Cabinet – 20 June 2018

Children's Services Ofsted Working Group - Report of the Education and Children's Services Overview and Scrutiny Committee

1. Summary

1.1 On 9 January 2018, the Education and Children's Services Overview and Scrutiny Committee created a Working Group to consider the report of Ofsted's inspection of Children's Services and the Council's post-Ofsted action plan.

1.2 The Working Group selected two of the twelve Ofsted recommendations, held three meetings to receive information and interview Council officers and representatives from partner organisations, formulated conclusions and recommendations, and produced the attached report. On 27 March 2018, the Education and Children's Services Overview and Scrutiny Committee approved the report and its findings and resolved that it be considered by the Cabinet.

3. Report detail

3.1 Following its establishment, an initial meeting of the Children's Services Ofsted Working Group was held on 22 January 2018, during which it was agreed to consider two of the twelve recommendations from the Ofsted report:

- Recommendation 1: Ensure that thresholds of need are understood and applied at every stage of the child's journey.
- Recommendation 2: Ensure that frontline management oversight of practice improves the quality of decisions and the provision of help to children.

3.2 Two meetings of the Working Group were held on 5 and 14 March 2018 respectively, when documentation was received and interviews with officers from the Children's Services Directorate and partner organisations were conducted. The Working Group then reviewed this evidence and formulated the conclusions and recommendations that are featured in the attached report.

3.3 On 27 March 2018, the Education and Children's Services Overview and Scrutiny Committee considered the Working Group's report. The Committee approved the recommendations, as detailed on pages 21-22 of the report, and resolved to recommend to Cabinet:

> **That the Cabinet receive the report of the Children's Services Ofsted Working Group, consider the recommendations contained therein and decide what action, if any, it wishes to undertake.**

Background papers

- *Inspection of services for children in need of help and protection, children looked after and care leavers*, Ofsted, 4 September 2017.
- *Walsall Children's Services Post-Ofsted Action Plan – Our Journey to Excellence*, Walsall Council, 1 December 2017.

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Councillor Chris Towe

Chair – Education and Children's Services
Overview and Scrutiny Committee

Children's Services
Ofsted Working Group

Final Report

As presented to the Education and Children's Services Overview and Scrutiny Committee on 27 March 2018

Walsall Council

Foreword

Following the inspection of services for children in need of help and protection, children looked after and care leavers that took place in June and July 2017, Ofsted produced a report that made twelve recommendations. In responding to this report, the Council has prepared a post-Ofsted Action Plan setting out how these recommendations will be addressed.

This Working Group was formed by the Members of the Education and Children's Services Overview and Scrutiny Committee and met on three occasions to review the responses in the post-Ofsted Action Plan. The approach adopted was to conduct a 'deep dive' into the responses to two of the Ofsted recommendations.

In carrying out its review, the Working Group was given full access to both staff and documentation. The honesty and openness of all involved was appreciated and their drive and determination to improve was clear. Despite the challenges being faced, it was evident that all members of staff were focussed and passionate about improving the current service.

Whilst it is essential to recognise the hard work and commitment of our staff and of the partner agencies who work collaboratively with the Council, it is also important to acknowledge that there is still room for improvement.

This open and transparent review process has produced seven recommendations in relation to Recommendation One of the inspection report and four recommendations in relation to Recommendation Two of the inspection report. It is the hope of the Working Group that its recommendations will be supported by the Cabinet and actioned accordingly.

Councillor Tim Wilson
Chair of the Children's Services
Ofsted Working Group

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Introduction

The Ofsted inspection of the Council's services for children in need of help and protection, children looked after and care leavers was held between 20 June and 13 July 2017. Published on 4 September 2017, the inspection report made twelve recommendations that are addressed by the Children's Services post-Ofsted action plan. On 16 October 2017, the Education and Children's Services Overview and Scrutiny Committee (the Committee) agreed that a working group be established to conduct an in-depth examination of one or more of the twelve recommendations and the responses provided by the action plan.

Terms of reference

Draft terms of reference were discussed and agreed by the first meeting of the working group on 22 January 2018. The terms of reference were subsequently agreed by a meeting of the Committee on 15 February 2018. The full version of the Working Group's terms of reference can be found at Appendix 1.

Membership

The Working Group is comprised of the following Members of the Committee:

	Councillor Tim Wilson (Chair of the Working Group)		Councillor Chris Towe (Chair of the Committee)
	Councillor Julie Fitzpatrick		Councillor Liz Hazell
	Councillor Tina Jukes		Mrs Teresa Tunnell (Parent Governor Member of the Committee)

The Working Group has been supported by the following officers.

Dr Paul Fantom	Democratic Services Officer
Mrs Nikki Gough	Democratic Services Officer
Ms Debbie Carter	Assistant Director (Children's Social Care)

Methodology

Since its establishment, the Working Group has held three meetings.

The first meeting, which took place on 22 January 2018, reviewed the twelve recommendations from the Ofsted inspection report and identified two of the recommendations that the Working Group wished to review. These are:

> Recommendation 1: Ensure that thresholds of need are understood and applied at every stage of the child's journey.
>
> Recommendation 2: Ensure that frontline management oversight of practice improves the quality of decisions and the provision of help to children.

The Working Group proposed to review the actions, measures and timescales for tackling these recommendations and, in order to achieve this, adopted the following approach:

- Who do you want to see?
- When do you want to see them?
- What will you ask them?
- What other data will you want to see?

A comprehensive list of questions was devised by Working Group members [See Appendices 2 and 3] and the other data/information required in advance of the meetings was specified and supplied to the Working Group by the Children's Services Directorate.

To review each of the two recommendations in turn, two meetings were arranged for 1 and 5 March 2018 respectively; however, due to adverse weather conditions, the meeting due to be held on 1 March was rescheduled and held on 14 March 2018.

For each meeting, the people or groups of people that the Working Group wished to interview were identified and invited to attend one of the meetings.

Given the number of questions formulated and people to be interviewed, in order to maximise effectiveness, the Working Group decided to divide into two sub-groups of three Committee Members and a support officer. At the conclusion of the interviews, the two sub-groups reconvened so that they could consider each other's findings and formulate conclusions and recommendations.

The timescales being adhered to by the Working Group were that this report should be presented to the meeting of the Education and Children's Services Overview and Scrutiny Committee on 27 March 2018. The Committee would then be invited to make recommendations as to whether the report should be presented to the Cabinet and/or the Council in due course for the consideration of its findings, conclusions and recommendations.

Findings

This element of the report contains a summary of the Working Group's findings.

For 'Recommendation 1': Ensure that thresholds of need are understood and applied at every stage of the child's journey.

The Working Group considered Recommendation 1 at the reconvened meeting held on 14 March 2018, when the following were interviewed: The Chair of the Local Safeguarding Children's Board (LSCB), representatives of West Midlands Police and the Walsall Healthcare NHS Trust, together with an Assistant Director, three Group Managers, a Team Manager and several social workers from the Children's Services Directorate.

The Working Group was informed about the composition of the Multi Agency Safeguarding Hub (MASH). Currently, this comprises six social workers, a Team Manager, two Assistant Team Managers, two West Midlands Police officers (a Detective Sergeant and a Detective Constable), a Safeguarding Nurse, an Education Welfare Officer, a Probation Officer, an Early Help worker and a representative from Black Country Women's Aid. It was stated at the outset that the MASH has only 24 hours to deal with a concern that has been referred to it. MASH believes it would be beneficial for the team to have representatives from mental health and housing involved in the MASH on a day-to-day basis.

There was a question on the support given in terms of the Local Safeguarding Children's Board's (LSCB's) training programme on thresholds. Members were advised that prior to the Ofsted inspection, on-going multi-agency training/ workshops were delivered by Heads of Service/Group Managers. This sometimes includes input from partners. This training is part of the LSCB training to raise awareness and embed so as to ensure that staff members are comfortable with using thresholds and managing risk. Furthermore, staff should be able to approach their line manager or the Safeguarding Lead to discuss any points of clarification regarding thresholds. It was pointed out that a new Thresholds document had been signed off and introduced [See Appendix 5].

Having regard to the making of referrals to the MASH, it was noted that this is done either by making a telephone enquiry, when advice and guidance is given, or by completing and submitting a Multi-Agency Referral Form (MARF). These records are kept for significant periods and in the case of a child in care would be kept for their lifetime, so may endure and have long standing consequences. When the threshold for referral is not met, referrals are classed as No Further Action (NFA) and 'pushed back' to the referring agency with advice about appropriate action. It was pointed out by the Group Manager that the Ofsted inspection had referred to the high number of such contacts coming into the MASH. The greatest number of referrals comes from schools and in September 2017, there were 40 referrals from schools that were classed as NFA and were 'pushed back' with guidance on what action to take. By February 2018, the number of such school referrals 'pushed back' has been reduced to 3 as a result of this educative process.

Members were advised that domestic violence (DV) is a significant issue in Walsall, and that to deal with this there is considerable joint working between the Council and West Midlands Police. However, of the 53 per cent of referrals being made to MASH by the Police, 73 per cent of these were subsequently classed as NFA. Since January 2018, new criteria for low-level concerns have been agreed with the Police, and they now screen prior to submitting to MASH and consequently an improvement in the position has been observed.

Similarly, for MARFs received from health workers, when 36 were reviewed in February, it was found that only approximately 2 per cent met the threshold. It was felt that there was a tendency for NHS staff to be more risk averse than other members of the MASH (as corroborated by NHS representatives – see below), which suggests a need for greater clarity and more work with other agencies. To address this, MASH has held meetings with the NHS's 111 Centre based in Sandwell and with the Beacon Drugs and Alcohol Team, and there is a willingness on the part of the MASH to meet with and work with all partners to continue to raise awareness.

Training on threshold policies is updated regularly, especially given the complexity of cases being handled and the requirement for staff members to be proficient in exercising decision-making and judgement skills. In terms of additional/new training being given, following questions from the Working Group it was confirmed that all MASH staff receive training, which occurs frequently, is reinforced weekly or even daily, and there are also regular discussions of cases by the MASH team. In addition, there is attendance of workshops by all new staff members, including social workers completing the Assessed and Supported Year in Employment (ASYE) programme.

