Audit Committee – 2 September 2013

Ofsted Inspection of Local Authority Arrangements for the Protection of Children

1. Summary of report

1.1 This report is an update for Audit Committee on the Ofsted inspection undertaken from 24 June to 3 July 2013. A full copy of the final Ofsted report published on 2 August 2013 is attached (**Appendix 1**). The inspection considered key aspects of a child's journey through the child protection system, focussing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered.

2. Recommendation

2.1 To note the findings of the Ofsted report and endorse the proposed next steps.

Rose Collinson – interim Director (Children's Services)
6 August 2013

Background papers

Ofsted Report – Inspection of Local Authority Arrangements for the Protection of Children – August 2013

Walsall Strategic Improvement Plan for Safeguarding – Updated August 2013

Ofsted Inspection of
Local Authority Arrangements for the Protection of Children

1. Purpose of Report

1.1 The purpose of this report is to provide the Audit Committee with an overview of the process and outcome of the recent Ofsted inspection of safeguarding, child protection and early help provision undertaken from 24 June to 3 July 2013. The full report of the inspection was published on 2 August 2013 and a copy is attached for reference (**Appendix 1**).

2. Background

2.1 Following the 2012 Ofsted inspection of Safeguarding and Looked After Children services, and the subsequent publication of the DfE improvement notice in November 2012, the Walsall Children's Improvement Board has been in place to oversee implementation of the Strategic Improvement Plan. This work has been critically informed by the original Ofsted findings, and through an increasingly strong self-evaluation of both emerging strengths and areas for improvement.

2.2 The recent unannounced inspection of local arrangements for the protection of children is the first inspection of Walsall under this framework and has provided a detailed analysis of those key areas of Children's Services which are in scope of the Improvement Board's priorities.

2.3 The principle focus of the inspection is on how effectively local services contribute to the help and protection of children and young people. There is an emphasis on partnership working around safeguarding and child protection and on how the local authority and partners work together to identify problems and offer effective early help, without the need for a formal referral to social care.

2.4 It is noted that this inspection took place only eight months on from receiving the DfE Improvement Notice. This provided a particular challenge and an opportunity for Walsall to evidence clear progress towards improvement within a relatively demanding timeframe.

3. The Inspection Process

3.1 The inspection team of 6 inspectors, including a lead inspector with quality assurance oversight of the inspection, were on site for a total of 8 days. During this time the inspectors undertook a detailed review of 100 case files and met with staff, partners and service-users. The scope of the case files looked at by inspectors was significantly higher than is typically the case. This has provided a robust evidence base for the analysis and recommendations arising from the inspection.

3.2 The Ofsted Lead Inspector commented on the high standard of support, cooperation and coordination received from the Council throughout the inspection. This was reflected across Children's Services where staff and partners commented on a calm and professional management response to the inspection process.

4. The Inspection Findings

4.1 The inspection found Walsall Council to be 'Adequate' across the four main areas of judgement:

- Overall effectiveness
- The effectiveness of the help and protection provided to children, young people, families and carers
- The quality of practice
- Leadership and governance

4.2 The report states that the Improvement Plan is being implemented and is resulting in better and more consistent arrangements for the protection of children. The report identifies evidence of improvements in frontline practice, strengthened management oversight, and improved leadership and governance that is focusing on the right priorities for securing long-term sustainable improvements.

4.3 Specific areas for improvement were identified as:

<u>For immediate action</u>

- Reducing social worker caseloads
- Increasing children's participation in child protection conferences
- Improving joint working across Children with Disabilities and Safeguarding Teams

<u>Within three months</u>

- Ensuring lead professional support to children stepping down from a child in need plan
- Reviewing Workforce Planning Strategy
- Improving complaints processes
- Embedding the quality assurance and performance framework
- Ensuring parents can access reports in advance of child protection conferences

<u>Within six months</u>

- Improving PARIS to better support practice, quality assurance and performance management
- Ensuring a shared understanding of safeguarding requirements for children who are privately fostered
- Putting in place robust succession arrangements at senior management level to sustain service improvements

4.4 A table summarising the findings from the Ofsted report and related management action is attached as **Appendix 2.**

5. Next Steps

5.1 The recommendations and wider findings of the Ofsted inspection report have been incorporated into the Strategic Improvement Plan for consideration by the August Improvement Board (**Appendix 3**). The plan will be further refined

following the Improvement Board's review of the Ofsted report and implications. It is a reflection on the increasing strengths of the self-awareness of Children's Services that the majority of recommendations had previously been incorporated in the refreshed Phase 2 Improvement Plan in June 2013.

5.2 The leadership team will take action to ensure that learning from the inspection findings, and from the positive internal management of the inspection process is applied across the wider spectrum of Children's Services.

5.3 The emphasis in planning and delivery for 2013/14 will be on moving progressively towards securing a 'Good' judgment across all areas of Children's Services.

6. Action for Audit Committee

6.1 The Audit Committee are asked to endorse this report and proposed next steps.

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Appendix 2

SUMMARY OF FINDINGS FROM OFSTED INSPECTION OF HELP & PROTECTION OF CHILDREN - AUGUST 2013

Overall Effectiveness - Adequate	
Strengths include	
• Clear vision, direction & prioritisation from leaders and managers • Strong self-awareness and self-evaluation across Children's Services • Evidence of changing culture & practice • Good staff & partner engagement with the improvement priorities	
Areas for improvement	**What we are doing to address this**
Improving but fragile – maintain momentum	• Embedding Ofsted recommendation & findings within Improvement & Delivery Plans • Apply learning from Ofsted inspection across the full spectrum of Children's Services
Succession & sustainability of change	• Agreement on 'fit for purpose' organisational model – key leadership roles approved • Clear succession planning for 2013/14 transition
Workforce strategy & use of agency staff	• Implementing Social Care Workforce Strategy • Strong focus on staff development, recruitment, retention, support & supervision
Data quality, QA & performance management	• New performance & QA framework in place from September 2013 • Progressively improving data quality and the use of data to inform key decisions

Effectiveness of Help & Protection - Adequate	
Strengths include	
• Early Help is increasingly effective • The Integrated Young People's Support Service is a good and effective model • Children and Young People at risk are identified early • Arrangements for tackling Child Sexual Exploitation are good	
Areas for improvement	**What we are doing to address this**
Early Help Strategy	• Continuing implementation of Early Help framework supported by clear strategy • Strengthening tools for analysis of early help impact & outcomes
Child Protection to Early Help - 'Step-Down' arrangements	• Increasingly strong partnerships between safeguarding, Child Protection and early help providers • Post-SERCO move towards better integrated Children's Services provision
Using data to inform practice	• Improving assessment, chronologies and case recording to inform plans • Cascading more reliable performance data to Teams to inform local decisions
Move from 'parallel' to joint working	• Better information sharing between Children With Disabilities and Safeguarding teams • Improving management oversight of practice within and across teams

Quality of Practice - Adequate	
Strengths include	
• Multi-Agency Screening Team (MAST) model – early days but positive impact • Improving quality of assessments • Good information sharing between professionals and across agencies • Good worker relationships with children, young people and families	
Areas for improvement	**What we are doing to address this**
Operational impact of high % of agency staff	• Prioritising conversion of agency staff to permanent roles • Increasing frequency and quality of supervision and management oversight
Variable quality of practice, plans, records	• Systematic case file auditing & applying learning from audit analysis • Continued implementation of staff training and development programme
PARIS / ICS system	• Strategic review of potential for alternative ICS systems • Clearer guidance and support to staff on using the PARIS system
CWD / safeguarding linkage	• Improvements to PARIS to enable more systematic information sharing on joint cases • Stronger management focus on joint working and cross-team communication

Leadership & Governance - Adequate	
Strengths include	
• Governance oversight is strengthened • Management oversight and support to staff is stronger • Increased staff confidence from frontline staff in management & leadership • Good prioritisation of frontline practice	
Areas for improvement	**What we are doing to address this**
Succession Planning - sustainability	• Appointments Board have agreed key new senior leadership roles • Moving towards more substantive permanent arrangements from early 2014
Caseloads & Capacity – impact on CYP	• New workload management tool in place – outcomes to inform resource allocations • Staff consultation to maintain dialogue with teams on capacity and way forward
Supervision is variable	• New supervision policy in place and evidencing impact from summer 2013 • Team Manager development programme and follow-up
Complaints – whole process	• New complaints strategy in place to improve handling and learning from complaints • Corporate lead on prioritising continuous learning from complaints & compliments

Appendix 3

WALSALL CHILDREN'S SERVICES

STRATEGIC IMPROVEMENT PLAN
FOR SAFEGUARDING CHILDREN & YOUNG PEOPLE

PHASE 2

Update for Improvement Board August 2013

INTRODUCTION & CONTEXT

Welcome to Phase 2 of our Strategic Improvement Plan (SIP).

This plan sets out the priority objectives that must be achieved to improve the quality of services and the improvements to outcomes for children and young people which were identified following Ofsted inspection of our Safeguarding and Looked After Children services in June of 2012. The DfE Improvement Notice of November 2012 set out specifically the required improvements and the framework for establishing an Improvement Board in Walsall to provide support, challenge and clear accountability for the improvement journey. This plan has been further developed to take full account of the further inspection of arrangements for the help and protection of children which was undertaken in June/July 2013.

This is our Phase 2 Plan. The plan directly reflects the priorities set out in the Improvement Notice whilst offering a sharper and more focused set of objectives and actions for partners. These objectives reflect progress to date, the most recent 2013 Ofsted recommendations and our increasingly strong self-awareness within the partnership of our strengths and areas for improvement. This is enabling us to make more effective and informed decisions on where to target our resources to support improvement activity to best effect. *Appendix A* provides information on our approach to self-assessment and the evidence base for this critical phase of our improvement journey.

