertaken for this inspection did not provide sufficient qualitative analysis. Managers do not have the skills or the capacity to undertake audits of the quality required to drive improvement. Two additional temporary posts have been created to provide this capacity and to support the development of audit skills.

127. The quality of management oversight and decision making is weak. This leaves some children and young people at risk, and too many cases with plans to reduce risk, or secure long term permanence, are not expedited quickly enough. At the time of the inspection, the local authority self-reports that 66% of cases had management decisions recorded in the previous six weeks. This leaves too many children and young people without management oversight in that period. The local authority accepts that the quality of management oversight and supervision is not yet consistently robust so that plans for children and young people have drifted, and there has been delay in responding to known risks that children and young people experience.

128. The chief social worker has only been in post since January 2016. Arrangements before this date were too weak to address the scale of the

known deficits in social work practice. Staff training has been limited. Annual staff performance reviews, where they have taken place, have not resulted in plans to develop the skills and knowledge of staff to undertake their role. For example, a social work practice model was introduced some years ago, but training was not refreshed and new staff were not trained in the model. This has led to inconsistent practice in assessing children's and young people's needs. The chief social worker also leads on workforce development and has done so since October 2015. He has very quickly begun to put in place infrastructure to build the skills and knowledge of staff reflected in a new workforce development strategy. This a coherent document that outlines priority areas and sequenced work streams. However, it is a very recently developed plan and work is in its infancy. The first phase of this has been implemented, with a training needs analysis completed by 85% of staff, although a full analysis has yet to be completed.

129. Best practice events clearly establish good practice standards and leadership expectations for social work staff and managers. These events have been held very recently and have yet to translate into improved practice. The excellence in practice reference group provides a useful forum for staff to consult and to engage them in the improvements required. Feedback from staff has led to the suspension of the recruitment of newly qualified social workers until the local authority is able to provide the support that is needed in their first year of employment.

130. Some successful recruitment activity has recently taken place with the offer of appointment to 24 new permanent social workers who have or are in the process of commencing their employment with Dudley. Similarly, six new permanent team managers have been appointed, two of whom have started. Turnover of team managers has been high with a 36% turnover since April 2015. This figure reflects the fact that senior leaders have taken effective performance management action to tackle some underperformance. However, reliance on some temporary agency team managers has created inconsistency for workers and drift and delay in risk reduction and care planning for children and young people. Additional social work capacity and the beginnings of a service restructure have reduced caseloads for some staff. Other workers continue to have high caseloads pending ongoing service redesign.

131. The voice of children and young people in effectively influencing service development is limited. Insufficient progress in developing a systematic strategic approach in response to complaints means that learning has been lost and not responded to effectively. The complaints web page is not child-friendly. This means that methods to hear from children and young people about their experiences have not kept pace with current opportunities that technology brings. Children and young people looked after have good access to a commissioned advocate's service, although very low numbers of children and young people with a child protection or child in need plan have accessed an advocate. The local authority does not yet understand the reasons for the low level of take-up of this service.

132. No formal engagement activities have taken place with children and young people as a result of the services that they receive from children's services. Recent analysis of engagement activity by the Children and Young People's Alliance established a number of key issues that it needs to address including the poor analysis of children's and young people's views already collected and duplication. Some useful consultation with children and young people has taken place on a wider scale to establish the Dudley Deal, including work on the vision and storyboards to support the JSNA. However, significant work to engage children and young people fully and to work co-productively with them as the Dudley Deal envisages is required.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The Dudley Safeguarding Children Board (DSCB) does not have arrangements in place to meet its statutory responsibilities. Performance management and quality assurance processes are not effective in identifying areas of work that require significant improvement, and the Board is not able to assure itself that partner agencies are fulfilling their statutory safeguarding obligations. The monitoring and evaluation of training is not effective, and the delivery of multi-agency training is not based on currently assessed need.

Significant drift and delay is evident in a range of Board activity. The Board business unit is not adequately resourced or appropriately configured to provide effective support to the Board, and the Board structure and processes do not yet support focused and timely activity.

The Board has recognised and acted on the need to evaluate and improve its effectiveness, and a detailed development action plan for the Board was signed off during the inspection period. It is too early to evidence any improvements as a result.

Board activity is not informed by the experiences of children and young people. No feedback is gained from children and young people who have received safeguarding services. Some positive engagement with young people to inform board priorities and contribute to website development has been lost due to inadequate agency responses in subsequent work with them.

The DSCB has driven and has strategic and operational oversight of work relating to child sexual exploitation and missing children and young people. There are positive developments in this area, although further work is required to embed this progress fully, and risks relating to future resourcing have not been resolved.

Child death review work meets statutory requirements and analysis of the work has underpinned practice improvements and prevention work. Recent progress is evident in other areas, including identification and learning processes for cases considered by the serious case review sub-group, but it is too soon for there to be evidence of practice improvement as a result.

Recommendations

133. Dudley Safeguarding Children Board should take immediate action to ensure that it is fully compliant with its statutory responsibilities.