Two full-time officers from West Midlands Police (a Detective Sergeant and a Detective Constable) are now assigned to the Walsall MASH. This is a similar configuration to that in other neighbouring local authorities, with the exception of Birmingham, which have a different set up due to the complexity of issues and size of area involved. The two Police Officers currently working in the MASH have been there since Christmas 2017, although one of these officers is returning to this type of work following a break. Although they have not received LSCB training, both officers have been given internal training on thresholds from a Detective Chief Inspector (DCI).

The Police role within MASH was explained. They are based in the MASH and are part of the strategy discussion and to share information. They also ensure, as part of a 'gate-keeping' role, that information is not shared unnecessarily when it is not relevant. The Police also contribute to the running of MASH by providing an input and suggestions on issues and process changes, with domestic violence screening being an area of particular concern.

The Central Referral Unit (CRU) is based at West Bromwich Police Station and provides a research and information service for six of the seven local authority areas. The information gathered by this unit is then sent back to the respective MASH. Some changes to working hours and shift patterns have been piloted in respect of Walsall, but not the other local authorities, and this has been beneficial

to the provision of research and information from the CRU to MASH. A version of the tool for the triaging of cases by the Police was developed in the Birmingham MASH and has been implemented in Walsall. Police officers in the MASH have a checklist that they use for this purpose.

Walsall Healthcare NHS Trust allocates a named nurse to the MASH and this staff member is also responsible for liaison with the Dudley and Walsall Mental Health NHS Trust (as there is currently no mental health nursing expertise within MASH) and with GPs. The named nurse uses the NHS's systems for carrying out checks using the NHS's electronic records to ascertain if there are any child protection issues, as there are health records for everyone.

The NHS representatives noted that there have been a high number of contacts referred to the MASH that have not met the threshold for statutory intervention. Some work and training has been initiated to address this. Nevertheless, it is recognised that many NHS practitioners remain risk averse. Training on MARFs for staff in hospitals is being carried out internally and Accident & Emergency staff members are required to do threshold training up to Level 3.

When asked about the LSCB training, the NHS representatives confirmed that nothing has been offered from a MASH training perspective to NHS staff, but as previously stated nurses do receive training and have expertise in relation to thresholds. It is acknowledged that participation in wider training could be beneficial; however, there is the issue of capacity and covering the work because it would not be possible to shut down the MASH for the long period of time that this type of training might require. The time factor and the workload balance, between attending strategy meetings and completing checks were also referred to during the interview.

It was reported that there are 'flags' on the Hospital's records if there is a child protection plan, or if there is a pattern over the last six hospital attendances that raises concerns, following which a social worker is advised. A national Child Protection Information Spine (CPIS) is due to go live in Walsall during March 2018 and this will allow health staff in an unscheduled care setting to enquire whether a child is looked after or on a child protection plan. This information is linked to their health record and should be available if the child is seen by health outside the Walsall area. During the recent Care Quality Commission (CQC) inspection, there was some criticism of 'A&E cards' (which indicate staff responsibilities), and it is noted that changes to these are being actioned.

In relation to health visitors, and what they should do when there is uncertainty about whether the threshold has been met, the NHS Trust does have a duty line staffed by named nurses, and which has been in place since 2014. Checks and consultations are made via this duty line before referrals to the MASH are made.

As regards having mental health expertise in the MASH, and this point had been raised during the CQC inspection, it is a matter the Clinical Commissioning Group (CCG) should consider. This reiterates earlier observations that having this additional expertise in relation to behaviours, diagnoses and treatments

would be welcomed by the NHS staff in the MASH, as well as their colleagues from Children's Services and the Police.

Referrals to MASH from the NHS are made using the MARF form, and this specifies contact details and the relevant line manager. When asked by Members whether they were satisfied that the right number of referrals is being made, the NHS representatives expressed confidence that the referrals coming through their team are appropriate and should not need to be pushed back. When MARFs are 'pushed back' by the MASH, the NHS may be asked by the MASH team to review what has happened. When compared with colleagues from the Police and Children's Services, the level of NHS support was discussed. It is felt that another named nurse would be of benefit to the MASH, and that this would be helpful with completing checks.

Turning to the social workers based in the MASH, they indicated that they are acutely aware of the high proportion of contacts not meeting the threshold for statutory intervention and action is being taken to address poor quality and inappropriate MARFs. This has included the development of a new, simplified MARF, with the intention of making it easier for partners to use. When a particular agency is submitting poor quality MARFs, or when a cohort of applications is made without sufficient reference to the threshold, this is noted and meetings are held with partners. This is found to be more effective than merely rejecting the MARFs. It gives all participants a better understanding of processes, pressures and each other's needs.

There was a question around the circumstances when a child needs to come into foster care or residential care but there is a delay. In such a situation placements are always arranged by Social Care, but if there is high demand on sourcing suitable places this can sometimes lead to delays. However, for children with complex needs, where it is safe to do so, a range of resources are put in place to enable the child to remain safely living with their family. There is collaborative working with a range of agencies including CAMHS. Reviews and dip sampling are used to learn from such experiences.

In response to a supplementary question from a Member, it was confirmed that kinship care (i.e. staying with their family) is always attempted whenever possible. There are a high number of children placed with connected persons; however, it is also recognised that there are situations when it may not be appropriate or safe to do this.

A Solutions Panel (which meets every Tuesday) identifies those children who are on the 'edge of care' and ensures effective packages of support are put in place to reduce the need to initiate Court proceedings. The Public Law Outline PLO panel (which meets on Thursdays, and has Children's Services and Legal Services in attendance) considers cases of children where court proceedings are necessary and makes recommendations to the Assistant Director.

A question was asked why there are differences in the number of MARFs received from the various agencies. There has been a reduction in the number of domestic violence referrals because they are now being screened differently

by the Police. This is due to the introduction of a new system where screening of the DV logs is carried out by the Detective Sergeant before they come to the social workers.

Additional NHS staffing in the MASH is needed because there is a consensus of opinion that there are issues because of a lack of consistency. Also, health visitor activity which contributes to child protection was raised, together with having support from the consultants in CAMHS on children with complex needs.

There can be difficulties when there is a child who is subject to a child protection plan and requires assistance from the wider partnership, and health visitors are visiting on a monthly basis. The view expressed by both the Working Group and interviewees is that health visits need to be more frequent and based on co-operation and support.

When asked whether there are other professionals who should be working in the MASH, it was felt that housing, mental health and the Beacon (alcohol and drug Team) should be represented. It was pointed out that representatives from housing attend the Solutions Panel and that this is very helpful. Notwithstanding this, the need to have housing expertise based full-time in the MASH was reiterated, so that the housing dimension to any of the problems would be easier to resolve. Also, a direct link to WHG/Accord/other social housing providers would be of benefit to the MASH.

In noting that most MARFs classed as NFAs originate from schools, this accounted for 95 per cent of advice and information calls. It remains evident that some schools are still unclear about their responsibilities and the use of thresholds. It had previously been possible to identify particular schools where this was the case, but there no longer appeared to be a pattern for this. It was asserted that more training for head teachers and designated safeguarding leads (DSLs) should be provided.

The Working Group heard from the Chair of the LSCB that data relating to thresholds is monitored through a sub-committee of the Board. This is a multi-agency audit process and data is received from MASH detailing the number and types of referrals.

There is an escalation policy that should be used when a referrer remains concerned about the safety of a child. In such circumstances, the case will be escalated to the Head of Safeguarding, who will further escalate to senior managers if necessary. It is suggested that this is not used enough, despite there being good awareness of the policy. It is acknowledged that the use of the escalation policy is not monitored meaning that there is not the data to support the statement.

The Working Group was advised that the document ‘multi-agency guidance for thresholds of need and intervention’ [see Appendix 5] had been updated and has just been finalised and signed off by the LCSB. Further guidance has been developed in response to criticism by Ofsted around a lack of clarity at Levels 3 and 4. In response to challenge from Members around the inclusion of children

with disabilities, the Working Group was reassured that this group was included, as the extra vulnerabilities of disabled children were acknowledged.

It has been recognised that previous training could be improved and did not have the desired impact. In the light of the updated thresholds, a plan for training has been developed to commence in May 2018. The revised training plan is to be piloted with LCSB Board Members. This will ensure that understanding of thresholds is embedded at Board level. The implementation plan included clarity that thresholds needed to be understood by all agencies. Members questioned how the impact of training is measured. It was concluded that the evaluation and measuring of training needs to be more robust.

In response to the Ofsted recommendations, the LSCB is now functioning in an improved way. This includes a better multi-agency auditing procedure to ensure that information is collated to give a 'picture' of a child's life.

Members questioned if the LCSB has the authority that is required to allow relevant information to be accessed. The Chair of the Board clarified that although the LCSB could not legally require access, it did have significant influence to ensure that this happened. Also relationships in accessing information from GPs were developing well through the CCG.

The Working Group heard that domestic violence was a problem in Walsall and this has made up a large number of referrals to the MASH. However, this has been improved by a filtering process carried out by the police, and this has made a difference. Monthly dip samples are being received by LCSB from MASH. These highlighted inappropriate referrals and also indicate those agencies that are not referring at all.

The Working Group was advised by the Assistant Director that the new Children and Social Work Bill is to remove local LSCBs. Transitional arrangements will be put in place and proposals in relation to how the future partnership arrangements will operate.

Members asked for clarification on how a child may need to be taken into care. The Group were advised of two routes. One route is a voluntary arrangement, meaning that parents retain parental responsibility for their child. It was noted by the Working Group that nationally there has been historical misuse of this route into care and judicial guidance has been issued. The other route requires a Court Order. This route requires significant evidence to demonstrate that the child is at risk of significant harm.

Officers outlined the process when a concern about a child is raised. Where there is evidence of physical or sexual abuse, the case will always be referred directly into social care. However, in other circumstances initially where appropriate, the Early Help Locality Team will become involved with the family to support parents to change. If there is poor engagement or no change the case will be stepped-up to Children's Social Care. In severe circumstances and where necessary, a child could be removed from their family on the same day as they are referred to social care. This could require the Police to use their

powers to protect the child so that they can be placed in foster care until an application to Court can be made. However, in most circumstances there is a prolonged period of working with parents to help them to improve their care of the child before court proceedings are considered. The Working Group heard that a tool called the 'graded care profile' is being used in social care and locality teams to help to assess situations of neglect, as this is often hard to measure and determine that harm is being caused as a result of neglect. This tool will be used by other organisations, such as health agencies, as part of the LSCB neglect strategy.