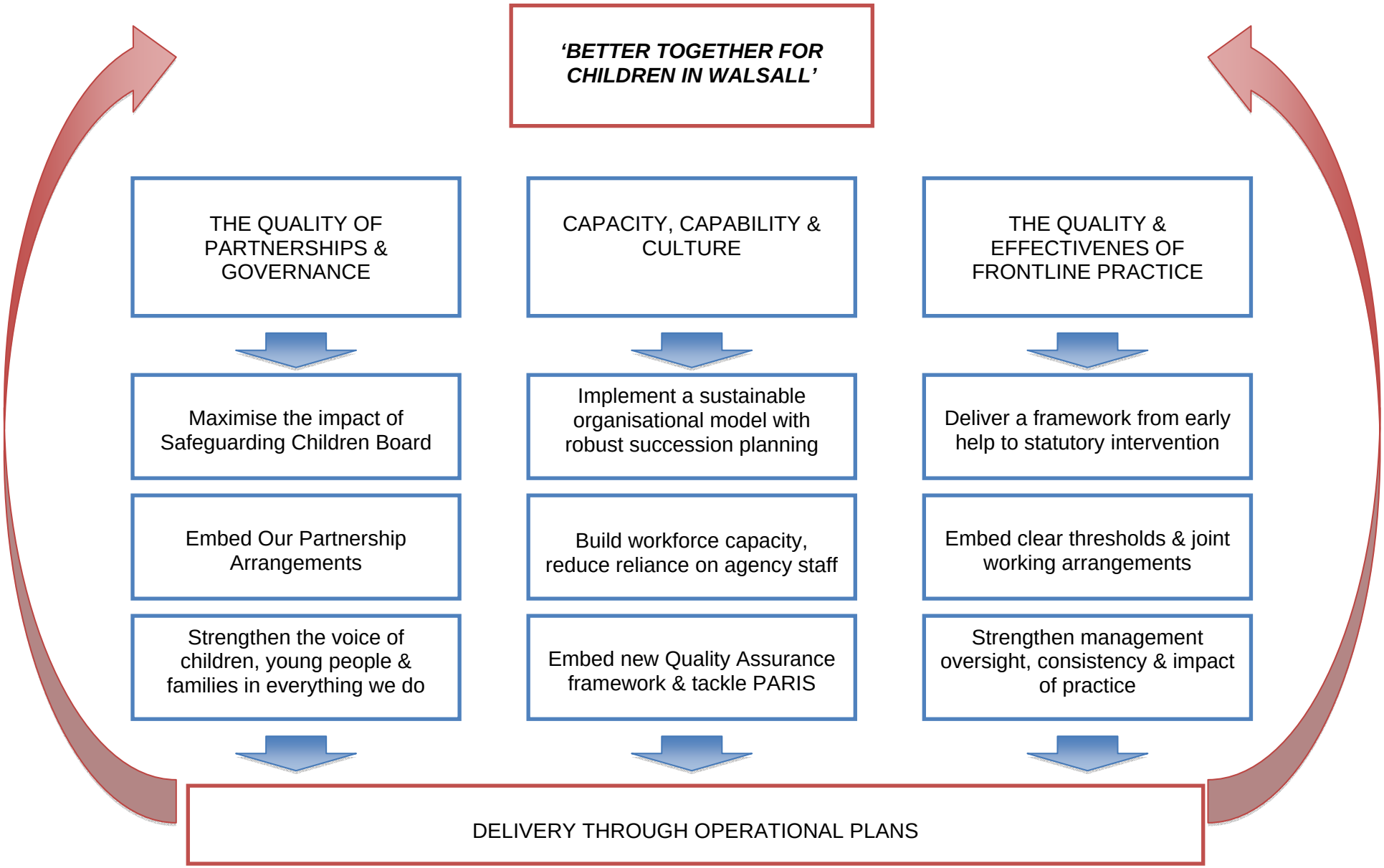
Evidence of progress from our original plan clearly illustrates how we have made significant improvements in the governance and leadership of provision, and in creating the optimum conditions for sustainable change and improvement within Children's Services. The primary focus of our Phase 2 SIP is on embedding these changes, whilst evidencing material improvements to the quality and effectiveness of frontline practice, and on improving outcomes for children in Walsall. Implementation of the SIP is secured through three Delivery Plans which span Children's Services provision.

This Phase 2 plan has been prepared in close consultation with our partner agencies, with our improvement partners and in dialogue with the independent Chair of the Improvement Board. Our plan is informed by the voice and views of young people. Engagement with young people will be a continuing focus for how we measure the impact of our work. The plan seeks to be increasingly 'SMART' in setting and measuring progress, and has been informed by robust independent challenge to our evidence base for demonstrating progress.

Robust and reliable new performance monitoring and reporting arrangement will be in place to inform Improvement Board Scrutiny of this plan from September 2013. For the August Board, we can offer text on impact pending full RAG ratings from September. The September SIP will also reflect any further Board feedback resulting from Board scrutiny of the most recent 2013 Ofsted report.

Rose Collinson
Interim Director of Children's Services
Walsall Council
August 2013

STRATEGIC IMPROVEMENT PLAN FOR SAFEGUARDING CHILDREN - PHASE 2: HOW IT WORKS



IMPROVEMENT THEME 1: THE QUALITY OF PARTNERSHIPS & GOVERNANCE (Theme Lead - Rose Collinson) * indicates objectives arising directly from 2013 Ofsted report						
	Objective and actions	**Lead & delivery deadline**	**Success measures and/or evidence base & key deadlines**	**Impact for children & young people**	**Action RAG**	**Impact RAG**
1.1	**Objective: To maximise the impact of Walsall Safeguarding Children Board**					
1.1.1	To implement the objectives set-out in the new WSCB Business Plan – supported by the x4 WSCB Committees: • Policy, Procedures & Training • QA & Performance • Serious Case Reviews • Child Death Overview Panel	Robert Lake *Deadlines determined by WSCB Business Plan*	Progress and impact updates against business plan themes agreed by WSCB. Exception reporting to Improvement Board. Committees have agreed terms of reference, work plans, meet regularly and are quorate.	The establishment of the WSCB and agreement on the Business Plan enables effective prioritisation of relevant service improvements for children and young people. The committee structure is now fully operational.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
1.1.2	To implement the WSCB Learning & Improvement Plan – ensuring that there is alignment with wider QA arrangements across Children's Services. This must support the systematic implementation of learning including from Serious Case Reviews, Peer Reviews & complaints and compliments.	Robert Lake *Deadlines determined by WSCB Learning & Improvement Plan*	WSCB receives quarterly performance reports, requests drill-down where necessary and implements agreed actions as appropriate.	Development and implementation of the Learning & Improvement Plan is being closely aligned with the wider Quality Assurance framework for children & young people's services to maximise resource capacity and impact.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
1.1.3	To undertake a thorough review of the form, function and impact of the newly-configured WSCB at 6 and 12 months to ensure that the new arrangements are fit for purpose and highly effective.	Robert Lake *Nov 2013 & April 2014*	WSCB reviews confirm realistic self-awareness of progress made and agreed actions for further improvement. Full reports to Improvement Board Nov 2013 & April 2014.	Full report to Improvement Board Nov 2013 & April 2014.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
1.2	**Objective: To embed our partnership arrangements, including implementation of Working Together 2013**					
1.2.1	To secure partnership buy-in and active multi-agency implementation of the new Children & Young People's Plan.	Rose Collinson *November 2013*	CYP Board receives quarterly performance reports, requests drill-down where necessary and implements agreed actions as appropriate.	Following full launch of the performance management framework for safeguarding in Sept 2013 and alignment to the WSCB, the CYP Board has scheduled a refreshed performance reporting arrangement from November 2013. This will ensure robust strategic alignment between governance bodies to secure maximised impact of resources on prioritised areas of need.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
1.2.2	To put in place partnership agreements and related safeguarding training as a basis for safe and effective joint working arrangements between Children's Services and: (a) Health Service commissioners and providers – specifically relating to services for vulnerable children (b) West Midlands Police – specifically relating to attendance and active participation in all key Child Protection forums. (c) Early Years Settings & Schools – specifically relating to services to vulnerable children (d) Partners and wider community stakeholders who share responsibility for safeguarding children who are privately fostered *	*November 2013* (a) Salma Ali (b) Tim Bacon (c) Keith Whittlestone (Secondary), Jenny Garratt (Primary) & Sue Morgan (Early Years Settings) (d) Tony McGregor	Health, Police, Schools & Early Years settings buy-in and sign-off is evidenced in CYPP, Improvement Plan, WSCB Business Plan and HWB strategy. Membership, attendance at meetings and partnership action reflects ambition and commitment. Performance reporting on plans for each Board demonstrates positive progress in achieving better outcomes. Quantitative and qualitative measures (including audits and review of QA systems) confirm the effectiveness of partner engagement & delivery of safeguarding & CP provision; Police attendance & engagement at CPC's; Strategy Meetings; S47 investigations & WSCB attendance; LAC Health assessments; health visitor and school nurse engagement in early help activities and referral outcomes. Quarterly progress reports on all elements to Improvement Board from July 2013. Good partnership awareness of private fostering requirements and how the safeguarding, health and wellbeing needs of these children need to be met are evidenced through systematic dip-sample audits of visit records.	Multi agency WSCB audits April, May and June indicate good attendance at Core Groups. Early Help Assessments (EHA) audits are routinely undertaken each month and the outcomes are taken to the Safeguarding Quality & Performance (Q&P) sub group as part of a detailed quarterly audit report. Dip audits to take place Sept 2013 and results to be communicated to QA&P Subcommittee for action as appropriate.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
1.2.3	To agree local arrangements for the implementation of the 2013 Working Together guidance across the partnership.	Sue Butcher *November 2013*	Evidence from CYP, WSCB & HWB meetings of engagement, understanding and buy-in from partners. Outcomes from analysis of 'Distance Travelled' tool – from early help to statutory services. Evidence from case file auditing to demonstrate quality and consistency of new assessment, planning and review practice within Safeguarding, LAC, CWD & Fostering & Adoption teams. Quarterly progress reports on all elements to Improvement Board from Sept 2013. (see also 3.2.2)	Practice requirements in line with WT13 are agreed. Some reporting requirements are pending agreement and Paris system changes are required. Audit activity April to June demonstrates improvement in children being seen alone and their views, wishes and feelings being captured. Statutory visits are generally within timescales. Assurance activity relating to any identified remedial actions will be undertaken by IRO's from June. Audit activity across Safeguarding & LAC services has moved to peer audits from July. Independent audit activity has taken place across Fostering & Adoption services which provide a useful starting point for developing audit activity.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
1.3	**Objective: To strengthen the voice of children, young people and families in everything we do**					
1.3.1	To implement a comprehensive programme of engagement and consultation with children, young people and families to inform decision-making at both a strategic and operational level throughout the partnership. Specifically, to ensure that parents are able to see all agency reports to child protection and other conferences in advance. *	Alan Michell *October 2013* Tony McGregor *October 2013*	Documented sign-off of strategy & delivery plan for strengthening the voice of children & young people in the work of the partnership. To include succession planning for young people. Evidence of where feedback from service users has impacted directly on partner agencies decision-making – evidenced in the commissioning and delivery of services and feedback / evidence on outcomes and impact. Quarterly progress reports on all elements to Improvement Board. Evidence of feedback from parents / families indicating level of satisfaction with the quality of relationships with social workers and services received. Improvements in timeliness of family receipt of agency reports to be captured via IRO QA system and reported to QA&P Committee.	An increase in the numbers of Children and Young People who are actively involved and the opportunities for them to take part in decision making. Improved skills and knowledge for children and young people who are involved (e.g. number of young people achieved accreditation).	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
1.3.2	To systematically ensure the voice of the child can be evidenced in the assessment, planning and review of casework. Immediate 2013 Ofsted requirement: Specifically, to ensure that children and young people are actively encouraged to participate in child protection conferences in the most appropriate way, including the use of advocacy support.*	Carol Boughton *November 2013* Tony McGregor *August 2013*	% CYP attendance at or contributions to Early Help Assessments and plans, CPP and LAC reviews. Evidence from case file audits and practice observations of child's voice explicit in assessment, planning & review of casework. Including evidence of child seen alone. Key measures included in scorecard report to WSCB & Improvement Board. Evidence from CP conference minutes of CYP attendance & engagement and inclusion of this aspect and advocacy use in forward IRO QA system.	Performance measures are being developed. There is good anecdotal evidence of increasing children's voice in planning & review. Audit activity April to June demonstrates improvement in children being seen alone and their views, wishes and feelings being captured. Focused work to ensure this is captured within Core Group activity planned as WSCB audits of Core Groups indicate a lack of the child's voice within this activity.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
1.3.3	To develop a young inspectors safeguarding framework to enable young people to inspect a wide range of providers and feed information to the WSCB To progressively strengthen mechanisms for securing young people's voice and influence within Council provision	Alan Michell *November 2013*	Establish targets for scope/reach of inspections of local provision in 2013/14. Reporting findings to WSCB at 6 and 12 months with follow-up action agreed by WSCB. The Council for Kids meets regularly with attendance by specified partner agency leads. Feedback from LAC CYP demonstrably impacts on service development and strategic planning. Quarterly reporting to Improvement Board.	Children and young people directly involved in quality assuring provision. Our Looked After Children and Young People say they feel their voices are being heard and as a result the services we deliver are more effective to meet their needs. Increased skills and knowledge gained by the children and young people involved.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

