

Ofsted  
Piccadilly Gate  
Store Street  
Manchester  
M1 2WD

T 0300 123 1231  
**Textphone** 0161 618 8524  
[enquiries@ofsted.gov.uk](mailto:enquiries@ofsted.gov.uk)  
[www.gov.uk/ofsted](http://www.gov.uk/ofsted)

21 January 2019

Ms Catherine Knowles  
Interim Director of Children's Services  
Council House  
Priory Road  
Dudley  
West Midlands  
DY1 1HF

Dear Ms Knowles

### **Focused visit to Dudley Metropolitan Borough Council children's services**

This letter summarises the findings of the focused visit to Dudley Metropolitan Borough Council children's services on 18 and 19 December 2019. The visit was conducted by Alison Smale and Tara Geere, two of Her Majesty's Inspectors.

Inspectors evaluated the local authority's arrangements for assessments, decision-making and next steps, following assessments of children in need and children for whom there are safeguarding concerns. Inspectors considered the experiences and progress of: children whose cases are open to the assessment teams in children's services; disabled children subject to an assessment; children vulnerable to radicalisation and young people aged 16 and 17 years old who present as homeless.

A range of evidence was considered. This included: case discussions with social workers; reviewing case records; and speaking with children and their parents. Inspectors also met with key leaders and scrutinised relevant local authority performance management and quality assurance information.

### **Overview**

Senior leaders acknowledge that the quality of social work practice has deteriorated since the last inspection. The new chief executive brought in an interim director of children services, who subsequently established and strengthened the senior leadership team within the service. The new leadership team is very new, and actions taken and associated plans have not yet had an impact on services. As a result, there are significant vulnerabilities within the service, which mean that too many children do not have their needs assessed in a timely and effective way. Consequently, some children do not receive the right service to meet their needs when they need it, and they remain vulnerable for too long. Leaders accepted all of the feedback provided by inspectors during the course of this visit. This included concerns raised about individual cases. Where necessary, senior managers

responded with immediate mitigating action. The children with disability service is part of the Dudley disability service that sits within adult social care. This service forms part of the whole-life offer to children, young people and adults with additional needs within Dudley. In response to weaknesses found in the assessment of disabled children, the director of children's services agreed to undertake an immediate review of all disabled children's cases.

### **What needs to improve in this area of social work practice**

- The timeliness and quality of assessments, including assessments of disabled children.
- The voice of children in assessments.
- The focus and detail of plans.
- The help offered to children and families to ensure that they receive the right help at the right time.
- Multi-agency engagement in strategy discussions in open cases.
- Thresholds for holding an initial child protection conference.
- Managers' oversight of frontline practice.
- Recognition of the impact of domestic abuse on children.
- Identification and understanding of long-term neglect.
- The response to children vulnerable to radicalisation.
- The approach to 16- and 17-year-old young people who present as homeless.

### **Findings**

The emergency duty team provides an effective response to out of hours referrals. When there are child protection concerns, a strategy discussion is held with the police, to agree next steps and ensure that children are immediately safeguarded. Information is passed through to the daytime team for action. The new leadership team is acting to ensure emergency accommodation provision is strengthened to meet the needs of these vulnerable children in crisis.

Early help services appropriately refer families for a social work assessment when their needs escalate, or concerns emerge that require a statutory assessment.

Threshold decision-making to step children and families down to early help following completion of an assessment are timely and appropriate. However, assessments

provide insufficient detail about the type of focused help that key agencies will provide to best assist children and families.

Chronologies are not up to date and do not fully consider key events and their impact on children. Some important events in children's lives are missing from chronologies. This means that children's histories and the impact of their experiences are not always fully understood.

Assessments are not always completed in a timely way, and children are not seen soon enough. Assessments lack depth and this means that children's needs and their lived experience within the family are not effectively explored. Social workers do not display professional curiosity to fully understand what children are experiencing. Two practice models are used by the local authority, but these are not fully embedded. This means they do not effectively support critical evaluation by social workers.

Strategy meetings are held appropriately in most cases when there are concerns about significant harm. Most meetings include key agencies. They result in clear multi-agency information-sharing and actions. However, when cases are already open, strategy discussions appear more like a procedure to action an initial child protection conference. These meetings do not benefit from multi-agency information-sharing from partners other than the police.

On completion of section 47 assessments, thresholds to proceed to initial child protection conference are not sufficiently coherent or consistent. This is due to variable thresholds between team managers and between social workers, where risks are sometimes minimised. There is too great a focus on the self-reporting of parents and a desire to work at a lower level if they consent to this.