The Working Group challenged what action is being taken for those children who have met the threshold of care but remain living with their birth families. The Working Group was advised that the Children Act 1989 has a number of key principles, one of which is the use of the least intrusive order to ensure a child's safety. However, the practice nationally as well as locally is seeing an increase in the use of care orders at home by the court system when the lesser measure of a supervision order could be more appropriate.

In relation to an overload of domestic violence cases referred to MASH, a screening tool has been developed by Barnardos. This is now being used to ensure that the correct cases are being referred. Members questioned how assurance can be given that cases are not being missed. Officers explained that for a period of 2 months all cases identified and those that had been filtered out by the tool are referred to the MASH, and this clearly demonstrates that the correct cases are being selected.

The Working Group learned that the quality of the child and family assessments are variable and too much emphasis is given to self-reporting by parents. It is considered that this should be challenged as the social worker assessment formed part of evidence when attending court. This is confirmed as an area of work that needs improvement through training, using a 'curiosity' approach to ensure that information is triangulated.

In response to concerns about children with disabilities, the Working Group was advised that these children will routinely be referred via the MASH to the Disabilities Team as this often requires a different approach by social workers with skills in both disability and safeguarding.

If intervention can be provided early on in a child's life, the impact can be more effective and reduce harm suffered by a child. It is acknowledged that if this does not happen, or the intervention is not effective, the legacy can be that children come into care later on when their needs have become more complex. This it is why it is important to make the right decision about a child coming into care at the right time. There has been an increase in older children, over 10 years old, coming into care. Officers stressed that a change in leadership and a stable management tier are now in place to ensure that the right children are coming into care at the right time and for as long as is needed.

Members questioned if the escalation policy is used, and officers confirmed that other professionals did not utilise the escalation process enough and it was

stressed that partners needed to hold accountability for the cases they have referred and these should be escalated where it is felt necessary.

Training on thresholds has been revised and implementation will be driven through the partnership to improve accountability across agencies. Training sessions are mandatory. The Working Group was advised that several audits had taken place and that the use of thresholds was found to be appropriate. Officers advised the Working Group that improvement is still required and the root cause and action required is understood.

In terms of timescales and processes, the Council has 24 hours to determine the outcome of a contact with a family and a maximum of 45 days to complete a children and family's assessment. If a child comes into the care of the local authority in an emergency, the child can be protected by the Police for 72 hours during which time the Council needs to go to court to obtain a legal order keep the child in care. It is acknowledged that the timescales involved are tight.

A weekly solutions panel comprised of early help, education, CAMHS and social care hears cases and has been helpful in identifying blockages and where the system is not working, for example, children getting a school place and the practice of health visitors. The panel assists social workers to identify solutions to practice issues.

For 'Recommendation 2': Ensure that frontline management oversight of practice improves the quality of decisions and the provision of help to children.

The Working Group considered Recommendation 2 at the meeting held on 5 March 2018. The Working Group interviewed an Assistant Director, Principal Social Worker, Group Manager, two Team Managers and several social workers (including two ASYE social workers) from the Children's Services Directorate.

The Working Group was informed that all social workers receive monthly supervision, but for newly qualified social workers on the ASYE programme, supervision is initially fortnightly and then becomes monthly. The ASYE social workers also receive support from the Social Work Academy. The new supervision monitoring system, which enables the identification of compliance issues, is being implemented and will take some time to become fully embedded. Although there are aspects of it that continue to be viewed as being bureaucratic, improvements are being made. The MOSAIC software has templates within which mandatory fields have to be completed. This software can be used to generate reports on supervision and it is hoped that it will be possible to run similar reports on Management Decision Records (MDRs). Trials on this development are being held and, if successful, this will be a powerful tool. However, the importance for supervision records being of high quality was emphasised. Quality audits had been conducted by the Principal Social Worker and it has been found that there is some variability in quality.

When responding to questions on training on the MOSAIC software, accuracy when recording supervision is considered of paramount importance. It is recognised that some people are better at doing this than others and, therefore, mandatory recording training is available three times per year to help to achieve this. When holding a supervision session, the notes are entered on to the MOSAIC system during the meeting because to type them up later would cause delay and have an adverse impact on the team managers' workload.

Members asked whether the use of practice standards in relation to supervision and management oversight are being reinforced. The practice standards were circulated before Christmas 2017 and are now reasonably well embedded at the 'front door'; however, there is greater variability in how well embedded they are in other parts of the service. The appointment of a number of permanent team managers has been beneficial and is expected to contribute to making further improvements. There have been improvements in MDRs but there are still consistency issues and gaps, so this continues to be viewed as work in progress.

Prior to the Ofsted inspection, progress was being made in regard to the embedding of the range of analytical tools to support good decision-making. Since the appointment of the Child Sexual Exploitation (CSE) Operational Lead, there has been a CSE practice uplift, which has been done via workshops. Analytical tools for the assessment of risk are being used by Team Managers, with the 'Resilience Matrix' and the 'Discrepancy Matrix' both contributing to having the correct information, thereby enabling social workers to have the necessarily challenging conversations about managing cases. Currently,

attention is being given to the use of new electronic devices, so that activities of this nature can be done in a timely manner and in the best way to give support.

It was confirmed that the Supervision Toolkit is Walsall Council's own document, but that it is similar to that in use at other local authorities. This document was revised by the Principal Social Worker at the end of 2016 and made available from January 2017. With reference to the provision of bespoke training, a highly regarded independent trainer, who has worked with the Council before, has been commissioned to provide training on supervision and child protection. The benefit of this training arises because, during supervision, managers may learn about aspects of cases that are distressful, and they also need support to be able to deal with this.

Reference was made to the introduction of the 'unit' model, which brings staff members together so that they can talk about their work and disseminate/share information with other team members.

When considering how managers prepare for supervision, it was explained to the Working Group that there are essentially four components: a support function, a managerial/ workload function, looking at specific cases and continued professional development (CPD) to review what training has been done by staff or is to be completed. This approach includes looking at caseloads and carrying out a 'temperature take' to find out if there are any other issues that might be impacting upon performance. Should staff experience additional caseload pressure, or be dealing with particularly complex or challenging cases, they can request extra supervision from managers. Where a case is very high profile and complicated, or there are legal or resource implications, then there can be a meeting to discuss issues with the Assistant Director or in some high profile cases even the Director of Children's Services.

The embedding of the new supervision system, and the difference being made by this, was addressed by Team Managers who use the statistics provided by their Group Managers to review the percentage of staff receiving supervision. However, there are accuracy issues and data can be skewed. For instance, if a staff member is away from work due to illness or pregnancy, then this employee is still shown in the statistics generated by MOSAIC as being in work.

Both Team Managers confirmed that supervision is conducted on a monthly basis and that they write up/input into MOSAIC during the session time, then sign and put the record in the staff member's file. Assistant Team Managers do not carry out supervision; Team Managers and above that have this responsibility. The Team Managers also supervise some administrative staff, which allows them to gauge more effectively how these staff can best support the work of their teams. In the Initial Response Service (IRS) Team, the busy working environment means that there have to be lots of conversations about cases between monthly supervisions.

Members asked the Team Managers about the use of the Practice Standards, the tool kit and other documentation, and whether they found these to be useful. The response received was that the amount of support required depends on the

individual staff member, as senior practitioners require less or different types of support to newly qualified ASYE workers who need to have their confidence developed. An important aspect of supervision, reiterated in several conversations with staff members, is the value of reflective supervision, and that these documents can act as a valuable reference tool. There is recognition that it is not always possible to have an in-depth discussion to deal with all issues during supervision. Hence, a further meeting might have to be convened to accommodate this.

Both Team Managers are aware of the criticisms that had been made by Ofsted in its inspection report. Their involvement in weekly meetings with Group Managers allows them the opportunity to participate in working towards the improvement plans and implementing recommendations.

The managers were asked about MOSAIC, and whether the system was meeting their needs. They acknowledged that because there are a lot of forms in its workflow that have to be completed sequentially, it can be time-consuming and the MOSAIC system cumbersome to use.

The Working Group met front-line social workers (ranging from newly qualified social workers on the ASYE programme to senior practitioners) drawn from a number of teams: Corporate Parenting, Initial Response and the Safeguarding Families Service. When asked whether they feel well supported and receive the right help and direction, the response was positive and unanimous. They feel supported by Team Managers and ATMs, regular supervision is provided and their managers are persistent so that nothing is 'let slip'. Value is also placed on support from colleagues and peers, especially in the context of 'unit' meetings, which has had a positive impact on case discussion, and in the case of the ASYE social workers support from the Social Work Academy.

When they have to access support, the social workers confirmed that their managers are responsive, give of their time and are good at providing guidance and direction via the issuing of MDRs. The recruitment of permanent managers was viewed very positively because the previous, temporary, managers had not always recorded everything and were not always easily contactable.

For social workers, in situations when things are 'not going to plan', it was noted that there is not just advice and support from their own managers; there is practical support from peers and other managers. If necessary, managers will accompany social workers on their visits. A further example was given by a social worker who had been on duty until 10.30 pm but whose manager (whilst not being on duty themselves at that time) had remained in contact, arranged support from the Emergency Duty Team (EDT) and followed this up the following day. It was also noted that compared with other local authorities, including those that had received a higher rating from Ofsted, the support for ASYE social workers is very good.

Supervision is viewed positively, as a time not just to receive direction but to be reflective with regard to the cases that are currently being dealt with. It is the responsibility of individual social workers to make the most of it. Social workers

are expected to write case summaries and prepare beforehand, so that they are fully prepared for supervision and can use the time allotted to best effect. This allows for discussion of the best ways to approach cases or problems and to improve the work with families. All staff members confirm that their managers are always prepared for the supervision sessions and that they make use of the Toolkit, and especially the 'discrepancy matrix' during supervision.

When asked how supervision can be improved, it is felt that fewer cases would give greater time for reflection, and ideally the amount of time available for supervision each month could be increased. There is also a degree of repetition in the recording of supervision, so that conversations that have taken place during the preceding weeks are repeated so they can be recorded on MOSAIC. There was a view that a more efficient way of recording these at the time and then incorporating them into the supervision record should be devised.