IMPROVEMENT THEME 2: CAPACITY, CAPABILITY & CULTURE (Theme Lead – Rose Collinson) * indicates objectives arising directly from 2013 Ofsted report						
	Objective and actions	**Lead & delivery deadline**	**Success measures and/or evidence base & key deadlines**	**Impact for children & young people**	**Action RAG**	**Impact RAG**
2.1	**Objective: To implement a sustainable organisational model with robust succession planning**					
2.1.1	To design and agree a whole-organisational model and phased implementation plan for Children's Services which will strengthen the child's journey and is informed by improvement priorities.	Rose Collinson *November 2013*	Initial organisational model for high-level consultation on overall shape with children & young people /WSCB/ Improvement Board Sept 2013 Formal consultation followed by implementation Dec 2013	Appointments board approved top level structure, established AD posts and endorsed underpinning rationale for redesign.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
2.1.2	To put in place robust succession arrangements for the leadership and management of Children's Services at tiers 1-3 to sustain improvements in service delivery and outcomes.*	Paul Sheehan *December 2013*	Clear succession plan for tiers 1-3 to be agreed internally by Oct 2013. This will be informed by agreement on wider organisational reshaping to be implemented from Dec 2013	Refer to 2.1.1 for related action above.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
2.1.3	Immediate 2013 Ofsted requirement: To ensure that Social Worker caseloads are manageable.* Specifically - to implement a workload management tool for Social Work teams which is consistently applied and that this informs direct management action to tackle demand and capacity issues.	Sue Butcher *August 2013*	Agreement on tool & pilot leading to full implementation across Safeguarding, LAC & CWD teams from Sept 2013. Quarterly reporting on implementation & findings to WSCB & Improvement Board from Oct 2013.	The tool was launched on the 1st July 2013 and is being actively used in the CWDT as from the 8th July 2013.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
2.2	**Objective: To build workforce capacity and reduce reliance on agency staff**					
2.2.1	To review and implement the priority objectives set-out in the Social Care Workforce Development Strategy. * To take action to improve stability in the social care workforce and reduce dependency on agency staff. *	Carol Boughton *October 2013*	Reporting in line with the timelines set-out in the Social Care Workforce Development Strategy. Quarterly reports to WSCB & Improvement Board from Sept 2013.	Full report to IB scheduled for Sept 2013 High response rate to recruitment drive underway for 15 social workers.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
2.2.2	To deliver a comprehensive programme of staff development to address skills deficits and to improve retention and progression opportunities for Social Work staff.* This includes embedding the role of the Principal Social Worker.	Paula Jones *October 2013*	Delivery to timelines set-out in the WSCB Training Plan; Social Care Workforce Development Strategy and individual partner organisations Training Plans. Quarterly reporting to WSCB & Improvement Board including sickness absence, turnover, vacancies and % agency staff, supervision & appraisal. Report & analysis from annual Social Work Health Check.	Stakeholder planning day for planning and implementation of evidence informed practice held June 2013. Gap analysis against Employer Standards completed.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
2.2.3	To deliver a continuing high-profile programme of communication and engagement ('Better Together for Children') with staff across Children's Services and the wider partnership to secure to engage and inform them on the vision and improvement journey for Walsall.	Rose Collinson *Monthly through to Dec 2013*	Agree & implement quarterly feedback tool for 'voice of staff' to measure progress & impact from Sept 2013. Quarterly report to WSCB & Improvement Board including delivery of staff briefings/workshops and feedback received.	200 frontline staff from across Children's Services, Health, Police and independent organisations attended multi-agency Practice Improvement workshops run by independent facilitators during May and June 2013.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
2.3	**Objective: To embed the new Quality Assurance framework and tackle PARIS**					
2.3.1	To strengthen the ICS (PARIS) information system to secure reliable oversight of casework and to inform QA and performance management. * To include clear and unambiguous direction to all ICS/PARIS users on the recording of key casework fields – in particular: • Assessments • Chronologies • Plans & Reviews • Management Decisions • Early Help Assessments • Statutory Visits To ensure that all statutory reporting requirements are met and that worker level information can be extracted to support key improvements.	Karen Marcroft *November 2013*	Agree needs and implement system improvements with agreement of Children's Social Care and performance leads. Give clear directive to ICS/PARIS users on recording requirements including assessment, planning, chronologies & management decisions, early help assessments & statutory visits. Weekly run-off and analysis of client level data e.g. to meet changing Ofsted & local data requirements to drive progressive improvements in the quality of data. Urgent action to ensure IT system fully complies with CIN return specification 2013/14.	Systematic review in progress of work areas and their respective system, recording and reporting requirements. Established as routine practice. This is being used to progressively improve data quality.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
2.3.2	To implement a systematic process of Quality Assurance throughout Children's Services and the wider partnership to continuously inform and evidence practice and better outcomes for children. To include a robust process for systematic analysis and learning from complaints. *	Karen Marcroft *October 2013* Carol Williams *October 2013*	Agree & implement a clear QA framework for Children's Services with the understanding and buy-in of staff and partners. Record through WSCB & Improvement Board with quarterly reports (see also 1.1.2). Develop robust approach around complaints and agree key intelligence measures for reporting from October 2013	Framework agreed and implemented across Children's Services. Full launch of performance reporting from September 2013. Maximise alignment with WSCB and Children and Young People's Board from November 2013.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
2.3.3	To embed a comprehensive rolling programme of case file audits across the partnership – using a common audit tool and reflecting the 'child's journey' across agency boundaries. Audits to evidence frequency of core groups; that children are visited with a frequency linked to their level of need; systematic use of chronologies.	Tony McGregor *September 2013*	Agree & implement core audit tool to be applied across partnership to support analysis of the 'child's journey' by Sept 2013 Quarterly reporting to WSCB & Improvement Board on the application and outcomes from systematic case file auditing.	Audit activity April to June demonstrates improvement in children being seen alone and their views, wishes and feelings being captured. Statutory visits are generally within timescales. Assurance activity relating to any identified Remedial actions will be undertaken by IRO's from June and Audit activity across Safeguarding & LAC services will move to Peer audits from July. Independent audit activity has taken place across Fostering & Adoption services which provide a useful starting point for developing audit activity.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