134. The local authority and partner agencies should ensure that the Board business unit is appropriately structured and resourced to provide effective management oversight and sufficient capacity to support the business of the Board.

135. The structure of and processes supporting the Board should be reviewed by the partnership and developed to ensure that there is outcome-focused, timely and effective activity linked to the Board's priorities. This includes engagement with children and young people.

136. The Board should ensure the implementation of an effective quality assurance framework, embedding robust single- and multi-agency auditing of practice, effective scrutiny of multi-agency performance data and feedback processes from children and young people, families and staff.

137. The Board should revise and implement the training strategy to ensure that training is delivered in line with identified priorities and needs and that effective evaluation processes are in place for single- and multi-agency training.

138. The Board should ensure that clear links are in place between the learning and improvement framework, training and quality assurance processes to identify, disseminate, evaluate and monitor effectively the impact of learning and improvement on the quality of service delivery.

139. The Board should scrutinise all areas of service delivery as required by statutory guidance and where key risks are identified.

140. The Board should ensure the prompt completion of the section 11 and section 175 audit processes and evaluate whether further work is required to support partner agencies to fulfil their statutory safeguarding requirements.

Inspection findings – the Local Safeguarding Children Board

141. The DSCB is inadequate because it does not have effective arrangements in place to fulfil its functions as required by statutory guidance. The governance arrangements between the DSCB and partner boards do not operate effectively. This is exemplified by a lack of Board representation on the children's trust and consequent absence of effective challenge or influence by the Board. A draft partnership protocol does incorporate recent developments with the establishment of the Children and Young People's Alliance and the Improvement Board, but this has not yet been signed off and it is too early for impact to be identified.

142. There is significant drift and delay in a range of Board activity. The Board business unit is not adequately resourced or appropriately structured to provide effective support to the Board. Efforts to remedy this with partner agencies have been unsuccessful and remain unresolved. The structure and processes supporting the Board do not facilitate timely and effective work despite some recent restructuring, including undertaking the chairing of some sub-groups by non-local authority representatives. Board members state that they are not well supported to understand their role and to develop their effectiveness as Board members.

143. The Board has recognised the need to evaluate and improve its effectiveness. The Board commissioned an external peer review and has undertaken a self-assessment. The self-assessment, reported on in November 2015, indicated that in 19 out of 21 standards the Board had not begun to consider that area of work, or that no active work was taking place. The peer diagnostic that reported in January 2016 indicated that the Board was not meeting basic requirements and that the overall management of both strategic and operational risk by the Board was underdeveloped. The Board development action plan arising from the diagnostic and the self-assessment was signed off during the inspection period. It is therefore too early to evidence any improvements as a result.

144. Inadequate quality assurance practices mean that significant areas where practice improvement may be required have not been identified through Board activity. At the point of inspection, the Board had no quality assurance framework. Coordinated multi-agency auditing and learning processes are not in place. No multi-agency audit activity took place in 2014–15. The need for a multi-agency audit plan was identified for 2015–16, but this has not yet been completed or implemented. Some audit activity took place in 2015, but the Board has not considered the results. An audit of cases of child sexual exploitation that was undertaken in summer 2015 did consider individual cases, but the identification of learning themes and an action plan to disseminate that learning have not yet been presented to the Board. An audit of contact and referrals was completed in December but findings have not yet been presented to the Board. There is no reporting to the Board of individual agency audit activity and findings. These deficits have significantly limited the Board's understanding of the effectiveness of safeguarding work across Dudley.

145. The range of performance data reported to the Board does not allow the Board to have an overview of safeguarding performance across agencies. The performance data is primarily provided by the local authority, and the scrutiny of that data has not been sufficiently rigorous to identify key areas of practice shortfall, including core child protection activity. There has been significant drift and delay in developing and implementing agreed multi-agency data set to underpin more effective scrutiny of partner-agency work in safeguarding. Additionally, there is an absence of feedback from children, young people, families and staff to inform judgements on the quality of services.

146. Arrangements to assess whether partner agencies are fulfilling their statutory obligations as set out in chapter 2 of 'Working together 2015' have been subject to unacceptable delay and drift. The section 11 and section 175 audit processes that where initiated in December 2014 are not yet completed at the time of the inspection. Action plans from those agencies that have made returns have been requested, but these have not all been returned at the time of the inspection. The length of time over which the data has been collected means that it is of limited use, exacerbated by the fact that there has also been organisational change in many agencies in the period. The section 175 audits have not been completed at the time of the inspection, which means that the Board is not able to assess whether or how schools are fulfilling their statutory obligations in relation to safeguarding. This is a significant gap.

147. The Board has received reports on some key areas of service including the management of allegations against professionals and private fostering. However, there has been no reporting on other key areas, including early help, which is required by 'Working together 2015'. The Board has not assessed the effectiveness of early help and has not been able to identify or drive any required developments in early help as a result.