Members enquired about the numbers of cases currently being handled by those who attended the Working Group's meetings, which were 13, 10, 12, 18, 19 and 14 respectively. The Social Worker with 18 cases stated that this had reduced from 28 cases when they came off duty last time. It is recognised that the caseload for duty social workers fluctuates considerably but staff do all that they can to bring the numbers down and address the balance.

In relation to the outcomes of the Ofsted inspection report, the social workers referred to the importance of good handover meetings, managers using MDRs to good effect, and clear and detailed tasks and timescales being set by managers.

The training for social workers in Walsall is considered to be very good, although there appears to be some variation in the way in which training opportunities are communicated to social workers. Some managers maintain a grid for all of their staff, specifying training completed or to be taken, and they raise this at 'unit' meetings; whereas others circulate emails to staff for them to book on to training. This is an inconsistency of approach and has led to some social workers (including agency workers) missing out on courses that are mandatory.

The Working Group heard from the Principal Social Worker that the supervision monitoring system has now been embedded and is providing transparency as to where further work is needed in terms of supervision. A target of 95 per cent of completed supervisions has been set internally. However, where supervision is not possible, for reasons outside of manager's control, this could distort the baseline figures and mean that the target is not met. In addition, the Working Group was advised that the supervision policy in Walsall was considered to be very good and one of the reasons why the Council is successful in recruiting new social workers. Managers receive training on preparation for supervision and typically draft an agenda, review case notes and compile questions. Evidence of supervision meetings is held on file, along with the associated action plans produced as a result of supervision.

Members were also informed by the Principal Social Worker that the practice standards in relation to supervision and management oversight had been reinforced through the practice improvement forum and also through further

dispersal and discussion with staff. It was noted that social workers felt positive towards supervision and found it to be supportive to their role.

The Principal Social Worker stated that improvement was ongoing. Permanent managers are now in place and work to retain staff is continuing. Members were assured that all front line managers receive supervision training which is mandatory. All managers and social workers are trained to use an analysis grid which is a simple tool that assists greatly in decision-making. Since the tool has been introduced, better analysis has been recorded on case files.

Members were informed by the Group Manager that the supervision policy is embedding and is a key element of the management role. The new supervision policy was implemented in April/May 2017 and is well established in some units. Where this had not been the case, the aim is to achieve consistency. Strategically, supervision levels are a regular item on the agenda at the Performance Board, and within the quality and assurance audits. It was noted by the Working Group that practice standards have been a re-launched.

It is possible to generate performance reports from MOSAIC demonstrating how the conversation held in supervision translates into a plan. The Working Group also learnt that supervision is held more regularly for new social workers and the record of this forms part of social worker's portfolio.

The Working Group asked for clarification on the operation of procedures when a social worker is absent due to ill health. Members were advised that social workers work together, are aware of cases and that the team will manage the case load if a staff member is absent due to illness. Although it is dependent upon the situation, a decision is made whether to re-allocate cases. Members learnt that social workers operate a buddy system to assist in such situations and to ensure that children are familiar with other staff members. In response to challenge from the Working Group, to question if the target of 95 per cent supervision rates is achievable, the Group Manager stated that where staff are absent due to long term ill health supervision is picked up in the next month. It was stressed that there is an expectation that supervision is prioritised.

The new supervision monitoring system has been embedded and is making an impact at management level, allowing further details and patterns to be identified. Also, managers are now more proactive as they were monitored against targets. The Working Group was advised that practice standards in relation to supervision and management oversight are reinforced every two/ three months and that this is working well. Managers are able to produce reports from MOSAIC management system; however, it would be desirable for MOSAIC to produce 'in-time' performance data.

Group Managers also receive monthly supervision which includes discussion of complex cases to ensure joint decision-making. Senior Managers have an open door policy and can always be contacted. Group Managers support each other and assist in resolving difficult situations. The Working Group heard that this often happens outside of supervision. Complex cases identified during supervision are taken to unit meetings for further consideration.

Conclusions

The Members of the Working Group were impressed by the honest, informative and open responses given to their questions by all of the interviewees.

Having regard to recommendations 1 and 2 of the Ofsted Action Plan, the overall view of the Working Group is that improvements are being made and that at the current time these are going in the right direction. Careful management of the actions is required to maintain the current improvements.

For 'Recommendation 1' (Meeting held on 14 March 2018)

In order to gain an appreciation of whether the thresholds of need are understood and applied at every stage of the child's journey, the Working Group interviewed the Chair of the LSCB, members of staff from different levels within the Children's Services Directorate, and representatives from the Walsall Healthcare NHS Trust and West Midlands Police. A significant element of these discussions centred on the operation of the partnership's Multi-Agency Safeguarding Hub (MASH), hosted by the Council, the referral processes and the contributions being made by the partner organisations.

It is noted that the statutory requirement for an LSCB is to be removed, this being in accordance with the new Children and Social Work Bill that is currently undergoing Parliamentary consideration and will appear on the Statute Book in 2018. It is recognised that the Board's authority and its role has been restricted to influencing partners.

The Working Group was assured that the number of inappropriate referrals relating to Domestic Violence has reduced, and that there are safeguards in place to ensure that cases are not missed.

There are concerns regarding the overly bureaucratic court systems and of children remaining at home with parents, but being the subject of a care order. The Working Group would like more information about the operation of the Children's Guardian and the Child and Family Court Advisory and Support Service (CAFCASS). Particular concern is expressed regarding the use of care orders at home and comparative data for other local authorities that use Wolverhampton Court is requested by the Working Group. It was also noted that there is an increase in the number of children over 10 years of age being taken into care by the Council. This information should be recorded in order to be made available for future Ofsted inspections.

The theme of partner organisations not making use of the escalation policy when referrals (whether via the submission of a MARF or via a telephone referral) are 'pushed back' is evident. There is a tendency to let matters lie and not to take full responsibility for what to do next when this happens; this responsibility lies with the referrer, and they should make greater use of the escalation policy when appropriate. The use of a suitable tool for all partners to use so referral decisions can be justified should a case eventually come to court was recommended.

The findings suggest that further development should take place to ensure that the quality of social worker assessments of families and children are consistent in order to allow a sound judgement to be made.

It is confirmed that new guidance for thresholds of need and intervention has been introduced [see Appendix 5] and that a major training programme for this will be initiated from May onwards. This document and its associated implementation plan will assist in ensuring that thresholds of need are understood by staff members and partner organisations. The Working Group was assured that a revised training programme would reinforce this understanding and, therefore, the impact of this should be monitored.

For 'Recommendation 2' (Meeting held on 5 March 2018)

To ascertain whether the frontline management oversight of practice is improving the quality of decisions and the provision of help to children, the Working Group interviewed members of staff from different levels within the Children's Services Directorate.

The evidence gathered from this questioning, as reported in the findings of this report, indicates that there is a level of consistency in the responses across the teams and within the hierarchy of the Children's Services Directorate. This led the Working Group to the conclusion that the supervision system is being implemented or is in the process of being embedded, that it is working well, and is being used to identify compliance and non-compliance. There is some variation, but there is work ongoing to address this.

All interviewees confirm that the practice standards, supervision policy and toolkit are used in relation to their own supervision. The support received from managers is positive and, with the recruitment of more permanent managers, the effectiveness of supervision has increased further. Particular emphasis is placed on the value of reflective supervision, the use of MDRs by managers, and daily support from managers, peers and colleagues. There is some repetitiveness, nonetheless, in that conversations carried out concerning cases are unrecorded until the next supervision, when they have to be repeated in order to be entered onto MOSAIC.

The identification of CPD opportunities is a key component of supervision. The Working Group notes that the communication of such events can vary and, as a consequence, some social workers have missed training opportunities that they should have been able to benefit from.

Several interviewees raised points concerning the MOSAIC package, with suggestions being proposed for ways in which this might be made more efficient, so that the data and reports produced by MOSAIC are timelier. Accordingly, a number of recommendations have been made in this report.

Recommendations

For 'Recommendation 1' (Meeting held on 14 March 2018)

That the report of the Working Group be endorsed by the Cabinet and/or the Council and that the following recommendations to the Executive Director (Children's Services) be considered and implemented as appropriate.

1. A further briefing to be provided to Members regarding the removal of the statutory requirement to have a Local Safeguarding Children's Board, to ascertain what arrangements are to be made to continue to exercise the functions that have been carried out by the LSCB.

2. That MASH team needs to be strengthened by the allocation of support from a housing worker and a mental health nurse, and that the partners for these areas of activity be invited to consider this request.

3. That the Walsall Healthcare NHS Trust be requested to consider allocating additional staffing order to increase the nursing support provided by the Trust to the MASH.

4. That the use of the escalation policy be encouraged and further information on the policy and its use (including a clear indication of how to escalate cases) be communicated to all partners to encourage them to take ownership of it and to incorporate it into their own processes and training programmes.

5. That there is a regular audit to improve social worker assessments of families and their children prior to such cases being referred to the MASH.

6. That comparative data be sought from the other local authorities that use the Wolverhampton Court and CAFCASS, in order to assess understand the regional practice in relation to making care orders at home.

7. That the forthcoming training on thresholds be subject to evaluation and follow up within six weeks of the events. This is to determine and assist the LCSB to understand the difference that is being made due to its impact.

For ‘Recommendation 2’ (Meeting held on 5 March 2018)

That the report of the Working Group be endorsed by the Cabinet and Council and that the following recommendations to the Executive Director (Children’s Services) be considered and implemented as appropriate.

1. That consideration be given to the commissioning of amendments to the supervision monitoring tool and MOSAIC in order to:

    a) Either:

        (i) take account of staff member absence, for example due to illness or being on maternity leave, and accurately reflect this in the statistics;

        or

        (ii) incorporate an additional field in the template to allow an explanation for when a supervision meeting could not take place;

    b) Provide managers with a facility on the dashboard that will enable them to generate both ‘in time’ data and reports.

2. That further investigation be carried out into the manner in which the informal discussion of cases can be more effectively recorded by managers and staff members, and then better incorporated into the supervision process.