IMPROVEMENT THEME 3: THE QUALITY & EFFECTIVENESS OF FRONTLINE PRACTICE (Theme Lead – Sue Butcher) * indicates objectives arising directly from 2013 Ofsted report						
	Objective and actions	**Lead & delivery deadline**	**Success measures and/or evidence base & key deadlines**	**Impact for children & young people**	**Action RAG**	**Impact RAG**
3.1	**Objective: To implement a whole-systems framework from early help through to statutory intervention. Including improvements to the quality and consistency of assessment, planning and review for vulnerable children**					
3.1.1	Phased implementation of a clear pathway for children from early help to statutory intervention and eventual de-escalation.	Louise Hughes *November 2013*	Outcomes & impact from analysis of 'Distance Travelled' tracking tool – from early help to statutory services. Implementation on Paris of end of intervention measures agreed for early help – August 2013. Analysis of financial / resource impact using 'value' assessment tool. Early Help Strategy sign-off – Oct 2013	Effectiveness of a range of tools is being ascertained. Full update to IB Sept 2013. A VfM analysis on 2011/12 budgets was completed in April 2013, this showed how our budgets and outcomes (as measured by PIs and Inspection reports) compared to our statistical neighbours. This will assist our budget setting process during 2013/14.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
3.1.2	To put in place communication, engagement and information sharing protocols and practice guidance for frontline staff to support effective multi-agency working across the spectrum of early help through to statutory intervention. Specifically, ensure that where a child is ready to step-down from a CIN plan that robust lead professional arrangements are in place to coordinate early help provision. *	Carol Boughton *November 2013* *October 2013*	Evidence of multi-agency communication and engagement in planning and implementation. Protocols & practice guidance in place. Completion of multi-agency staff development programme to support effective delivery. Increase monitoring and learning from audits of children's journeys including step-up / step-down outcomes. October 2013 for tracking system finalisation.	Information sharing protocols agreed on Child Sexual Exploitation & pending on Strengthening Families programme.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
3.1.3	a) To implement a high quality and child-centred single assessment framework incorporating explicit assessment of risk, evidence that children are seen alone during assessment, and inbuilt management sign-off & QA process. b) To ensure that robust assessment is reflected in SMART child protection and LAC plans that are clearly focused on risk.	Anne Thompson *November 2013*	Develop and agree a single assessment tool – by Sept 2013. Early alignment with regional protocols. Delivery of targeted staff development programme on effective assessment & planning from Sept 2013. Evidence attendance & impact through quarterly reports to WSCB & Improvement Board from Oct 2013 (see also 1.2.3) *N.B. Delivery of a single assessment is framework interdependent and reliant upon structural issues being resolved e.g. transfer points.*	Information being sought from neighbouring authorities and pilot authorities. Once designed and agreed Workforce Development & WSCB training resources to be engaged in staff development programme.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
3.2	**Objective: To put in place clear thresholds and joint working arrangements**					
3.2.1	To implement clear up-to-date local practice and policy guidance for frontline staff to support and inform decision-making on thresholds and inter-agency or team transfers.	Carol Boughton *October 2013*	Agree and implement clear threshold guidance across the partnership. Sign-off of refreshed policy to be agreed at WSCB & Improvement Board Sept 2013. Evidence of comprehensive attendance at staff training programmes/briefings to support implementation. Monitor and report progress to WSCB & Improvement Board through quarterly reports on referrals NFA'd and cases escalated by agency.	Work in development for agreement with partners and sign off by WSCB in September.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
3.2.2	To embed new Front Door arrangements for Children's Services – supported by training and clear communication which achieves understanding and buy-in across the partnership.	Euston Copeland *October 2013*	As in 3.1.1 (above) and evidenced through systematic case file auditing, service-user and staff/partner feedback measures. Quarterly reporting to WSCB & Improvement Board from Sept 2013.	As detailed in 3.1.1 (above)	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
3.2.3	Put in place robust out-of hours arrangements for responding safely and effectively to safeguarding concerns.	Sue Butcher *September 2013*	Appropriately resourced system and procedure in place and communicated to key professionals.		Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

	Objective and actions	Lead & delivery deadline	Success measures and/or evidence base & key deadlines	Impact for children & young people	Action RAG	Impact RAG
3.3	**Objective: To strengthen management oversight, consistency and impact of practice within Children's Services**					
3.3.1	To implement a programme of staff supervision, appraisal and practice observation which is rigorously monitored through quarterly scorecard reporting, the outcomes of which inform staff training and development strategy.	Paula Jones *October 2013*	Staff supervision & appraisal policy implemented from June 2013. Quarterly reporting to WSCB & Improvement Board from Sept 2013	Supervision policy launched June 2013, linked to the quality assurance framework and including observations of practice against the Professional Capabilities Framework. Regular audits of supervision records scheduled with first two completed.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
3.3.2	Immediate 2013 Ofsted requirement: To ensure that services for children with disabilities are of a good standard and that joint work with safeguarding and child protection teams is robust, clearly recorded and receives sufficient management oversight. *	Alison Glover *August 2013*	Process & tool to support joint working in place from June 2013. Quarterly management report on progress to WSCB & Improvement Board from Sept 2013.	These requirements are explicitly stated within staff supervision & appraisal policy implemented from June 2013.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013
3.3.3	To embed the new performance framework and to ensure that up-to-date, relevant and easily digestible performance data is made available to all levels of managers with data analysis to team and individual-level to inform management action on key areas including Early Help and Commissioning. *	Karen Marcroft *October 2013*	Performance management & QA frameworks are in place with supporting staff guidance and training with effect from Sept 2013. Quarterly management reports on progress to WSCB & Improvement Board from Sept 2013.	Interim performance report presented to July IB. Scheduled for full launch Sept 2013.	Full RAG system in place from Sept 2013	Full RAG system in place from Sept 2013

APPENDIX A: OUR APPROACH TO SELF-EVALUATION OF PROGRESS ON THE FIRST IMPROVEMENT PLAN

The Strategic Improvement Plan (SIP) was produced in November 2012 in direct response to the DfE Improvement Notice following Ofsted inspection. The SIP addresses the findings of the 2012 Ofsted report and any outstanding recommendations from previous inspections, and has been further developed to reflect recommendations from the most recent 2013 Ofsted inspection of Local Arrangements for the Help and Protection of Children. To review progress on the SIP to date we have undertaken a rigorous process of both internal and independent challenge and review. This has included discussion with Improvement Board colleagues and our staff and partners, capture of service-user views and wider Children's Services and partnership performance data and a programme of independently sourced case file auditing. This work has been undertaken against a background of culture change within the organisation where we have placed an increased emphasis on frank and open self-evaluation and organisational learning. We are increasingly confident that this is producing evidence which not overly aspirational but is firmly and robustly grounded in reality.

This process has differentiated evidence of progress on the following basis:

(a) Evidence that **we have put in place key enabling factors / levers for change**. For example, the significant improvements to the governance and oversight arrangements for the WSCB. These are a critical pre-requisite of securing sustainable system-wide improvements and impact on safeguarding outcomes for children in Walsall. This was a headlining improvement priority identified by Ofsted in 2012 and is reflected positively in the 2013 Ofsted report.