148. DSCB has not effectively monitored the application of all key thresholds. The threshold document has only recently been revised and signed off and there has not been time for this to be widely disseminated. The Board has considered performance data in relation to the threshold to social care and has supported the implementation of the single point of access (SPA) and the development of the multi-agency safeguarding hub (MASH). The Board has not scrutinised the application of thresholds for children and young people entering care or thresholds within early help.

149. DSCB has not robustly monitored and evaluated the effectiveness of training to safeguard and promote the welfare of children and young people. The delivery of training to date has not been underpinned by a training needs analysis or been clearly informed by Board priorities. There has been a lack of management oversight and the training resource has not been targeted to prioritise need. The evaluation of training is limited and is not linked to other quality assurance activity. The Board has recognised the shortfall and has currently suspended the training delivered by the Board trainers to release capacity to support a training review, including a training needs analysis. The workforce development approach is currently being reviewed, with plans to link with regional training developments. A training strategy has been written, but this will need to be reconsidered on completion of the review and needs analysis.

150. Board activity is not informed by the experiences of children and young people. Positive initial engagement with young people in 2014 did inform some Board priority setting, but subsequent planned scrutiny of multi-agency activity by young people did not materialise due to lack of partner-agency engagement. Suggestions made by young people in relation to the website were not acted

on. The participation officer reports that this lack of consultation and participation has led to disengagement of young people from the Board and will present significant challenges for future work with them.

151. There have been some positive developments in relation to responses to child sexual exploitation and missing children, although further work is required to embed this progress fully, given this inspection's findings in relation to current operational practice. The DSCB's strategic and operational oversight of the work and recent developments linking missing and child sexual exploitation work is evident. Awareness-raising work has taken place, with further work planned in March 2016. Intelligence information on victims, perpetrators and locations is used to inform actions, and quarterly performance data gives an oversight and some analysis of activity relating to children and young people at risk and locations. The multi-agency data set relating to child sexual exploitation is not yet sufficiently developed to give a comprehensive oversight of multi-agency work in this area. Police did report that a regional police data set for child sexual exploitation had recently been agreed, but this is not yet available to the Board. Further work is required to ensure that prompt information sharing between agencies always takes place, and that themes and patterns from all missing and sexual exploitation work are comprehensively utilised to inform activity. Risks relating to future resourcing have not been resolved to date. Progress in this area of work is at risk because partner agencies have not agreed to continue funding the child sexual exploitation coordinator post beyond March 2016, and there has been no agreed resourcing to meet the identified need for administrative and analytical support.

152. Cases that may meet the criteria for serious case reviews are now robustly considered following process improvements in the last six months that were driven by a new sub-group chair. Current work includes a joint thematic review of two cases that uses a recognised systems-based approach with an independent lead reviewer. One of the cases has met the criteria for a serious case review. There has been appropriate liaison with the national panel, which has agreed the current approach by Dudley. Dudley has contributed to a serious case review led by another authority that was published during the inspection. When cases do not meet the criteria for a serious case review, but when learning may take place, participative learning processes are used. Learning from recent exercises has not yet been disseminated, so it is not possible to evaluate how effectively practice improvements have been embedded.

153. The learning and improvement framework has recently been finalised. However, it does not detail effectively how key links between serious and other case reviews, quality assurance processes and training will operate to identify, disseminate and evaluate the impact of learning. Findings from this inspection have indicated that learning and required practice improvements identified from a previous case review in 2013 (Child C) have not been wholly embedded.

154. The Board has not consistently driven strategic or practice developments, even when board activity and practice information have identified a clear need. Previous case reviews, individual management reviews and numbers of children and young people subject to a plan under the category of neglect have clearly indicated the need for a neglect strategy. This has not been progressed in a timely way, and work on the strategy and implementation is in its early stages. This has meant that improvements in the quality and timeliness of responses to neglect have not been developed.

155. The Board has initiated work in response to female genital mutilation but it is too early to evidence impact. The Board has set up a task and finish group and initial community engagement was reported. A female genital mutilation strategy has recently been developed but no detailed action plan was evident at the time of inspection, so it is unclear how issues will be addressed or by whom.

156. The work of the child death overview panel in Dudley meets the requirements of 'Working together 2015'. The child death review annual report 2014–15 gives a detailed analysis of the local picture, appropriately locating this in a national and regional context. Recommendations from learning are identified and practice improvements evidenced.

157. The DSCB annual report 2014–15 does not give a rigorous and transparent assessment of the performance and effectiveness of local services. Information and data used in the report are limited, and analysis undertaken does not clearly identify and understand weaknesses or detail actions required to address those weaknesses. The report does detail broad areas of learning from case reviews but does not detail how that learning has or will be disseminated. Contributions made by partner agencies and board expenditure as required by 'Working together 2015' are not detailed despite the insufficient resourcing of the Board being a key unresolved issue. The annual report had not been presented to the health and well-being board at the time of the inspection.

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 that 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 whom it is trying to help, protect and look after.

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

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

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

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

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