3. That the communication of information on training programmes be reviewed to achieve a consistency of approach, so that all members of staff are aware of training opportunities as and when they are available.

4. That a further investigation be carried out into the caseloads being borne by on-call and duty social workers.

Background papers

The Working Group received the following documents in advance of each of the meetings and used them both as a reference sources and for formulating their questions. [See Appendices 2 and 3]

For the Recommendation 1 meeting:

- Children's Social Care and Early Help Directorate performance scorecard (January 2018)
- Looked After Children – performance on a page (19 February 2018)
- Summary of LSCB training on thresholds
- Briefing on MASH referrals

For the Recommendation 2 meeting:

- Practice standards for supervision
- Practice standards for management decision record (MDR)
- Supervision policy (6 January 2017)
- Supervision toolkit v.4 (6 January 2017)
- Walsall Children's Services HR – performance on a page (December 2017)
- Record of Supervision 2017/18 – performance summary (January 2018)

Appendix 1

Ofsted Working Group Initiation Document

Work Group Name:	Children's Services Ofsted Working Group
Committee:	Education & Children's Services Overview & Scrutiny Committee
Municipal Year:	2017/18
Lead Member:	Councillor Tim Wilson
Lead Officer:	Ms Debbie Carter, Assistant Director (Children's Social Care)
Support Officer:	Dr Paul Fantom, Democratic Services Officer
Membership:	Councillor Julie Fitzpatrick Councillor Liz Hazell Councillor Tina Jukes Councillor Chris Towe Councillor Tim Wilson Mrs Teresa Tunnell
Co-opted Members:	N/A

1.	**Context**
	The Ofsted inspection of the Council's services for children in need of help and protection, children looked after and care leavers was held between 20 June and 13 July 2017. The inspection report was published on 4 September 2017 and it made twelve recommendations that have been addressed by the Children's Services post-Ofsted action plan dated 1 December 2017. This document has now been forwarded to Ofsted. At its meeting on 16 October 2017, the Education & Children's Services Overview & Scrutiny Committee agreed that a working group should be established to carry out a more in-depth examination of one or more of the individual issues arising from the inspection. In due course, the recommendations of the working group would then be presented for consideration by the Committee.
2.	**Objectives**
	The working group has identified two of the twelve recommendations from the Ofsted inspection report that they would wish to review: Recommendation 1: Ensure that thresholds of need are understood and applied at every stage of the child's journey. Recommendation 2: Ensure that frontline management oversight of practice improves the quality of decisions and the provision of help to children. With reference to the post-Ofsted action plan, the working group propose to review the actions, measures and timescales for tackling the Ofsted recommendations and to submit a report and recommendations to the meeting of the Education and Children's Services Overview and Scrutiny Committee to be held on 27 March 2018.

3.	**Scope**
	The working group have adopted the following approach: • Who do you want to see? • When do you want to see them? • What will you ask them? • What other data will you want to see? To review each of the recommendations in turn, two meetings have been arranged for 1 and 5 March 2018 respectively. For each meeting, the individual people or groups of people that the working group would like to see have been identified. In order to maximise responsiveness, it is proposed that the working group is split into two sub-groups to facilitate this and to operate in a more informal way via focus groups. A comprehensive list of questions has been provided by working group members and other data/information required in advance of the meetings has been specified to be supplied by Children's Services.
4.	**Equalities Implications**
	The working group will ensure that its recommendations will take into account the different strands of equality and ensure that no group is disadvantaged.
5.	**Who else will you want to take part?**

	<u>1 March 2018 meeting:</u>
	• Chair of Walsall LSCB
	• MASH: Group Manager, member of Staff, health representative, police representative
	• Service users, i.e. children and families
	• Head of Safeguarding
	• Front line social workers
	• Head of Performance
	
	<u>5 March 2018 meeting:</u>
	• Assistant Director (Children's Social Care)
	• Head of Safeguarding
	• Principal social worker (Lisa Harris)
	• Group manager (to ask about their experience of supervision) and members of their team (to ask whether this has been done)
	• Selection of team managers/social workers from:
	  ○ Front door
	  ○ Safeguarding
	  ○ Corporate parenting

6.	Timescales & Reporting Schedule

Date	Action	Who
22 January 2018	Prepare terms of reference	Working group
15 February 2018	Approve terms of reference	E&CS O&S Cttee
1 March 2018	Consider/review recommendation 1	Working group
5 March 2018	Consider/review recommendation 2	Working group
27 March 2018	Present final report/ recommendations	E&CS O&S Cttee

7.	Risk factors

Risk	Likelihood	Measure to Resolve
Being unable to cover all identified themes within the available time	High	Organise a schedule of meetings to plan ahead where possible
Officer time available to support the working group may limit its ability to deliver the outcomes desired	High	Select two of the twelve recommendations, with one meeting of the working group to review each recommendation
Interviewees may feel intimidated by a formal committee-style setting	High	Minimise by: 1. Splitting working group into two sub-groups 2. Interview some participants in groups, rather than individually

Date Agreed:		Date Updated:	

Working group timetable:

Date	Activity
22 January 2018	Meeting 1: Consider terms of reference, etc.
26 January 2018	Group members to provide any further questions
9-16 February 2018	Administrative arrangements for meetings (Democratic Services) and invitations to participants (Children's Services) to be progressed.
22 February 2018	Children's Services to provide data/information in advance of meetings
1 March 2018	Meeting 2: Consider/review recommendation 1
5 March 2018	Meeting 3: Consider/review recommendation 2

Recommendation 1 - Questions 14 March 2018: **Appendix 2**

	Interviewee	**Question**	
1	LSCB Chair	a	How does the LSCB monitor how thresholds are being used correctly, and what assurance can we be given that it the process is working?
		b	Have LSCB reviewed the thresholds?
		c	Has any additional/new training been implemented?
		d	How is it being delivered?
		e	How has this had an impact?
		f	What assurance are you seeking that it is effective?
		g	What else are you doing differently?
		h	Are you confident that the new measures will continue to make a positive difference?
		i	Are you receiving monthly dip sample results from MASH?
		j	If so, what do they show and is the feedback being given to partners?
		k	What progress is being made to review the threshold document
2	Head of S/guarding [Assistant Director (Children's Social Care/ Group Manager – Early Help to cover)]	a	Re 1.8, how do people get into the care process? What is the length of time between referral and taking a child into care? What is the escalation process? How are we dealing with any unnecessary delay that is occurring?
		b	What is being done about the small number of children who have met the threshold for care but remain living with their birth families when they should be in care?
		c	What impact is this situation having on the children?
		d	Is the situation improving? What else can be done to improve the situation? Can the delays be eradicated completely?
		e	Has the overload in domestic violence reports been addressed?
		f	Has any work been started on improving the quality of social worker assessments?
		g	Has the ATM/Group Manager appointment strengthened the quality and consistency of decision making and if so, how?
		h	Have you reviewed the MARF and, if so, how is it different?
		i	What training is being offered within Children's Services to understand and implement thresholds?
		j	How many Staff have accessed the training? What percentage does that represent?
		k	What is being done differently as a result of training?
		l	By resolving some of the issues, has the time saved been allocated to other areas/tasks?
		m	What progress is being made to review the threshold document
3	Head of Perform [Assistant Director (Children's Social Care/ Group Manager – Early Help to cover)]	a	Can you briefly explain trends and particularly concerns in relation to time taken from referral to being taken into care and also from when a threshold is met to being taken into care?
			What is the benchmark on the time taken for a child to come into care against the average time taken
		b	Can you explain the average length of the delays experienced by children who have met the threshold but remain with their birth parents?
		c	Can you please explain how many staff members have undertaken any threshold training and how we monitor its effectiveness?
		d	What audits are being undertaken to ensure consistent application of thresholds?
		e	Re 1.2, how do we know the audits are of good quality
		f	What progress is being made to review the threshold document

4	MASH		
	1. Group Manager	a	What audit activity are you conducting regarding MARF?
		b	Can you explain the direct work being carried out with referrers?
		c	What additional/new training is being given and how often?
		d	What percentage of MASH staff have had the training?
		e	What is being done differently as a result of training?
		f	Are monthly dip samples of contacts and referrals being taken?
		g	If so, are the results being fed back to the LSCB
		h	Has your new post strengthened the quality and consistency of decision making? If so, how?
		i	What is being done about the small number of children who have met the threshold for care but remain living with their birth families due to a delay?
		j	Is there an escalation process when this occurs?
		k	Re 1.4, has the overload of inappropriate contacts to MASH regarding domestic violence been addressed?
		l	By resolving some of the issues, has the time saved been allocated to other areas/tasks?
	2. Health/ Police	a	Can you briefly explain your role in MASH?
		b	Are you aware of the high proportion of contacts that do not meet the threshold for statutory intervention?
		c	Are you aware of and have you taken any LSCB training regarding this?
		d	What additional training have you had specific to your MASH job role?
		e	What is being done differently as a result of training?
		f	Have you looked at the low level domestic violence referrals into MASH?
		g	If so, what is your interpretation? Has any work been undertaken to reduce these?
	3. Staff Members (Team Manager/ Social Workers)	a	Are you aware of the high proportion of contacts that do not meet the threshold for statutory intervention?
		b	Are you receiving any additional/new training regarding thresholds for quality referrals?
		c	What is being done differently as a result of training?
		d	Have you had the opportunity to feedback regarding the whether MARF quality is improving?
		e	If so, who is this fed back to?
		f	Do you think that partners are understanding the thresholds better? If so, why? If not, why not?