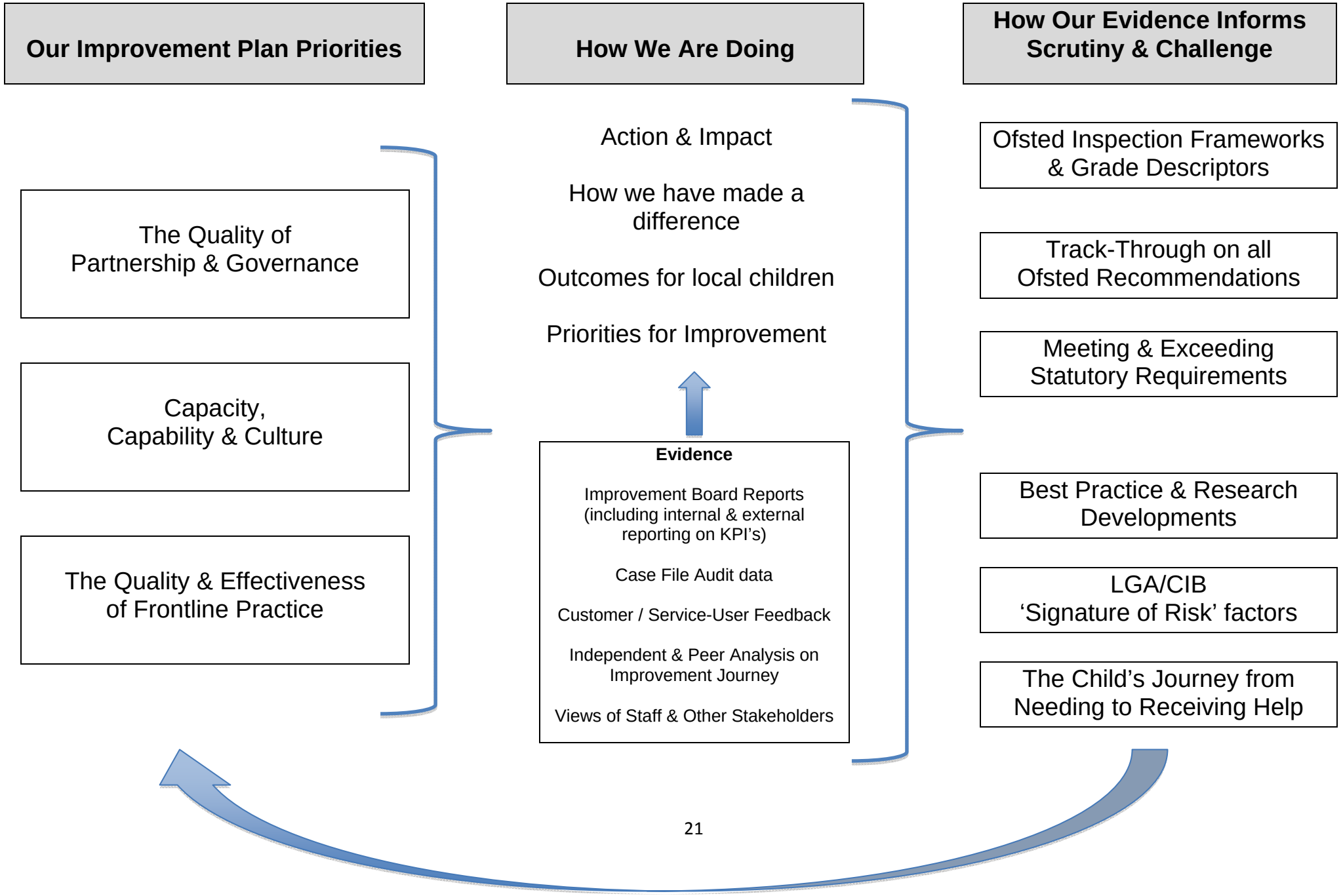
(b) Where there is early but tangible evidence of where **improvement activity is making a difference to children** and having an impact on them from needing to receiving help and moving forward, we have directly referenced the evidence source for this. For example, improvements in the frequency, quality and impact of Core Group meetings, which have a direct implication for the effectiveness of care planning and support for individual children. The 2013 Ofsted report has provided further supporting evidence drawn from an analysis of 100 case files.

(c) Where there is **a lack of tangible evidence to support progress**, but where qualitative information from staff and our partners is suggesting that there is progress towards achieving improvement priorities. For example, multi-agency staff workshops have produced accounts, some directly observed by Improvement Board colleagues, of positive progress in improved inter-agency working and joint assessment and information sharing.

(d) Where there was **slower progress on some key improvement priorities,** for example on evidencing the voice of the child in casework planning and review, we have developed sharper actions for our Phase 2 Improvement Plan which we are confident will deliver significant improvements over the next 3 months. The 2013 Ofsted report has helpfully provided some firm analysis to suggest that performance is improving in these areas (for example the voice of the child) which is encouraging and supports our approach to improvement.

The outcome of this self-evaluation has directly informed the preparation of our Phase 2 Improvement Plan.

APPENDIX B: <u>OUR FRAMEWORK FOR SELF-EVALUATION OF THE FIRST IMPROVEMENT PLAN</u>



APPENDIX C: LEVERS FOR CHANGE EVIDENCED FROM THE FIRST IMPROVEMENT PLAN

IMPROVEMENT THEME 1: THE QUALITY OF PARTNERSHIPS & GOVERNANCE	
1	A Wholly refreshed Safeguarding Board is in place, supported by strong committee arrangements with clear work plans for 2013/14
2	Robust new strategic partnership arrangements are in place as a long-term platform for delivering improvement priorities. These include the new Children & Young People's Partnership and Health & Well-Being Board. Both are supported by strong plans with a high-level of multi-agency buy-in to the delivery of clear priorities for local children and young people.
3	The transition back to the local authority of an outsourced contract with SERCO has enabled significant progress to be made in joining up services and support for children.

IMPROVEMENT THEME 2: CAPACITY, CAPABILITY & CULTURE	
1	The refocused Scrutiny Panel and the reshaped Corporate Parenting Group, now chaired by the portfolio holder are evidence of a notable strengthening of the governance and oversight of Children's Services provision in Walsall.
2	A further layer of scrutiny from Health Commissioners is in place with the DCS called to account to the CCG for progress on safeguarding improvements. This is informing commissioning plans for 2013/14 and beyond.
3	Phasing & scoping of a new organisational structure which will deliver sustainable improvements in Walsall has been agreed with Chief Executive and Lead Member

IMPROVEMENT THEME 3: THE QUALITY AND EFFECTIVENESS OF FRONTLINE PRACTICE	
1	Significant changes to senior management & leadership arrangements across Children's Services to secure stronger and more informed focus on frontline practice. This has involved direct tackling of performance, capacity and capability issues.
2	A comprehensive review of services for Children with Disabilities has been informed by voice of children & families. Evidence from case file audits and parental feedback indicates early improvements in the quality of management oversight, practice and outcomes for children.
3	Reshaping of the Front Door access point for Children's Services is evidencing improvements in the consistency of decision-making, completion of assessments to timescale and overall capacity of social work staff. These developments are a critical element of securing effective Early Help as we move towards system-wide improvements to the child's journey in Walsall.

APPENDIX D: GOVERNANCE ARRANGEMENTS

Corporate governance arrangements remain unchanged. The Phase 2 SIP will be driven by the Improvement Board. The purpose of the Board is to ensure effective, cross-partnership oversight to the delivery of the SIP, enabling it to deliver the requirements set out in the Improvement Notice and Ofsted report.

The Board has an independent chair, appointed by Walsall Council and approved by the Parliamentary Under Secretary of State for Children and Families. The chair provides the Parliamentary Under Secretary of State for Children and Families with written reports on a 6 monthly basis. The Board meets on a monthly basis and will delegate work to relevant organisations or partnership working groups.

In addition to reports to the Minister, the Board will report to the Leader of Walsall Council. Its work will also be reported to:

- Walsall Safeguarding Children Board
- The Children and Young People Scrutiny and Performance Panel
- Children and Young People Partnership Board
- Partner agencies individual governance arrangements

Membership of the Improvement Board includes:

- Council Chief Executive
- Elected Members
- West Midlands Police
- Clinical Commissioning Group
- Walsall Healthcare Trust
- Walsall Safeguarding Children Board
- Primary Schools Forum representative
- Walsall Association of Secondary Head Teachers representative
- Department for Education Participant Observer
- LGA – Children Improvement Board Participant Observer

A multiagency operational group has been established to drive through activity to ensure improvements are delivered. The role of the group is to:

- To maintain a risk register and to manage and report on risks to delivery of the Improvement Plan. This includes identifying specific risks associated with the transition from the first Improvement Plan to Phase 2.
- Enable delivery of improvements by ensuring issues are addressed and there are no blockages to making necessary changes to the current way of operating to ensure outcomes for children improve.
- Co-ordinate updates to the Improvement Board and facilitate the monthly monitoring reporting via the provision of timely and accurate updates on activity and the impact of activity on children and their families.
- Drive forward the required actions in own organisations / services to deliver required sustained improvements.
- Collectively manage risks associated with the delivery of the SIP.

APPENDIX E: GLOSSARY OF TERMS

CIB	Children's Improvement Board
CPC	Child Protection Conference
CWD	Children with Disabilities
CYP	Children & Young People
CYPP	Children & Young People's Plan
DART	Domestic Abuse Referral Team
DCS	Director of Children's Services
DfE	Department of Education
HWB	Health & Well-Being
IB	Improvement Board
ICS	Integrated Children's System
LAC	Children & Young People Looked After by the Local Authority
LGA	Local Government Association
PARIS	Specific ICS Software Programme for Children's Services Case Recording
QA	Quality Assurance
SERCO	Independent organisation – formerly education services provider for Walsall
SCR	Serious Case Reviews
SIP	Strategic Improvement Plan
SMART	Specific, Measurable, Achievable, Realistic, Time-bound – methodology for objective / target setting

APPENDIX F: LINKS TO KEY DOCUMENTS

Document	Link
Children & Young People's Plan	Link
DfE Improvement Notice (November 2012)	Link
First Strategic Improvement Plan	Copies of monthly updates available on request from Mandeep Bassi Tel: 01922 655814, bassim@walsall.gov.uk
Health & Well-Being Strategy	Link
Social Care Workforce Development Strategy	Copy available via Paula Jones Tel: 01922 655438 jonespaula@walsall.gov.uk
WSCB Business Plan	Copy available on request from Mandeep Bassi Tel: 01922 655814, bassim@walsall.gov.uk
WSCB Learning & Improvement Plan (Draft for Consultation)	Copy available on request from Mandeep Bassi Tel: 01922 655814, bassim@walsall.gov.uk
Full Ofsted Report on the Inspection of Local Authority Arrangements for the Protection of Children – August 2013	Link

Inspection of local authority arrangements for the protection of children

Walsall Metropolitan Borough Council

Inspection dates: **24 June – 3 July 2013**
Lead inspector **Fiona J Millns HMI**

Age group: All

Website: www.ofsted.gov.uk

Further copies of this report are obtainable from the local authority or at www.ofsted.gov.uk

Contents

Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Walsall is judged to be adequate.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Walsall, the council and its partners should take the following action.

Immediately:

- ensure that social worker caseloads are manageable so that children receive good quality input and this is recorded promptly

- ensure that children and young people are actively encouraged to participate in child protection conferences in the most appropriate way, including the use of advocacy support

- ensure that social workers undertaking enquiries into child protection concerns regarding disabled children work closely with the social worker from the disability team so that the information is clearly recorded and coordinated resulting in well informed evidence and findings and that this work receives sufficient management oversight.