Child in need plans are not robust. They do not reflect multi-agency information-sharing. Expectations of parents lack clarity about how they need to improve their parenting to meet their children's needs. Only a minority of plans have a contingency, and it is unclear how these will be triggered and what the consequences will be for the family. Help offered to children and families varies. Plans for intervention are not purposeful enough and lack clarity about the focus of services. While some children and families receive services which are helpful, for example the child and adolescent response team, which provides intensive help and support, there are others who do not receive the right help at the right time.

It is positive that team managers meet with social workers to allocate work and agree actions. Management oversight of frontline practice is regular, but it does not always evidence the reflective supervision staff say that they receive. Managers do not regularly display professional curiosity when there are indications that there may be disguised compliance or underlying concerns. Management actions are too formulaic and process driven, and they do not focus adequately on the individual child's needs and experience, or on the quality of practice. Managers do not sufficiently prioritise and track the timescales for completing assessments or seeing children where there are more immediate concerns or more needs evident.

Participation and direct work with children are evident in the work of the assessment team, but is often based on only one visit. For some children, this is not enough for them to open up and share their lived experience. Staff speak positively and knowledgeably about the work being done with children. However, recording does not always evidence the work being undertaken. Social workers do not always recognise the need to slowly build relationships and see children more often when they live in neglectful circumstances and/or chronic emotionally challenging situations. This means that some children are not given opportunities to provide a complete view of their experiences or to explore this in a meaningful way with their social worker.

The impact and risks posed by current and historical exposure to domestic abuse is not well recognised. Too much weight is given to self-reporting by the adults in the family, meaning that concerns are not effectively addressed soon enough. There is little consideration of long-term neglect in assessments, and neglect is not effectively identified. Tools to assist with the evaluation and impact of neglect are not embedded, and social workers have only recently started to be trained on their use.

Children with disabilities do not have regular re-assessments when they are children in need. Assessments are instigated only at parental request. Reviews of direct payments are not timely. Some children have not received an assessment for several years. This means that there may be children who have unassessed and unmet needs which add to their vulnerability. In some assessments, children are not seen. When children are seen, their views or observations are not meaningfully captured. Integrated assessments for brothers and sisters mean that it is difficult to differentiate between their individual complex needs. Management oversight is not regular or effective in monitoring progress to meet children's needs. Recording in the children with disabilities team is less strong than the assessment teams. The director of children's services acknowledged these concerns and agreed to undertake an immediate review of disabled children's cases.

When children are vulnerable to radicalisation, 'Prevent' processes are not always followed. Recording quality is inconsistent, and referrals are not routinely sent to the multi-agency information sharing hub (MASH) or placed on children's files. A significant number of these children have complex additional needs. Records do not evidence how the local offer could support these children in light of their wider complex needs.

Most young people who have presented as homeless recently have not been made aware of their right to become looked after, or offered sufficient advice or support. This means that most of these young people have continued to live unnecessarily in vulnerable living situations. The new leadership team has taken immediate action to develop a new process to assess young people who present as homeless. For those assessed as homeless, it includes an offer of accommodation under section 20 as a primary option, or under section 17 if preferred by the young person. Irrespective of route, young people will subsequently be offered the same level of support as care leavers. However, this process has not yet been embedded.

The corporate structure has been reconfigured to enable stronger oversight of children's services by the chief executive, who the director of children's services now directly reports to. The new children's services senior management team has brought energy and direction and is developing a clear vision for the service. It has focused on understanding and rectifying the weaknesses in the service, and has identified immediate and medium-term priorities, but team members understand that there is much more to be done. Senior managers had identified unsafe practice and took steps to rectify this prior to this visit. Examples of this work include the service's approach to young homeless, the quality of emergency out of hours provision and strengthening the centre for professional development.

Leaders know the service well. Leaders accepted all feedback provided by inspectors during the course of the visit, including concerns about individual cases. Where necessary, senior managers took immediate action to address concerns.

Senior leaders and managers are rebuilding the important partnership arrangements that had weakened since the inspection last year. Action is being taken to refresh and strengthen multi-agency engagement in the improvement board.

Performance management arrangements have been strengthened. Audits are now being completed by managers and moderated by the centre for professional practice. Senior managers know that more needs to be done to ensure that learning from audits has an impact on systematically improving practice.

Recruitment and retention of social workers is starting to improve, and there are early signs that the workforce is beginning to stabilise. Social workers are overwhelmingly positive about the changes being implemented by visible senior managers. The focus of leaders and managers on listening to staff, as part of the improvement programme, is a strength. Inspectors were particularly impressed that the director of children's services had written individually to social workers thanking them for their specific contribution and recognising their personal skills. Social workers also value the strengthened training and development offer.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit.

Yours sincerely

Alison Smale  
**Her Majesty's Inspector**