Recommendation 2 Questions 5 March 2018: **Appendix 3**

	Interviewee	Question	
1	Assistant Director (CSC)	a	Has the new supervision monitoring system now been embedded and if so, what difference is it making?
		b	Has the use of practice standards in relation to supervision and management oversight been reinforced?
		c	Has this made a difference?
		d	When will the process to introduce and train managers and social workers to effectively use analytical tools that will support good decision making begin?
		e	Has any bespoke training been conducted or scheduled for frontline managers regarding supervision and effective decision making?
		f	If so, what impact has/will this have?
		g	Have you begun introducing and training managers and social workers to effectively use analytical tools that support good decision making and audit for compliance?
		h	Can you explain the difference this will make?
		i	How do managers prepare for supervision
2	Principal S/Worker	a	Has the new supervision monitoring system now been embedded and if so, what difference is it making?
		b	Has the use of practice standards in relation to supervision and management oversight been reinforced?
		c	Has this made a difference?
		d	Has any bespoke training been conducted or scheduled for frontline managers regarding supervision and effective decision making?
		e	If so, what impact has/will this have?
		f	Have you begun introducing and training managers and social workers to effectively use analytical tools that support good decision making and audit for compliance?
		g	Can you explain the difference this will make?
		h	How do managers prepare for supervision?
3	Group Manager	a	Has any work been done to reinforce with managers expectations of the supervision policy and key decision for management oversight?
		b	If so, what and how effective will it be?
		c	Has the new supervision monitoring system now been embedded and if so, what difference is it making?
		d	Has the use of practice standards in relation to supervision and management oversight been reinforced?
		e	Has this made a difference? Have managers been instructed to record management oversight?
		f	If so, how does this work? Has any work being done regarding the ODP leadership program and workforce development program?
		g	Are group managers routinely ensuring undertaking direct observation of their managers and their social workers? What are the numbers of these staff and how many of them are supervised each month?
		h	How do you know you are making a difference
		i	Are you receiving supervision and is it making a difference
		j	What do you expect from supervision, do you get it and can it be improved?
		k	How do managers prepare for supervision

4	Head of S/guarding	a	Are you able to quantify the number of children affected by the drift and delay in taking action when risks increase or progress is limited or not sustained?
		b	Has the new supervision monitoring system now been embedded and if so, what difference is it making?
		c	Has the use of practice standards in relation to supervision and management oversight been reinforced?
		d	Has this made a difference? Has any bespoke training been conducted or scheduled for frontline managers regarding supervision and effective decision making?
		e	If so, what impact has/will this have?
		f	What work has been done to introduce and train managers and social workers to effectively use analytical tools that support good decision making and audit for compliance?
		g	Can you explain the difference this will make?
		h	Have any audits been conducted yet and if so what do they show?
		i	How do managers prepare for supervision
5	Front-line (Team managers and social workers)	a	Do you feel well supported and feel that you get the right help and direction?
		b	If so, who by and how? If not, why do you think that is?
		c	Do you have access to support whenever you need it?
		d	How much supervision do you receive?
		e	Do you feel that your supervisions have a positive impact on you and your casework?
		f	Have you been trained to use any analytical tools to support good decision making?
		g	Do you think this is beneficial?
		h	What have you learned from training? Who put the training on? Who attended?
		i	How do you know you are making a difference
		j	Are you receiving supervision and is it making a difference
		k	What do you expect from supervision, do you get it and can it be improved?
		l	What barriers get in the way? What prevents adequate supervision?

Appendix 4

Key Abbreviations

ATM:	Assistant Team Manager
ASYE:	Assessed and Supported Year in Employment
BB:	The bigger the number, the better
CAFCASS:	Child and Family Court Advisory and Support Service
CAMHS:	Child and Adolescent Mental Health Services
CCG:	Clinical Commissioning Group
CHIS:	Child Health Information System
CMEC:	Children Missing Education Committee
CMOG:	Children at Risk of Exploitation & Missing Operational Group
CPB:	Corporate Parenting Board
CPD:	Continuous Professional Development
CPP:	Child Protection Plans
CQC:	Care Quality Commission
CSE:	Child Sexual Exploitation
DSL:	Designated Safeguarding Lead
DV:	Domestic Violence
EDT:	Emergency Duty Team
EHH:	Early Help Hub
FGC:	Family Group Conferencing
HCPC:	Health and Care Professions Council
HWB:	Health & Wellbeing Board
IAPT:	Improving Access to Psychological Therapies
ICPC:	Initial Child Protection Conference
IRS:	Initial Response Service (team)
LAC:	Looked After Children

LGA: Local Government Association

LSCB: Local Safeguarding Children's Board

MARF: Multi-Agency Referral Form

MACE/MASE: Multi-Agency Child Exploitation/Multi-Agency Sexual Exploitation (meeting)

MASH: Multi-Agency Safeguarding Hub

MDR: Management Decision Record

NAG: NEET Action Group

NEET: Not in Employment, Education or Training

NFA: No Further Action

NRM: National Referral Mechanism

ODP: Owning and Driving Performance (training programme)

PEP: Personal Education Plan

PF: Private Fostering

PIF: Practice Improvement Forum

PLO: Public Law Outline

PPO: Police Protection Order

PSW: Principal Social Worker

RAA: Regional Adoption Agency

RCPC: Review Child Protection Conference

RHI: Return Home Interview

RISE: **R**educe the number of looked after children;
Improve practice;
Skilled/stable workforce;
Early help, early on

SB: The smaller the number, the better

SFS: Safeguarding and Family Support (team)

SUTSW: Step Up to Social Work (initiative)

TLC: Transition in Leaving Care (team)

Appendix 5

Walsall Safeguarding Children Board

Multi-agency guidance for thresholds of need & intervention

(in accordance with 'Working Together to Safeguard Children 2015)

Final Version March 2018
Review date: April 2019

Introduction

Multi-Agency Guidance for Threshold of Need & Intervention

What does this mean?

- In order to support decision making and provide a guide for professionals, WSCB has developed this guidance. Thresholds define what assessments/interventions should be undertaken with children, young people & their families. Some children will have needs that cross thresholds and some will only have a single issue of vulnerability that outweighs everything else that is positive in the child's life. The use of 'threshold' is the starting point for a dialogue between relevant professionals and agencies that focuses on the needs of the child and their vulnerability to risk in order to decide what action is required and by whom.
- The needs of children & families are dynamic and will depend upon a range of changing circumstances, therefore the response from professionals will need to reflect this and may increase or decrease at any time.
- Each professional will need to consider the threshold guidance and decide whether the 'threshold' is met for a referral to Children's Services or whether an issue can be managed by a single agency or within another level of need (e.g. Early Help). This guidance is intended to support professionals in making this decision.
- Whatever their level of need, children & young people should always have access to universal services and for most this will provide all the opportunities they need to reach their full potential. Useful Link

Underpinning Principles

What Good Practice Looks Like?

What does this mean?

- The child/young person is at the centre of everything we do and every assessment & intervention will consider the 'lived experience' of the child/young person and the impact of this upon their development.
- All intervention should be in the best interests of the child.
- The best interests of the child must be a top priority in all decisions and actions that affect children.
- Consistent with the 'Early Help Strategy' our vision is to make Walsall an 'Early Help' place by helping families at the earliest point, improving children & young people's life chances and reducing demand for specialist and/or crisis services and intervention (Useful Link)
- All children affected by neglect are supported and safeguarded by effective partnership working to ensure they get the right help at the right time.
- Professionals must talk to each other - good communication protects children – never assume that someone else has passed on crucial information. Building good quality relationships helps to protect children.
- Professionals should operate in a high support/high challenge context and should therefore be prepared to challenge each other based on their evidence if they strongly disagree & ultimately use the 'Escalation Policy' to escalate a concern if they remain dissatisfied with the outcome Useful Link (Chapter 3.13)
- Recording must be; factual, clear, prompt and in accordance with each individual agency's Standards, Procedure and Guidance. Recording must clearly provide the evidence to support the escalation of concerns.
- Professionals must continue to support a child /family even when a referral has been made to Children's Services (Early Help or Children's Social Care).
- Professionals must consult with their DSL (Designated Safeguarding Lead) if in any doubt and for advice and guidance regarding the application of thresholds.
- A referral should only be made to Children's Social Care when there is clear evidence that the threshold is met for a child who is in need or is at risk of significant harm. Advice and guidance can be sought if there is any doubt but without evidence to support the threshold for statutory intervention, the referral will be pushed back to the referrer for a solution at a lower level of intervention in line with our vision within the Early Help Strategy.
- For all children, the aim of every individual professional should be to ensure that each child's needs are met at the right time and in the right way.

Advice and Guidance

Safeguarding is Everyone's Responsibility

What does this mean?

- Each agency and individual professional is responsible for making the decision about what level of intervention is required to meet the needs of a child/young person.
- Children's Social Care (CSC) is not the only agency responsible for protecting children.
- There must be sufficient evidence to escalate a case and before making a referral to Children's Social Care the rational must be clear and backed up by the evidence that has been obtained. Without sufficient evidence the referral cannot be accepted as having met the threshold for statutory intervention.

Thresholds

What does this mean?

- There are four levels of intervention and we use the 'threshold' as the point that a case 'steps up' or 'steps down' to or from each level.
- Each professional must be clear why they consider a case has reached the threshold for 'Level 3 – Multi-Agency Co-ordinated Intervention' and 'Level 4 – Statutory Intervention and this decision may be challenged when a referral is made to CSC.
- If there is insufficient evidence then advice should be sought from the relevant DSL
- Professionals should consider the work that has been undertaken and the ongoing risks and vulnerabilities before considering whether the threshold is met to 'step up' a case.
- At each point the professional working with a family must be able to provide evidence of ongoing risk of vulnerability to support the request to step up a case or provide additional resources
- The majority of families will be supported through Levels 1-3 and may only need to step up to CSC for a short period of time before 'stepping down again.

Escalating Concerns/'Stepping Up/Stepping Down'

What does this mean?

- Each professional should consider the relevant 'Indicators' in Section 2 to help in deciding the appropriate level of intervention and when to consider stepping up or down'. Useful Link (Chapter 3.25)
- Each professional should consult with other professionals working with a family before reaching the decision to step up' or step down.
- Concerns may develop incrementally over a period of time or as a result of a specific incident. All professionals must consider the history of a case and the impact of incremental neglect/abuse on a child's development.

Seeking Advice/Guidance

What does this mean?

- Advice and guidance may be sought prior to making an actual referral. The advice should be sought from the relevant agency DSL, in the first instance.
- The MASH & Early Help Hub provides a single point of contact and gives professionals and members of the public the opportunity to discuss the needs of children/young people with specialist professionals.
- Professionals can ask for a case to be considered at the Locality Panel for multi-agency solutions or to unblock issues.

Consent

What does this mean?