Within three months:

- ensure that, where children are ready to step down from a child in need plan, a lead professional is identified that can effectively coordinate early help services that continue to support improved outcomes

- ensure a review of the workforce planning strategy and take action to improve stability in the social workforce and reduce dependency on agency staff

- ensure appropriate responses to complaints processes and demonstrate learning from complaints

- ensure the new quality assurance and performance framework is embedded to enable effective monitoring of service delivery, such as early help and commissioning

- ensure that parents are able to see all agency reports to child protection conference in advance so they appreciate the full range of professional staff's views of risk and protective factors.

Within six months:

- ensure that the child's electronic recording system facilitates and supports social work practice, quality assurance and performance management processes

- ensure that everyone in the community, including key professionals, is aware of the requirements about safeguarding to children who are privately fostered

- ensure suitable succession arrangements are in place at senior management level to ensure that current improvements in service delivery and outcomes for children and young people can be sustained.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals, including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the council holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of four of Her Majesty's Inspectors (HMI) and two seconded inspectors.

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Walsall Council has approximately 67,000 children and young people under the age of 19 years. This is 25% of the total population. The proportion entitled to free school meals is above the national average. Children and young people from minority ethnic groups account for 32% of the total population, compared with 25% in the country as a whole. The largest minority ethnic groups are Asian: Pakistani, Indian and Bangladeshi. The proportion of pupils with English as an additional language is above the national figure.

10. In April 2013 Walsall established a children's multi-agency screening team known locally as MAST who pass on any referrals to the Initial Response Service (IRS). The IRS then undertake any initial assessments and Section 47 investigations. There are six safeguarding and family support teams (SFS) responsible for delivering services to vulnerable children and their families. There is an emergency out of hours service providing cover for the council.

Overall effectiveness

11. The overall effectiveness of the arrangements to protect children in Walsall is judged to be **adequate**. In June 2012, following a safeguarding and looked after children services inspection, Ofsted judged the arrangements for safeguarding children and young people in Walsall as inadequate. Following the inspection there were significant changes to senior management arrangements in Walsall and the council was subject to an improvement notice from the Department for Education (DfE). The DfE improvement plan is being implemented and is resulting in better and more consistent arrangements for the protection of children. There has been substantial progress with the development of the multi-agency screening team (MAST) and Initial Response Service (IRS), with significantly improved responses to contacts and referrals and better quality assessments, ensuring that children and young people are protected. However, other improvements are not firmly embedded or are recent developments. This inspection identified key areas of fragility with regard to the reliance on agency staff, high caseloads, the electronic children's recording system and quality assurance and performance systems. The council acknowledges the need to be vigilant and to continue to drive improvement and ensure sustainability within children's services.

12. The interim Director of Children's Services (DCS) took up post in September 2012. The DCS has clear expectations for herself and the senior management team to be highly visible to frontline staff, listening to their views and working together for better outcomes for children in Walsall. The senior management group have been able to gain partnership support and staff commitment for an agenda for change. There is an understanding of the need and a continued commitment to prioritising the commissioning and provision of child protection services by the chief executive, elected members and senior officers.

13. Dedication from elected members working with senior management in Walsall has been important in driving improvement. They have a clear understanding of the challenges and demonstrate commitment to drive improvements in frontline practice, ensuring children and young people are effectively protected. The children and young people's scrutiny and performance panel is working to enhance their understanding of current issues to ensure that they provide effective challenge. Most recently, they have published a safeguarding working group report following visits to frontline social work teams to consider issues affecting the workforce such as: high caseloads, use of agency staff, training and the electronic children's recording system.

14. The Walsall Safeguarding Children Board (WSCB) meets its statutory duties with a chair who is regarded as effective and a membership who are now more challenging of each other on issues such as attendance and contributions. As a result the Board is becoming increasingly effective in

setting appropriate standards and holding services to account for their performance. The 2013/14 Business Plan is in draft form but sets out a realistic timetable for key strategic priorities. A comprehensive range of training is provided on a multi-agency basis and attendance is good, for example a recent forced marriage and honour based violence course had over a hundred general practitioners attending. Plans are in place to enhance the effectiveness of the evaluation of training in order to measure and enhance its impact on practice and outcomes. There are appropriate sub-committees, including quality assurance, a serious case review group and a short term group considering issues relating to missing children and child sexual exploitation. There is a multi-agency audit programme with recent audit activity on core groups and a review of the impact of serious case reviews.

The effectiveness of the help and protection provided to children, young people, families and carers

15. The effectiveness of help and protection provided to children, young people, families and carers is **adequate**. The newly established multi-agency screening team (MAST) provides an effective single point of access, ensuring that referrals are managed appropriately, leading promptly to an offer of early help or an initial assessment or, in cases involving risk of significant harm, to a section 47 enquiry. Partner agencies welcome the new arrangements, particularly the opportunity to consult a social worker, and are confident about being able to identify and raise safeguarding issues and concerns. However, in some instances feedback to referrers on the progress of referrals is not immediately forthcoming. Inspectors also saw some evidence of drift, including delays in completing initial assessments, although no children were found to have been left at risk as a result.

16. The majority of the 18 children's centres are delivering a good or outstanding service. A health visitor linked to each centre routinely shares information on all new births, enabling children's centre to staff to make contact with, and register, all of the children in their catchment area. Children's centre services are targeted at the most vulnerable. One children's centre was able to provide very good evidence of its success in engaging local fathers. In respect of the children's centre judged by Ofsted to deliver an inadequate service, senior managers took swift and decisive action by ensuring that new management arrangements were put in place and the weaknesses identified by inspectors are being actively addressed.

17. Early help is increasingly effective. An early help coordinator, based in the MAST, quickly redirects children and families who would benefit from early help to coordinators based in one of the six multi-disciplinary area family support teams (AFSTs). Early help planning meetings are used to mobilise

advice, assistance and support in a child and family centred way. Where families need, and want, a more coordinated, multi-agency approach, an early help assessment (EHA) is completed. The multi-agency family support panel quality assures and reviews all EHAs and ensures that resources are allocated effectively. Most EHAs seen identify need and risk appropriately and are outcome focused. However, the lack of a coherent early help strategy is undermining the effectiveness and coordination of the early help offer. Confusion by some agencies and parents about the new EHA processes and paperwork, combined with a lack of clarity about what support and services are available, mean that early help resources are not always well coordinated. The council have identified as a priority the need for an early help strategy and work has already begun to address this.

18. AFSTs strategically located in areas of greatest need provide valued advice and expertise to other professionals and are crucial to the development of the early help offer. AFSTs deliver well-resourced packages of support to substantial numbers of children and families using the good range of skills and knowledge within each team. The majority of individual user feedback received on the effectiveness of the AFSTs is positive. However, in the absence of a comprehensive quality assurance and performance management framework or an effective outcomes evaluation tool, the local authority cannot be certain that resources are being deployed in the most effective way, or what impact the AFSTs are having.

19. Early intervention and support for young people is effective. The Integrated Young People's Support Service (IYPSS) provides targeted youth support and detached youth work. Clear joint working protocols and strong management oversight ensures that child protection issues are dealt with appropriately. There are good links to the Street Teams, to the young carers' service and to the teenage parent initiatives. Evidence of improved outcomes for young people, families and communities is seen in the reduction in youth related anti-social behaviour and the engagement of children and young people in positive activities. Over half of the young people who participated in the summer programme in 2012 believe that it had helped to keep them out of trouble.

20. Children and young people who are clearly at risk of harm are identified by both early help and children's social care services and most receive a prompt, and when required, robust response. Most children who are the subject of a child in need or child protection plan are helped and protected by the support that is provided. The way in which child protection conferences are organised, chaired and run, and the quality of child protection paperwork and plans has improved. Consequently, the information and planning arising from conferences has made core groups more effective in reducing risks and protecting children from significant harm.

21. The social work service for children with a 'permanent and substantial' disability is delivered by the Children with Disabilities (CWD) team. The service has been subject to considerable change since the last safeguarding and looked after children inspection, at which point it had just transferred from a private company to the council's management. In response to significant concerns identified at the last inspection, robust action was taken by senior managers. Currently, where there is an identified child protection issue, the IRS undertakes the initial investigations and then a social worker from the safeguarding and family support service will co-work the case with a social worker from the CWD team. However, whilst these arrangements may strengthen the safeguarding responses to children, cases were seen which demonstrated 'parallel' working rather than co-working. As a result needs were not always fully assessed or responded to and children and families had to engage with a larger number of often unfamiliar staff.

22. The 'Think Family' team provides intensive family support with children who are at risk, or already subject to a child protection plan. Inspectors saw some good examples of input from 'Think Family' helping to protect children and young people and making it possible for them to be stepped down from child protection to child in need. They also saw examples of the work of the team being used to support legal proceedings where it was judged that it was no longer possible to keep children safe at home.

23. Parents of children who had received early help were very positive about the difference that had made. For example, one group of parents talked positively about the impact of the Mellow parenting programme, one of a number of parenting programmes being delivered. The opportunity to meet with other parents, and talk openly about the pressures they faced, had enabled them to improve their parenting skills. All of the parents, whose children were the subject of a child protection plan, to whom inspectors spoke, understood why their child was the subject of a plan and what was expected of them as parents in terms of the changes that were required. Parents spoken to by inspectors reported very variable experiences of social work support to produce the changes required by the child protection plan. Some described very positive relationships which had clearly led to improvements for their children but others reported poor or variable contact with child protection workers and struggled to see how this had benefited their children.

24. Social workers have ready access to good quality interpreters, as well as British sign language interpreters. Assessments included appropriate attention to cultural sensitivities, including forced marriage, which reflected cultural and religious issues.

