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Mr Tony Oakman
Strategic Director People Services
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Dear Mr Oakman

Monitoring visit of Dudley Metropolitan Borough Council Children's Services

This letter summarises the findings of the monitoring visit of Dudley children's services on 12 and 13 October 2016. This was the first monitoring visit since the local authority was judged inadequate in January 2016. The visit was carried out by Jenny Turnross and Alison Smale, Her Majesty's Inspectors. From a very low base, the local authority is making positive progress to improve services for children and the pace of change is appropriately swift.

Areas covered by the visit

- During the visit, inspectors reviewed the progress made to ensure that services to help and protect children are effective. They focused on the multi-agency safeguarding hub (MASH), which became operational in May 2016, the understanding and application of thresholds for statutory intervention, and the quality of management oversight and decision making. Inspectors also reviewed the arrangements to plan for children looked after who are subject to court care proceedings.

- The visit considered a range of evidence, including electronic case records and from interviews with a range of staff, including managers, social workers, other practitioners, children and families.

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Summary of findings

- Leaders and managers are fully aware of the scale of change that is required to ensure that all children are consistently helped and protected. They have worked hard to stabilise the workforce by introducing new operating principles. A permanent leadership team is now in place and the council has increased the number of social workers. However, challenges remain to recruit the required number of permanent social workers. Workforce morale in Dudley is high; social workers and managers appreciate the recent changes and understand that services for children in Dudley need to rapidly improve.

- All children's social care staff are undertaking back-to-basics training to ensure that they understand the expected practice standards. The new quality assurance framework is starting to support managers in understanding and guiding practice. Management oversight and decision making is improving, caseloads are reducing, children are seen more often and child-focused work is starting to be seen in the teams visited.

- Thresholds for intervention are better understood and applied in the MASH. This progress is recent but is an improvement in practice, resulting in children who are referred to children's social care receiving an appropriate and timely initial response. Inspectors did not see cases where children had been left at risk.

- The majority of partner agencies share information effectively that supports appropriate decision making. However, the quality of health information available to social workers is poor and this is not helped by the absence of health representation in the MASH. The absence of a key health professional at strategy meetings is undermining the improvements that the local authority needs to make.

- The quality of practice demonstrates very early signs of improvement. Social workers know the children they work with well and case records seen evidence appropriate management oversight and decision making.

- Progress in the management of court work is evident. All court statements and reports are now written by social workers who know the children and families. While improvement is at an early stage, feedback from CAFCASS guardians is positive in terms of the confidence and skills of the team's practitioners.

- Care planning is not yet effective and independent reviewing officers are not appropriately challenging or escalating the issues of poor quality or verbally reported care plans being presented at children's statutory reviews.

Evaluation of progress

Thresholds are now being consistently applied by children's social care staff in the MASH. Clear and appropriate operating principles are in place, as well as detailed guidance for social workers and partners, leading to an increased understanding and application of thresholds. This is an improvement in practice, resulting in children who are referred to children's social care receiving an appropriate and timely initial response.

All contacts to the MASH are now received by qualified social workers, who make timely decisions. Referrals are dealt with swiftly. Inspectors saw no cases where children had been left at risk.

Daily and necessary meetings in the MASH ensure that work from the previous day has progressed. These meetings mitigate against the continuing poor quality of performance information available to managers. Despite this, inspectors saw no delay in progressing contacts and referrals. The addition of a service manager based in the MASH supports ongoing improvement in practice. Case records seen evidenced the recording of management oversight and rationale for decisions, including the rationale for the need to override consent. Managers in this team are making safe and appropriate decisions.

The quality of multi-agency information gathered by the MASH has improved. Partners share relevant information quickly and this supports appropriate decision making. Further work needs to be done to strengthen the quality of written referrals from partner agencies. Currently, social workers are spending too much time clarifying basic details such as dates of birth. The quality of health information available to social workers is poor and this is not helped by the absence of health services representation in the MASH.

Strategy meetings convened in the MASH are now led by a team manager from the relevant assessment team, which will take the work forward. This practice is resulting in more timely decisions at the point of referral. A recognised model of practice is beginning to be used to consider risks and strengths in families and is helping agencies to decide on the most appropriate response to children's needs. The absence of a key health professional at strategy meetings undermines the improvements that the local authority is so keen to progress.

Arrangements with the police to assess and respond to incidents of domestic abuse when there are children present need to improve. Daily notifications received from the police are timely. However, the quality of information is poor. Social workers do not have access to the original police reports, so have no understanding of the risk assessment made at the time of the incident. Notifications are triaged every day in the MASH and are dealt with swiftly. However, there continue to be too many gaps in information, and these mean that the local authority cannot be assured that all children are being assessed or safeguarded effectively.

The court team is now leading on all court work. Early signs of improvement in the management of court work are evident in terms of timeliness of care proceedings,

quality of assessments and court reports. Staff from other social work teams are now based in the same building, enabling straightforward access to advice and information sharing. The legal adviser based in the team offers immediate legal advice on new and current cases and this is a strength. Social work caseloads are manageable in the court team, ranging from between eight and 12 cases, which appropriately reflects the complex nature of the work. All court statements and reports are now written by social workers who know the child and family. Early feedback from the children and family advisory and support service guardians is positive in terms of the reported confidence and skills of the team's practitioners.

The development and implementation of a public law outline tracker has resulted in robust and timely management oversight of court cases. Further work needs to be undertaken to ensure that the public law outline is consistently applied in all cases across the wider service where and when it is necessary. Use of the pre-proceedings protocol is beginning to show early signs of the desired impact being established in cases where care proceedings are being initiated. A legal gateway panel has been established and evidence demonstrates that this is being used well to facilitate discussions and make effective decisions.

The quality of assessments completed by the court team is improving. Assessments are detailed and comprehensive and, in some cases, reference appropriate use of up-to-date research. Evidence of direct work is demonstrated in a number of assessments, both with children and families, and this is leading to an increased understanding of the child's views. Assessments undertaken prior to proceedings could be strengthened by an increase in the quality and frequency of partners' contributions, reducing the need for specialist independent assessments.

Improved standards of work in the court team have not yet translated into care management teams. In these teams, inspectors saw evidence of greater inconsistency, such as legal letters not being sent to parents and failure to use templates that support good social work practice. Senior managers acknowledge this weakness and the next stage of their improvement plan includes actions to build skills capacity within the workforce and disseminate good practice across the service.

Care plans are not yet effective. In too many cases, the current care plan does not reflect the care plan agreed in the children looked after statutory review and too often does not reflect the care plan that has been filed before the court.

Independent reviewing officers do not challenge or escalate issues such as care plans being presented verbally at children's statutory reviews; this remains an area of poor practice. Failure to review a detailed written plan by professionals, family members and the child, particularly in care proceedings, means that the local authority cannot be assured that risks identified in the assessment have been considered, challenged, addressed and managed effectively.

Evidence and statements for court are now of a good standard. Statements include genograms and clear chronologies, which evidence impact. The development of a pre-final evidence meeting is well embedded. This has improved the quality of evidence and the preparation for final hearings, and is regarded positively by social workers, managers and legal advisers.

The vast majority of new cases led by the court team are on track for completion within the statutory timescale of 26 weeks, despite assessments being undertaken and commissioned within the court process. Where delay occurs, a clear rationale is set out, often relating to the complexity of a particular case. Timeliness of new court cases is improving. However, the local authority is still dealing with some legacy cases which will have negative impact on reported performance over the short to medium term.

In summary, positive progress has been made. The local authority knows that further sustained improvements are needed to ensure that all children are helped and protected effectively.

I would like to take this opportunity to thank you and your staff for your positive engagement with the programme of monitoring visits. I am copying this letter to the Department for Education. This letter will not be published on the Ofsted website.

Yours sincerely

Jenny Turnross

Her Majesty's Inspector