- Any concerns about a child should be discussed with the family first & their agreement sought before sending in a referral (MARF). The ONLY exception to this is if you think the child is in immediate danger, if this is the case you will need to clearly state why consent is not appropriate. Without consent, unless there is risk of significant harm the MASH will not be able to accept your referral.
- Encourage transparency with parents – it is information about their family – they can have sight of it to ensure it is correct and they know & understand what you're worried about. Having had the conversation and secured consent will also help in engaging families better.

Matrix of Need

(Incorporating the Graded Care Profile for reference & those agencies who are currently using this tool)

	Level of need	Graded Care Profile	Assessment	Level of Intervention	Consent
Level One	**Universal**	**GRADE 1** All the child's needs are always met. The child is always put first **& GRADE 2** All essential needs are always met. The child is a priority	Universal Assessments undertaken by individual agencies for all children & young people	Needs are met by; parents/carers, community & universal services	Arrangements will be determined by each Agency.
		NO NEGLECTFUL PARENTING			
Level Two	**Low risk to vulnerable**	**GRADE 3** **Most of the time the essential needs of the child are met**	Individual Single Agency Assessment	Single Agency Early Help Support in addition to Universal Services	Consent must be obtained
		MILD NEGLECT			
Level Three	**Multi-agency co-ordinated intervention**	**GRADE 4** **Most of the time the essential needs of the child are not met. The child's needs are placed second to those of the parent/carers**	Early Help Assessment	Referral to Early Help Hub is required to access Level Three support Specialist/Targeted support Early Help Plan	Consent must be obtained – a service cannot be provided without consent & engagement
		MODERATE NEGLECT			
Level Four	**Complex needs &/ or at risk of significant harm**	**GRADE 5** **The child's essential needs are not met. May be due to intentional disregard. The child is not considered.**	**Statutory Assessment completed by a Social Worker under:** **s17 - Child in Need (Child & Family Assessment) OR;** **S47 - Child in Need of Protection (s47 Enquiry)**	**Social Worker will be Lead Professional)** **Child in Need Plan or** **Child Protection Plan** **Statutory & Non Statutory Services will also be involved**	Consent should be obtained unless to do so would place the child at risk of significant harm
		SEVERE NEGLECT			

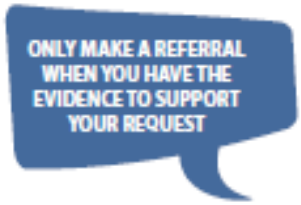
A CHILD MAY MOVE THROUGH THE FOUR 'LEVELS OF NEED' AS THEIR NEEDS & CIRCUMSTANCES CHANGE – THIS WILL BE BASED UPON AN ONGOING ASSESSMENT OF NEEDS & RISK

Criteria to support the levels of need

Level One:	Universal – example indicators
Child Development Factors	**Learning & education** • Achieving key stages and full potential • Good attendance at school, college and training • No barriers to learning • Demonstrates a range of skills/interests • Engaged with a future plan **Health** • Good physical health & emotional well being • Registered with a gp and a dentist • Health needs are being met by universal services • Up to date immunisations & developmental checks • Adequate nutritious diet • Sexual activity/behaviour/knowledge appropriate to age **Social, emotional, behavioural & identity** • Positive and safe relationships with peers • Growing levels of competencies in practical and emotional skills • Able to adapt to change • Able to demonstrate empathy • Secure early attachments are formed, child is confident in social situations • Responds appropriately to boundaries and guidance • Positive sense of self and abilities • Able to express needs verbally & non verbally • Demonstrates feelings of belonging & acceptance • Access to community resources **Family & social relationships** • Stable family where care givers are able to meet the child's needs • Good relationships with siblings and peers **Independence** • Growing level of competencies in practical and emotional skills (e.G. Feeding, dressing, developing age appropriate independent skills
Family and Environmental Factors	**Family history & well being** • Stable and supportive family relationships • Good support from extended family network **Housing, employment & finance** • Child fully supported financially • Suitable housing **Social & community resources** • Good social and friendship networks • Safe and secure environment • Access to positive activities
Parenting Factors	**Basic care, safety & protection** • Parents able to meet child's physical needs • Parent protects from danger or significant harm in the home and elsewhere **Emotional warmth & stability** • Parents or carers provide secure and caring parenting • The child is shown warmth, praise & encouragement **Guidance, boundaries & stimulation** • Parents provide appropriate guidance and boundaries to help child develop holistically • Facilitates cognitive development through interaction and play.

Level Two:	Low Risk to Vulnerability – Early Help Single Agency Response Example Indicators:
Child Development Factors	**Learning & Education** • Occasional truanting or non-attendance, poor punctuality, poor links between home & school and child is not supported to reach educational potential. • Developmental delay • Few or no qualifications or NEET (not in Education, Employment or Training) • Mild learning or behavioural difficulties emerging, poor concentration, lack of interest in education and other school activities. • Frequent school moves • Needs additional support in school • Identified language and communication difficulties • Fixed term exclusions/exclusions • Regular unexplained absence from school or education provider **Health** • Slow in reaching developmental milestones • Mild or specific learning disability • Missing immunisation or checks • Minor concerns regarding health, diet, hygiene and clothing • Missing health checks/routine appointments • Issues of poor bonding/attachment • Emerging signs of deteriorating mental health **Social, Emotional, Behavioural & Identity** • Low level mental health or emotional issues requiring intervention • Difficulties with peer group, family or other relationships • Vulnerable to emotional problems in response to life events such as parental separation or bereavement • Lack of confidence, suffering from anxiety or withdrawn. Can be overly friendly or withdrawn with strangers. • Difficulties in expressing empathy, understanding impact of actions upon others or taking responsibility for actions • Victim or perpetrator of bullying or discrimination • Experimentation with tobacco, alcohol or illegal substances. • Lack of positive role models • Disability **Independence** • Lack of age appropriate independent living skills that increase vulnerability to social exclusion. • Personal hygiene is becoming problematic

Family and Environmental Factors	**Housing, Employment & Finance** • Overcrowding • Families affected by low income or unemployment **Family & Social Relationships** • Parents or Carers have relationship difficulties which affect the child • Parents request advice to manage their child's behaviour. • Child affected by difficult family relationships or bullying • Parent or Carer has physical or mental health difficulties that may affect the child • Child is a young carer& this is having a negative impact upon the child Useful Link • Child/young person's relationship with family members not always stable • Poor home routine • Child not often exposed to new experiences • Limited support from family/friends **Social & Community Resources** • Insufficient facilities to meet need • Family requires advice regarding social exclusion • Family has limited support or is new to the area • Child is associating with anti-social or criminally active peers. • Limited access to contraceptive and/or sexual health advice, information and services.
Parenting Factors	**Basic Care, Safety & Protection** • Inconsistent care (inappropriate child care arrangements) or young inexperienced parent • Parental learning disability, parental substance misuse or mental health which may be impacting upon the parents ability to meet the needs of the child • Parents struggle without support or adequate resources • Some exposure to dangerous situations in the home • Level 1 or 2 on the Barnardo's Multi Agency Domestic Violence Risk Assessment Matrix **Emotional Warmth & Stability** • Inconsistent parenting including emotional availability but development not significantly impaired • Depression or persistent low mood which affects the child. **Guidance, Boundaries & Stimulation** • Parents have inconsistent boundaries or lack of routine in the home. • Lack of response to concerns raised regarding the child • History of parenting difficulties with siblings • May have a number of different carers • Lack of stimulation impacting upon development



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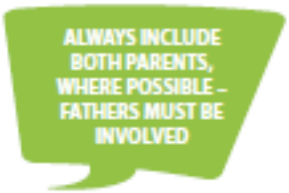
Level Three:	Early Help – Multi-Agency Co-ordinated Intervention Example Indicators
Child Development Factors	**Learning & Education** • Chronic or poor nursery/school attendance/punctuality/ poor home and nursery or school links/ no parental support for education. • Risk of permanent exclusion, persistent absence or no education provision. • Previous exclusions • EHCP Plan or ongoing difficulties with learning and development. • No access to books, toys or educational materials • Is (or is at risk of becoming) NEET - Not in Education, Employment or Training. • No or severely acrimonious school links **Health** • Child/young person who is consistently failing to reach their developmental milestones and concerns regarding their parent's ability to care for them. • Growth falling 2 centile ranges or more • Developmental milestones are unlikely to be met/concerns about weight, dental decay and language development delay. • Child has some chronic/recurring health problems; not treated or badly managed/missed appointments • Inconsistent access to medical attention for health chronic/recurring health needs • Age inappropriate sexual activity/teenage pregnancy/smokes/uses illegal substances • Teenage pregnancy of parent **Social, Emotional, Behavioural & Identity** • Child finds it difficult to cope with or express emotions • Family relationships or with other adults are a cause for concern • Significant poor peer relationships/difficulties sustaining relationships/issues of attachment/ isolation • Appears regularly anxious significantly impacting on all relationships • Mental health issues emerging requiring specialist intervention • Subject to persistent discrimination or harm from crime • Disruptive/challenging/high risk behaviour at school, home or in the neighbourhood which is unresponsive to level one and two interventions. • Concerns regarding behaviour development and the development of appropriate social skills • Starting to commit offences or coming to notice of the police on a regular basis/re-offending/ victim of crime • Early onset of offending behaviour or activity and coming to the notice of the police because of this behaviour • Received fixed penalty notice/reprimand or warning • Evidence of disregard to risk • Early indicators of potential grooming for gang affiliation • Repeated incidents of missing from home or school **Independence** • Lack of age appropriate independent living skills likely to impair development or lead to alienation from peers

Family & Environmental Factors	**Family and Social Relationships and Family Well Being** • Acrimonious divorce/separation impacting upon child • Risk of relationship breakdown with parent and the child or young person • Young carers • Children of prisoners • Persistent relationship difficulties • Family has poor relationship with extended family/no support network **Housing, Employment & Finance** • Family require support services as a result of social exclusion or no access to local facilities • Housing conditions impacting directly on children, including severe overcrowding • Children are experiencing frequent moves • Parents or carers have been assessed as intentionally homeless • Extreme poverty impacting directly upon the welfare of children
Parenting Factors	**Basic Care, Safety & Protection** • Physical care or supervision of child is inadequate • Parental learning disability, substance misuse, mental health or lifestyle which is impacting upon parents ability to meet the needs of the child • An absence of effective parental boundaries affecting emotional and behavioural needs **Emotional Warmth & Stability** • Inconsistent parenting impairing emotional or behavioural development • Low warmth, high criticism



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Level Four:	Statutory Intervention Example Indicators
Child Development Factors	**Learning & Education** • Chronic non-attendance, truanting/no parental support for education • Permanently excluded, frequent exclusions or no education provision • No or severely acrimonious school links • Severe and complex learning difficulties requiring residential educational provision • Significant development delay due to neglect or poor parenting **Health** • Clear allegation of harm and/or disclosure of harm • Growth faltering and no 'organic' cause identified • Sexual or criminal exploitation • High level of disability which cannot be maintained in a mainstream setting. • Serious physical and emotional health problems. • Refusing medical care placing child's health and development at significant risk • Persistent failure to access medical attention for health/chronic/recurring health needs. • Persistent and high risk substance misuse. • Non accidental injury • Fabricated /induced illness • Female Genital Mutilation (FGM) • Disability requiring specialist support to be maintained in mainstream setting **Social, Emotional, Behavioural & Identity** • Subject to or at risk of physical, emotional, sexual abuse of neglect • Severe emotional/behavioural challenges resulting in serious risk to the child and others • Child or young person exhibiting sexual harmful behaviours • 3 or more incidents of missing from home or school • Child/young person is at risk of/experiencing Child Sexual Exploitation (CSE) Useful Link • Forced marriage of a child • Challenging behaviours resulting in serious risk to the child/young person or others • Complex medical issues requiring specialist intervention including inpatient treatment • Failure or rejection to address serious (re)offending behaviour, as well as being part of a gang. • Distorted self-image • Child/young person experiencing current harm through their use of substances • At risk of extremism or radicalisation • Child/young person believed to be trafficked or a victim of modern day slavery **Independence** • Severe lack of age appropriate independent living skills likely to result in significant harm e.g. bullying, isolation, inappropriate self presentation. • Lack of age appropriate independent living skills likely to impair development or lead to alienation from peers.

USE THE ESCALATION POLICY (CONFLICT RESOLUTION IF YOU UNHAPPY WITH THE OUTCOME OF YOUR REFERRAL

CHECK WITH YOUR DESIGNATED SAFEGUARDING LEAD – THEY WILL ADVISE

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Family & Environmental Factors	**Family and Social Relationships and Family Well Being** • Family life is chaotic and the home environment is unsuitable for children. • Family have abandoned child/young person • Privately Fostered children and young people • Adoption breakdown • Parents are unable to care for the child • Suspicion of physical, emotional, sexual abuse or neglect • Children who need to be looked after outside of their own family • Looked After child/young person or Care Leaver • Unaccompanied minors seeking asylum (UASC) **Housing, Employment and Finance** • No fixed abode or homeless or imminently homeless/housing conditions are posing a serious threat to the welfare of the child/young person • Family with a lack of access to finance and living in extreme poverty. • Family who have no recourse to public funds (NRPF) • Household income is used to fund parent/carers own prioritised needs (e.g; substance misuse/ gambling) • Young person aged 16/17 presents as homeless. • Frequent police visits/calls to the home **Social and Community Resources** • Child or family at immediate risk due to harassment or discrimination • No access to community resources
Parenting Factors	**Basic Care, Safety and Protection** • Parents have seriously abused/neglected the child/young person • Level 3/ 4 of the Barnardo's Domestic Violence Matrix • Parents unable to provide 'good enough' parenting placing chid/young person's development at significant risk • Little or no improvement in parenting despite professional interventions • Parents are believed to have caused physical injury to a child/young person • Chronic and serious domestic violence directly or indirectly involving a child/young person • Previous children placed at risk by parent's actions • Previous children removed from the parent(s) care • Parental non-compliance/disguised compliance • Parents involved in crime unable to restrict access to home by dangerous adults. **Emotional Warmth or Stability** • Evidence of emotionally abusive relationships placing child's development at significant risk **Guidance, Boundaries and Stimulation** • An absence of effective parental boundaries placing child's development at significant risk • Child beyond parent/carers control/offending/has no-one to look after them • Parent displays or condones serious anti-social behaviour within the community

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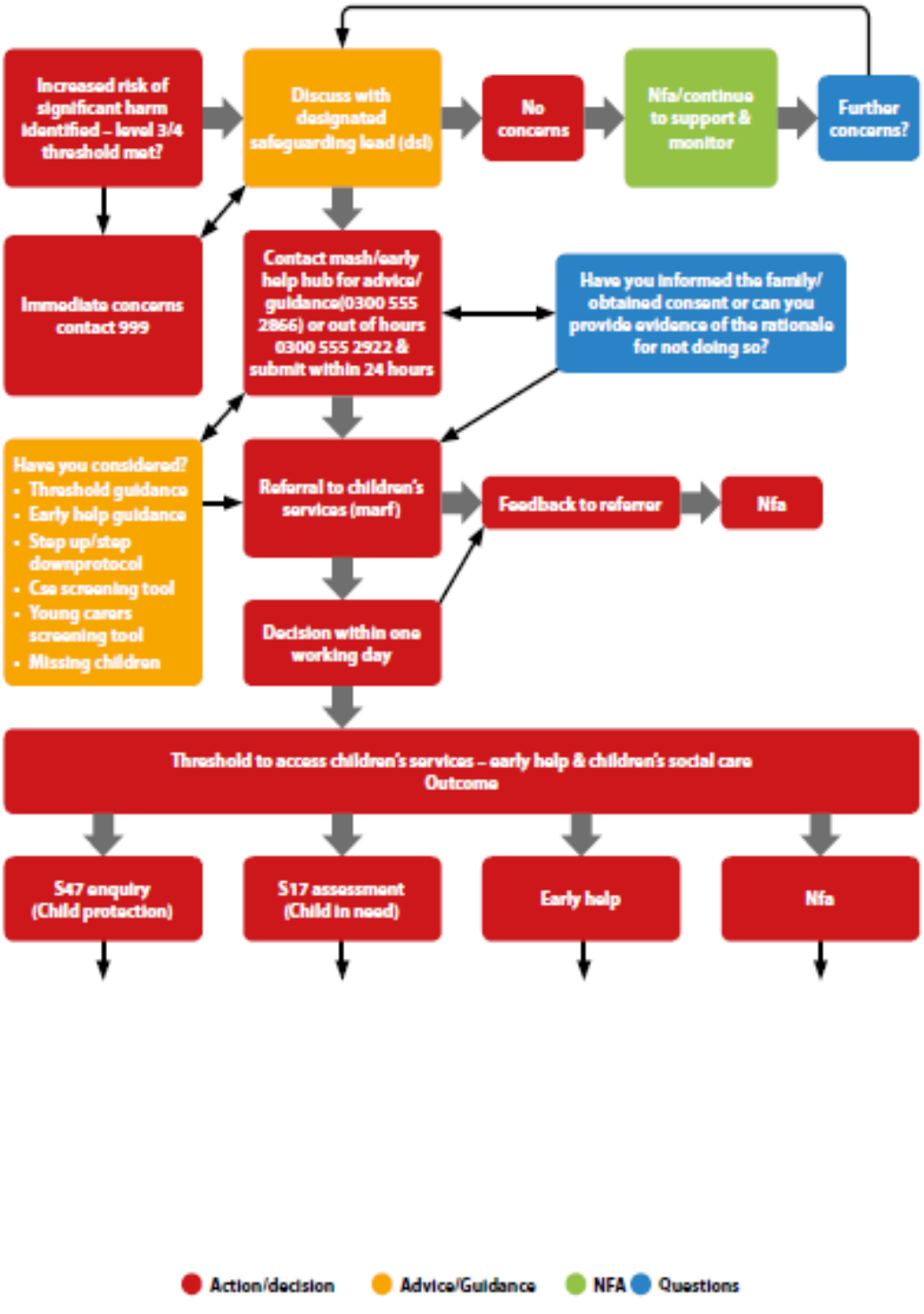
What should be done now?	REFERRING TO CHILDREN'S SOCIAL CARE
Have you Considered?	• Read the 'Top Tips to completing a MARF 'Useful Link • Where you consider a child to be at risk of CSE have you completed the CSE Risk Assessment Tool? Useful Link
Decision Making	• Every professional working with a child/young person will need to decide whether they have sufficient evidence to make a referral. The response will be determined by the thresholds guidance and should be proportionate & consistent with the concerns, including gaining consent. • The referral will not be accepted if there is insufficient information on the MARF. • The decision to make a referral should be clearly recorded and followed up if no response is received from MASH: the referring agencies responsibility does not cease when they make a referral
Consent	• You will need to give the reason why you have not discussed the referral with parents or obtained their consent when making a referral to Children's Services
Referrals	• There is only one route to refer a concern to Children's Social Care. MASH is the single point of contact to access advice/guidance or make a referral through the completion of a MARF Report a concern • For urgent safeguarding concerns a referral should be made by telephone to **0300 555 2866 (out of hours – 0300 555 2922)** and the MARF submitted within 24 hours • Where it is believed there is an **IMMEDIATE** risk of significant harm, the police should be contacted on 999. • Before making a referral the concerns should be discussed with the relevant DSL (Designated Safeguarding Lead) within the referring agency. • Concerns can be discussed with MASH prior to a specific referral being made and ensure you have sufficient reason to refer to Children's Services (see link above).
Assessment	• Upon receipt of a referral a decision will be made by MASH within one working day. All statutory intervention will be based upon an assessment of the needs of the child/young person within the context of the 'framework of assessment' Useful Link & provide clear recommendations on the 'level of intervention' necessary to meet those needs. • Following a decision being made the referrer will receive feedback from MASH to let them know the outcome of the referral • The outcome of any assessment will determine the level of intervention; Child in Need/Child Protection/Early Help/NFA. The relevant policy/procedure and standards will be followed.
Effective Planning	• All children who are subject of Statutory Intervention will have a clear plan that sets out what is to be achieved, by whom and within clear timescales. The plan will be regularly reviewed at a multi agency meeting – consistent with the level of intervention (i.e. Child Protection Plan or Child in Need Plan)
Escalating Concerns	• If you are dissatisfied with the outcome of a referral and believe that a child continues to be at risk of harm. You may escalate these; (insert link).

Flowchart – Summary of the process to follow



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