25. There is an established history of partnership working in Walsall and partners spoken to reflected that, historically, it has not always been as effective as it needs to be but has improved in effectiveness over time. The

six area partnerships provide a focus for agencies, including voluntary and community groups, to work together to improve the lives of children and families. There is a good range of support services. T3 provides structured substance misuse interventions for young people aged 11-19. A high percentage of young people leave treatment in a planned way and the rate of alcohol related under 18 years old hospital admissions is considerably lower than elsewhere in the West Midlands and slightly lower than the national average.

26. Most children are receiving help and protection at the right level. Decisions to make children and young people subject to child protection plans are usually appropriate, reflecting the fact that decision making within children's services is undertaken at a suitably senior level. In most cases seen, the step down from child protection to child in need was entirely appropriate but in some there was a lack of clarity and some children may not be receiving the most appropriate service to meet their needs.

27. Arrangements to tackle child sexual exploitation are good. There is a bespoke service, 'Street Teams' that undertake all return interviews with young people. There is a monthly multi-agency operational group that reviews all identified vulnerable young people and ensures plans are in place and on track to support them. These arrangements are currently overseen by a multi-agency strategic group which is being replaced with a time-limited 'task and finish' group. This group has commissioned a national voluntary organisation to undertake a review of its child sexual exploitation arrangements and make recommendations for any improvements.

28. The council currently supports nine children who are subject to private fostering arrangements. They are all allocated to social workers and visited at six-weekly intervals. Promotional material regarding private fostering is available and information is available via the Walsall Safeguarding Children Board's (WSCB) website. However, the council acknowledges there is more to do to raise awareness of private fostering in the wider community.

The quality of practice

29. The quality of practice is **adequate**. The multi-agency screening team (MAST) effectively contributes to the application of thresholds and the role of the family support panel in reviewing early help assessments and further ensures that appropriate thresholds for services are met. Following an independent review of the application of threshold criteria in Walsall, the Walsall Safeguarding Children Board (WSCB) is refreshing the threshold criteria guidance and aims to produce a new document in the autumn. In the meantime, referral flowcharts have been produced and disseminated, setting out clear arrangements for escalating children through levels of support from universal to early help, then into statutory support or child

protection arrangements. However, arrangements to coordinate support when stepping down from a child in need plan to early help are less well defined and contribute to agencies' anxieties about the withdrawal of a coordinating social worker from children's support plans. Cases were seen where children were re-referred to social care relatively quickly after being closed, despite input from other agencies in the meantime, where more robust early help coordination may have reduced the need for this.

30. There is an effective and timely response to referrals and contacts, particularly with the recent introduction of the MAST. These arrangements are strengthened by the team, including specialist staff such as an 'Early Help' coordinator, an education welfare officer and a 'Safeguarding Education' specialist. A designated nurse is scheduled to join the team in the near future. Although the MAST does not include police representation, there is a concurrent multi-agency screening team, including a social worker, that reviews all domestic abuse referrals from the police. There is a high level of expertise in managing domestic abuse within the domestic abuse referral team (DART), ensuring appropriate and robust support arrangements are put in place and systematically reviewed for effectiveness. Links between the DART, the multi-agency risk assessment conference (MARAC) and multi-agency public protection arrangements (MAPPA) means that information about the most serious offenders is shared with children's services and other partners who are appropriately represented on these forums.

31. Appropriate responses are made to referrals where there are parental difficulties such as substance misuse, domestic abuse and mental health issues. These issues are assessed in terms of their impact on children's welfare and the clear delineation between adult and children's social work responsibilities ensures that children remain the focus of attention.

32. Managers have made good efforts to embed good practice for MAST and other Initial Response Service (IRS) staff such as always enquiring about the presence of siblings or other co-located children, and the need to take history into account in determining appropriate next steps. These messages are well articulated by staff but the practice is not consistently applied. Inspectors saw good duty activity to establish the full circumstances of a child, but also saw a small number of missed opportunities to identify and assess the needs of siblings. There is generally appropriate consideration of children's individual characteristics such as their age, gender, disability and ethnic heritage, although gaps in the electronic recording of these were seen, including some errors such as misspelling of names and incorrect dates of birth. Ethnicity is not always recorded in the child's basic details section, even where it is clearly being considered within assessments. Young people's sexual orientation is not referred to within any guidance or documents seen by inspectors. Children and young people's views are also evident in case recording but there is

more to do to enhance this and embed this practice further as some records are too brief.

33. External agencies report positivity on recent arrangements whereby they are encouraged to use the MAST service for consultation as well as referral, and inspectors saw evidence of this in practice. There is good use of the multi-agency referral form. The council is keeping MAST arrangements under close review, as evidenced by them increasing the management complement for the service in response to identified need.

34. Senior representatives from schools who met with inspectors are positive about the support they receive regarding safeguarding advice and support, including termly designated safeguarding leads' meetings. Schools are clear about their safeguarding responsibilities, know how to make referrals and are confident about being able to escalate concerns if the need arises. However, a recent referral from an academy showed delay in informing local child protection services about children believed to be at risk of forced marriage; this is being followed up by senior managers to learn lessons and reduce the likelihood of repetition.

35. Appropriate referrals to children's social care are made by a range of agencies including private schools and academies. Examples were seen where issues such as safeguarding in Mosques and safeguarding young people at risk of forced marriage were appropriately referred to children's social care.

36. In most instances, children and young people who are the subject of a concern are seen and seen alone. Practice is variable in the extent to which it focuses on the experience of the child. Senior managers have identified these issues and have plans in place to improve practice. Most workers spoken to expressed a clear understanding of the need to develop effective relationships with children and young people, and undertake direct work to achieve this. However, not all were able to provide examples of how they have done this. Some services have very good examples of development of effective relationships with children and young people, for example the 'Think Family' service. Two factors contribute to the difficulties in staff maintaining consistent relationships with children and young people; first the structure of teams leading to different workers undertaking the initial and core assessments, and second the high use and turnover of agency staff.

37. There is evidence of children's wishes and feelings being taken into account and shared within appropriate forums such as child protection conferences, core groups, early help meetings and in case recording, but there is more to do to enhance this and embed this practice further. Parents routinely attend their child protection conferences, accompanied by a supporter if they wish. Parents confirmed to inspectors that they had sight of the social worker's report prior to conferences, although not

always sufficiently in advance. In addition, other agencies are not routinely sharing their reports with parents prior to the conference. Significantly improved relationships between social workers and families are reported since fortnightly visiting requirements replaced the previous less-frequent requirements. This also enhances social workers understanding of families' circumstances and needs.

38. Section 47 enquiries are thorough, timely and always carried out by qualified staff. Strategy meetings are usually held via the phone with the police given the centralised nature of the police central referral unit. There are occasional difficulties in securing a police officer to participate in a joint home visit; however a range of cases were reviewed which contained evidence of appropriate police presence during section 47 enquiries. In cases seen, there was prompt and appropriate action taken. The current recording arrangements for section 47 activity requires detailed recording which is appropriate but more akin to a core assessment rather than child protection enquiries. The volume of recording required at this stage ensures that full details of these activities are on the child's file, but coupled with the complexity of uploading and authorising the record, can contribute to delays in fully recording activity. However, cases seen showed prompt and appropriate actions recorded.

39. The revised arrangements implemented since the introduction of MAST has led to initial assessments being initiated swiftly and assessments in most cases lead to appropriate offers of help and/or protection. However, initial and core assessments frequently take a long time to be fully completed and be signed off by managers; this appears to be due to a range of factors. The current electronic recording system does not support the needs of social workers requiring some documents such as section 47 recording and child protection plans to be constructed separately then uploaded to the system before then being authorised which contributes to delays. In some instances, delays were caused because IRS social workers are required to complete not only initial assessments and transfer summaries but also child plans before a case is transferred to the family support and safeguarding teams. In other instances, delays were due to high caseloads and, in a minority of cases, delay was due to assessments not being progressed swiftly enough, despite allocation.

40. Child protection plans are adequate but vary in terms of how outcome-focused they are, with some having clear, measurable targets and others lacking these. The majority of plans are reviewed in a timely manner. The council have introduced a new template for core groups and recent good recording using the template has been seen although some lacked analysis and are descriptive.

41. The drive by managers to emphasise the importance of chronologies and take history into account was seen in the MAST and IRS service. Chronologies are being started routinely with careful attention being given

to histories of children. Some chronologies are detailed and comprehensive, highlighting key events in a child's life; others are system-generated with little apparent attention to their quality or usefulness. Chronologies are being used effectively to appropriately determine the next steps such as proceeding to an initial assessment, undertaking section 47 enquiries and/or commencing a core assessment.

42. The quality of case recording is variable. Sometimes it is too brief but some children's records contain good quality, detailed analysis. In a small minority of cases, records are absent, attributed by staff to insufficient time available to write up their activities, although they could appropriately describe the work they had completed to inspectors. In some instances, workers could articulate risk factors well but these were absent from case recording. Some cases lacked key documents, such as child protection plans or core group minutes.

43. Information sharing between agencies is generally good. This is further facilitated by the education staff embedded in MAST having access to the (education) 'Capita One' system. Police attendance at child protection conferences has improved from a very low baseline a year ago of attendance at about 10% to the current performance of 70-80% attendance. However, where police do not attend there were a minority of cases cited where inaccurate or no information from the police was shared at conferences. The Detective Superintendent for the police public protection unit (PPU) advised that a West Midlands Force area coordinated Local Safeguarding Children's Board (LSCB) task and finish group has been established to identify the core requirements of all agencies with respect to attendance and information-sharing across all councils served by the West Midlands force. There is also an improving level of information-sharing from general practitioners, providing reports to conferences in around 50% of cases. The issue of a lack of general practitioner information-sharing is currently compensated for by good information sharing from other health professionals.

44. Case conferences and core groups are generally well attended by relevant agencies and these function well, although they would be further improved if agency reports were shared with families before the conference. Active consideration is not always given as to how young people might contribute to the conference with very limited use of advocacy services to promote this. Core group work is generally improving but, in a small number of cases seen, did not always demonstrate a focus on the children's plans but had greater emphasis on information sharing, rather than using planning to progress matters.

45. Decision making within children's services is undertaken at an appropriately senior level. The council has worked to strengthen and clarify the discretionary powers and role of team managers. Whilst some management posts are held by temporary staff, these are frequently

amongst the most experienced staff, with many having held temporary posts for a long time, providing stability of oversight. Senior managers are aware of the need to stabilise the workforce at all levels to ensure that the services provided can be sustained at an adequate level. Recording of management oversight and decision making is generally satisfactory. Some very robust records of decision making have been seen, with only a minority of cases containing no written account of management decisions. However, most children's case records include accounts of management decision making and these are evident at all key points in the child's journey. In the IRS service, managers routinely sign off assessments and are involved in all key decisions. Management directions on case records in the IRS seen by inspectors are clear and succinct.

46. Supervision of social workers is variable. Files contain evidence of annual appraisals and probationary support for newly qualified social workers and social workers are positive about the support they receive from their managers. Supervision files seen indicate that supervision is generally in line with the frequency prescribed, although missed sessions are evident on occasion. Some supervision files demonstrate that managers have provided staff with detailed case discussion opportunities, effectively capturing the requirement for reflection as well as recording of management oversight of casework decisions. A revised supervision policy and procedures has very recently been launched, having been developed largely by team and operational managers in the service. This is more user-friendly, geared towards reflective supervision and includes observed practice of workers but it is too early to see any impact of this.

47. Caseloads in all the teams, but particularly in the IRS service, are high and this also impacts on the timeliness of activity, such as case recording, on cases. Whilst there is a high turnover of casework within IRS, and some cases require relatively little input, the high caseloads mean that the overall system is fragile. For example, if a worker goes off sick, their cases may not progress during that period as there is insufficient capacity for re-allocation and this also contributes to delays.

48. The out of hours (Emergency Response Service, ERS) service is currently managed within adult services and is a joint service for both adults and children, although includes specialist staff. The capacity of the service is limited so only emergency situations can be responded to but responses in such cases are sufficient to ensure children are adequately protected. The council recognise the limitation of the service and during the inspection re-instated a rota system to further strengthen the staffing that the ERS is able to draw on whilst awaiting the review.

49. Legal advice is reported by social workers and team managers to be readily available to them and is of a good quality. There are appropriate arrangements in place for support to progress legal proceedings for children through a regular Public Law Outline (PLO) panel, where advice on

thresholds and evidence is provided. Social workers report good ongoing support from the council's legal team as children's proceedings progress to ensure a good quality of reporting. Compliments from the family court have been received by staff in Walsall.

50. Inspectors were advised by MAST staff they now routinely assess young people aged 16-17 years who are placed in accommodation to ensure the services provided match their needs. Housing staff are clear about the council's responsibilities for homeless young people aged 16-17 years, and have received safeguarding training. They describe good working relationships with children's social care services and shared understanding of the options available to this group. Housing managers attend MARAC and MAPPA for further strengthening information sharing and multi-agency working.

Leadership and governance

51. Leadership and Governance are **adequate**. The DfE Improvement plan is being implemented and is resulting in improvements in the arrangements for the protection of children.

52. The senior management team, actively supported by elected members, have driven improvement in service delivery at the frontline. Clear and appropriate priority has been given to improving the quality of front line practice, thus ensuring children are adequately protected. Staff morale has improved and there is a wholehearted commitment from workers at all levels to provide a safe service to children and young people. Senior managers have regular face to face contact with staff and provided regular e-bulletins on progress, initiatives and practice issues. Elected members have a clear understanding of current issues affecting staff and as part of the scrutiny process visited all social work teams. In May 2013, the scrutiny panel published a paper on workforce issues affecting frontline staff and, as part of this process, noted that staff said that they were well supported by senior managers.

53. The Children and Young People's Partnership Board plays a central part in the governance of the strategic partnership in Walsall. The Walsall Plan, the Health and Well-Being Board Plan and the Joint Strategic Needs Assessment have all been considered in developing the eight priorities for improvement. Partners 'sponsor' each of the priorities to develop improved partnership working. The partnership board's plan, Health and Well-Being Board's plan and Children and Young People's Plan have clear links and inform planning and priorities for frontline team planning. As a result appropriate high priority and attention has been given to improving duty and assessment services.

54. The senior management group have a clear vision and have been able to gain partnership support and staff commitment for an agenda for change. There is an understanding of the need and a commitment to prioritising the commissioning and provision of child protection services by the chief executive, elected members and senior officers with a range of initiatives being implemented although many of them are still in the formative stages.

55. Managers are aware of the strengths and weaknesses in children's services, including continuing difficulties in evidencing the child's journey and inherent difficulties in the use of the electronic child's recording system. Key improvements to front line practice have been prioritised by senior managers but slower progress in the implementation of some strategic plans and reviews of service has meant delays in service improvement in some areas. Progress has been made on the further development of partnership working through the Children and Young People's Partnership Board, the Improvement Board, Walsall Safeguarding Children Board (WSCB) and the Walsall Health and Well-Being Board, with the delivery of plans and objectives which include a robust health and well-being strategy. This ensures, at a strategic level, that all key partners are working more effectively to develop and strengthen child protection arrangements across Walsall. There is an improved level of councillor involvement with an active lead member and a challenging scrutiny panel, with councillor visits to front line services enhancing political awareness of service issues. Members of the scrutiny panel are committed to their role and have taken action to improve their understanding of current issues through recent training on missing children and child sexual exploitation provided by another local authority with detailed experience of these issues.

56. Whilst there are a range of early help services available, the current early help strategy and offer is being reviewed and a new shared local strategy is not yet in place. The Improvement Board has identified significant gaps in joint service planning and delivery in relation to early help within the local authority and a current inability to evidence impact and therefore outcomes of services provided. Common assessment framework and the child concern model have recently been re-designated as early help. As a result there is evidence that other agencies are more willing to take a lead role and seek advice and guidance at an early point. But further work is required to ensure that children who may be in need are considered at the earliest possible point and that 'step down' processes are effective and robust. The council have identified and prioritised the need for an early help strategy and work has already begun to address this.

57. Performance management and evaluation is established within children's services but is challenged by the quality of data available. The envisaged tiered hierarchy of performance data remains under developed, with only higher tier strategic information fully available. The authority has approved

a new quality assurance and performance framework that has yet to be implemented. There are, however, quality assurance processes at team level, with managers auditing casework on a regular basis and ensuring that key areas of casework performance are reviewed. The quality of auditing by managers is variable with many good examples but there is inconsistency in the overall evaluation of quality between managers, potentially leading to mixed messages for front-line staff. Progress has been made in improving front-line practice, with improved recording, ensuring that statutory visiting is being undertaken and in the overall quality of response to referrals. There are a range of quality assurance initiatives involving child protection chairs in conference evaluation and decision making but these are too new to be able to demonstrate impact. Staff members have stated that they feel more motivated and that senior management have been able to provide a sense of direction in relation to practice expectations and the quality of support for staff.

58. Significant concerns are attributed to the electronic children's recording system which is seen as cumbersome and no longer fit for purpose. Management reported that some team leaders choose to keep manual records relating to performance data as the integrity of the information provided is questionable. There are often delays in ensuring that records are up to date as the system does not support planning and assessment work, requiring documents to be uploaded on to the system. At all levels, it is difficult to track, monitor and review cases and consequently, the electronic children's recording system does not adequately reflect the child's journey. Further, given the high caseloads for staff and the reliance upon agency staff, the system hinders timely and effective social work practice. Managers have a clear grasp of the limitations of the current system and are actively engaged in developing both short term fixes and a long term solution.

59. There is some evidence that the voice of the child is heard, with improved recording of children's wishes and feelings, use of the safeguarding children's team young inspectors in recruitment activity, in aspects of the tendering process in commissioning and scrutiny of policy.

60. There is little evidence of a strategic approach to workforce planning. The current workforce strategy lacks targets and outcomes. However, the building blocks of an effective strategy are present, including good support for newly qualified social workers, early professional development for social workers, opportunities to undertake post graduate learning, the beginnings of a career progression policy, evidence of successful recruitment of staff, a new supervision policy and a work load weighting system. Actual staffing vacancies are low but there is significant use of and dependency on agency staff and this is a cause of concern. There are no targets to reduce numbers of agency staff over time and there is no indication that this issue is being addressed strategically, making this is an area of considerable vulnerability. Both the Director of Children's Services and Assistant Director

Specialist Services are interim appointments. Careful consideration needs to be given to an appropriate replacement strategy for these key posts to ensure sustainability and maintenance of progress.

61. There is some evidence of continuous learning and a commitment demonstrated through the WSCB. The independent chair has recently agreed that the Board should commission a serious case review following a significant injury to a child. There is little evidence of learning from complaints and little sense that there is a coherent overview of complaints or key issues arising. A review of the complaints process has been undertaken and actions arising from recommendations have been identified.

62. The authority lacks a developed children's services commissioning structure but has made a recent investment of £250k and appointed a commissioning manager to develop processes. Although there has been work completed to ensure that data from the joint strategic needs assessment informs processes and links with plans such as the Health and Well-Being Strategy, lack of robust commissioning processes and evaluation of the impact of services mean that the local authority cannot evidence that services are being effectively tailored to meet the needs of children and families.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate