Walsall Metropolitan Borough Council

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

and

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

Inspection date: 20 June to 13 July 2017

Report published: 4 September 2017

Children's services in Walsall requires improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

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

Executive summary

Services for children in Walsall are not yet good overall. Senior leaders have worked intensely to improve the quality of children's social care services and to ensure that children receive the help and protection that they need. The director of children's services (DCS) and the senior management team provide visible leadership; they are keenly focused on improving children's services and the lives of vulnerable children and families in Walsall. The local authority understands well its strengths and areas for development. There are a number of wide-ranging initiatives, such as the caseload promise, a comprehensive training and development offer and a clear practice framework based on restorative practice. Progressively, this commitment is strengthening practice and the quality of services. However, the necessary improvements are not yet in place across all services and, as a result, some key areas still require improvement to be good.

The local authority recognises the improvements that need to be made. Significant corporate investment and increasing momentum are enhancing the workforce and improving service quality through the 'practice uplift' initiative. Restructuring to smaller social work teams with lower supervision ratios, along with manageable caseloads, is improving services for some children. Social workers, including newly qualified social workers, are increasingly well trained and supported.

Embedding and sustaining positive change is undermined by the high turnover rate of frontline social workers and first-line managers. This constant change, across many service areas, continues to challenge the delivery of the local authority's ambitious improvement plan. Performance information available to frontline managers has yet to become effective in some parts of the service. Without this level of assurance at the front line of services, the local authority cannot be certain that it has an accurate overview of every child's circumstances.

Good-quality staff supervision is not yet established across all teams. Inspectors saw some case supervision records which critically evaluate progress by challenging and providing detailed and purposeful actions. In many cases, management oversight is too brief and the rationale for decision-making is not always evident on children's files. This means that it is not always possible to track key events and identify evidence for decisions made. As a result, there is drift and delay in taking action when risks increase or progress is limited or not sustained. This is more evident where social workers have experienced a constant churn of team managers and have high caseloads. In the past six months, supervision has been of a better quality.

Multidisciplinary teams across the borough deliver intensive early help services successfully, providing support to a wide range of needs. Early help is making a positive difference to children's lives, but is not yet reducing the number of referrals to children's social care. Partners' understanding of the thresholds of need is not sufficiently established across all agencies. Although referrals from professionals are timely, a high proportion of contacts either do not meet the threshold for statutory intervention or are insufficiently detailed for managers to make a decision about the

next steps. Consequently, the local authority is not yet able to be effective in building an accurate enough picture of children's circumstances to make sure that they always receive the right support for their needs. Social workers and managers do not always sufficiently understand the impact of children living in situations of neglect, domestic abuse and parental drug misuse and, in a small number of cases, children have not received the necessary level of support. Work to protect children at risk of, or experiencing sexual exploitation, is not rigorous enough. Risk assessments are evident but vary in quality, and there is limited analysis. As a result, risks of sexual exploitation to some children, including children looked after, are not responded to effectively.

Some children who should be looked after experience delays when the threshold for care has been met. A small number of children who are already looked after experience delays in permanence planning. Friends and family fostering arrangements are not always sufficiently assessed. This can leave children looked after without the right level of support and protection. Service improvements are clearly evident in adoption, where services are good. However, the local authority does not yet routinely support children to live with their adopters at the earliest opportunity through foster to adopt arrangements.

The majority of children are seen alone by their social workers and, in many cases, social workers make the time to see children very regularly. Social work visits routinely include direct work with children, using a range of interactive tools. Social workers work hard to establish positive relationships with children, and for many children, whose wishes and feelings influence their assessments and plans, this is a strength. However, the high turnover of staff can hinder relationships, as some children experience frequent changes of social workers and team managers. Improvements in the role of the independent reviewing officer (IRO) add benefit for the majority of children and assist them to understand their situations. However, not enough children with a plan for permanence benefit from life story work.

Services for care leavers have improved significantly. However, they are not yet good. Pathway plans do not support care leavers to develop important skills for their independence. There have been significant gaps in the health provision for care leavers. As a result, a high number of young people do not have a clear view of their physical and emotional health needs or their health histories.

The scrutiny committee does not sufficiently understand and challenge the quality of services for children effectively. Scrutiny does not challenge officers effectively about the quality of services and the impact of social work practice. The corporate parenting board is not yet evidencing the impact of its focus and challenge. It cannot demonstrate how its work is influencing service delivery and outcomes for children looked after and care leavers. The current arrangements for ensuring the safeguarding of privately fostered children are poor; the local authority is not meeting its statutory duties.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates five children's homes. Three were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's arrangements for the protection of children was published in August 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was published in July 2012. The local authority was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since September 2014.
- The chief executive has been in post since January 2008.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since September 2015.

Children living in this area

- Approximately 66,142 children and young people under the age of 18 years live in Walsall. This is 24% of the total population in the area.
- Approximately 30% of the local authority's children aged under 16 years old are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 20% (the national average is 15%)
  - in secondary schools is 19% (the national average is 13%).
- Children and young people from minority ethnic groups account for 31% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 24% (the national average is 20%)
  - in secondary schools is 18% (the national average is 16%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At 31 March 2017, 2,521 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,662 at 31 March 2016.
- At 31 March 2017, 333 children and young people were the subject of a child protection plan (a rate of 51 per 10,000 children). This is a reduction from 375 children (58 per 10,000 children) at 31 March 2016.
- At 31 March 2017, four children lived in privately arranged fostering placements. This is a reduction from eight at 31 March 2015.
- In the last two years prior to inspection, seven serious incident notifications have been submitted to Ofsted and one serious case review has been completed but not yet published.
- There were no serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2017, 648 children were being looked after by the local authority (a rate of 99 per 10,000 children). This is an increase from 620 (96 per 10,000 children) at 31 March 2016. Of this number,
    - 322 (or 50%) live outside the local authority area
    - 10 live in residential children's homes, of whom 90% live out of the authority area
    - one child is placed in a residential special school which is out of the authority area
    - 482 live with foster families, of whom 48% live out of the authority area
    - 53 live with parents, of whom 28% live out of the authority area
    - eight children are unaccompanied asylum-seeking children.
- in the last 12 months:
    - 31 children have been adopted
    - 25 children became subject of special guardianship orders
    - 183 children ceased to be looked after, of whom 4% subsequently returned to be looked after
    - 11 young people ceased to be looked after and moved on to independent living
    - no young people are living in houses of multiple occupation.

Recommendations

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

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

3. Improve the response to all children at risk of child sexual exploitation, making sure that all assessments, safety plans and interventions are of a consistently good quality.

4. Increase the number of care leavers who are in education, employment and training.

5. Enable care leavers to have access to good physical and emotional health services and ensure that they are able to understand their health histories.

6. Ensure that pathway plans set realistic targets for care leavers to support their progress into a fulfilling life.

7. Ensure that managers and social workers have clear guidance and legal advice when placing children in arrangements with friends and family, to ensure that their needs are fully understood and met.

8. Ensure that managers and social workers correctly apply private fostering regulations so that children who meet the criteria have thorough assessments of their needs and that these include all required safeguarding checks.

9. Take steps to ensure that care plans for all children who have a plan for permanence progress within the child's timescale to avoid children experiencing delays, including the identification and support of children who could be placed in foster to adopt arrangements.

10. Improve the delivery of life story work for children looked after.

11. Improve the functioning of both the scrutiny committee and corporate parenting board to ensure that their work has a positive impact on improving services for children and the outcomes that they achieve.

12. Ensure that frontline managers are supported to use performance information so that they can manage and support good frontline practice effectively.

Summary for children and young people

- Services for children in Walsall require improvement to be good. Sometimes, children do not receive the support they need at the right time.
- Social workers know the children they are working with really well. They understand children's wishes and feelings. Sometimes, social workers take too long to understand what children need to make things better.
- Children only come into care when they really need to. Social workers support children by finding them homes where they can feel safe. For example, children might go to live with their aunts, uncles or grandparents. Whenever possible, brothers and sisters live together.
- Children who need permanent new homes, including children who have plans for adoption, are supported well and most children live with their carers for a long time.
- Not all children are helped to understand their situation through detailed stories and pictures about their lives.
- Senior leaders, elected members and social workers make sure that children and families have a say in the decisions made about them. They listen carefully to what children say. When they can, they do things differently to make things better.
- When children go missing from home, they have the opportunity to talk to someone about what has happened and anything that is worrying them. Information from these conversations is not always used to make sure that children get the help they need.
- Managers make sure that everyone has a good understanding about children being at risk of exploitation and why it is important to work together to keep children safe. More needs to be done to make sure that everyone works well together to support children.
- Most care leavers are happy and safe in their homes. Young people who have left care do not always receive the support they need at the right time. Managers and workers need to offer more help to young people to make sure that they are healthy and attending training or education or have employment.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Early help services and support to children and families in Walsall are well targeted and coordinated effectively. Partners have worked purposefully to improve the quality and effectiveness of early help services. Early help assessments and plans are comprehensive. Effective services lead to improved outcomes for many children and families.

Staff and partner agencies in the multi-agency safeguarding hub (MASH) make prompt and mainly appropriate decisions about the level of intervention required to safeguard children. Nevertheless, information sharing in the MASH is not always good enough. Although referrals from professionals are timely, a high proportion either do not meet the threshold for statutory intervention or are insufficiently detailed for managers to make a decision about the next steps.

Children who have the greatest welfare and safeguarding concerns generally receive a service that meets their needs. Strategy meetings in the MASH are timely and make good decisions. These lead to comprehensive child protection enquiries and, when necessary, child protection conferences. However, situations of unassessed risk, due to an absence of professional curiosity and over-reliance on parental self-reporting, are common features in a small number of children's cases.

Managers and social workers do not consistently apply the private fostering regulations. This means that the local authority cannot be assured that private fostering arrangements for children are appropriate. Furthermore, a very small number of children who are living in private fostering arrangements should be looked after.

The response to children who are at risk of sexual exploitation is not thorough enough. Return home interviews are taking place when children go missing. However, they are not always timely, and the quality needs to improve to ensure that children receive appropriate support.

Caseloads are reducing to levels that are more manageable, but they remain too high in some teams. Social workers visit children regularly; their views are sought and listened to. However, there is not always sufficient understanding of the lived experiences and impact of children living in situations of neglect, domestic abuse and parental drug misuse. A recent restructuring of the safeguarding and family support teams and the introduction of a social work model have enhanced the quality of work undertaken. The quality of practice, although improving, is not yet consistent. Arrangements for protecting children outside of office hours work well. The local authority and partners have responded proactively and effectively to children at risk of radicalisation.

Inspection findings

13. The local authority has improved its early help provision significantly, following a comprehensive review and redesign of services, to ensure that children and families receive the right interventions at the right time. Early help services are fully incorporated into the locality teams. Family support and youth support workers work closely with schools and health professionals. As a result, children and families benefit from a range of well-coordinated services that provide effective targeted interventions, which improve outcomes for many children.

14. The early help hub provides good advice and support for professionals to complete assessments. Multidisciplinary teams across the borough deliver successful intensive early help. During 2016–17, they have supported a significant number of children and families who have a wide range of needs, including those associated with domestic abuse, behavioural issues and parental mental ill health. Early help assessments and plans are mostly of good quality. Decisions to step down from statutory services to early intervention services are largely appropriate. The local authority evaluates the impact of early help through an effective quality assurance process informed by feedback from children and parents. This is making a positive difference to children's lives, but is not yet reducing the number of referrals to children's social care.

15. When children are in need of help and protection, the MASH is the central point of contact for members of the public and professionals. Although prompt, the screening of contacts and referrals by managers is not consistently thorough. Referrals are not always supported by good enough information sharing from partners. Inspectors saw a small number of referrals which had been closed before all relevant information to support effective decision-making on the next steps had been gathered and analysed. Parental consent to share information is appropriately considered and sought.

16. Good arrangements are in place to ensure that children are protected outside of daytime hours. In cases sampled by inspectors, actions taken by out-of-hours staff were promptly communicated to daytime services, ensuring that children received a seamless service.

17. Partners' understanding of the thresholds of need is not sufficiently established across all agencies. During 2016–17, contacts to the MASH increased by 23%. Despite extensive training, many contacts do not meet the threshold for statutory intervention. Too many multi-agency referral forms and police notifications contain insufficient detail. All of these factors place significant pressure on the MASH and result in staff spending unnecessary time screening and chasing information, which blurs effective decision-making. Consequently, some children experience an insufficient response to their needs when they first come to the attention of children's social care. (Recommendation)

18. When child protection concerns arise, the vast majority of children, including those who have disabilities, receive a swift service. Strategy discussions or meetings held in the MASH are timely, with relevant multi-agency attendance, and good decisions are made, reducing risks to children. Child protection enquiries are, in the main, comprehensive and, when necessary, lead to initial child protection conferences.

19. Inspectors identified a small number of children receiving statutory intervention where drift and delay was evident. These children experienced delays in the local authority taking decisive child protection action through the use of pre-proceedings under the Public Law Outline (PLO). These deficits in practice concur with the findings of the local authority's review, in May 2017, of 258 children in need who were open to the safeguarding and family support teams. Senior leaders accepted inspectors' concerns and took immediate action to strengthen intervention, to make sure that these children received the right level of help to meet their needs.

20. Social workers see children regularly and alone when appropriate. Child-centred direct work is effective. Inspectors saw some good examples of sensitive engagement with disabled children that is ensuring that their voice, opinions and feelings are heard. Social workers make strong efforts to build trusting relationships with children, but the high turnover of staff makes this difficult, as children experience frequent changes of social workers and managers.

21. Inspectors saw some good examples of assessments, including pre-birth assessments, with sound analysis of risk. Overall, assessments are timely and completed in accordance with the needs of children, but the quality is not consistently good. Many children have assessments that capture their voice and history. However, they are not yet effective in gaining an accurate enough picture of children's circumstances, so that children receive the right support for their needs. Weaknesses include an insufficient consideration of the impact of culture, of equality and diversity. Assessments often lack the views of absent fathers and other significant adults. Very few assessments are informed by research. (Recommendation)

22. A high proportion of assessments (60%) lead to no further action by children's social care. Audit work has concluded that the thresholds to progress to assessments are appropriate. This is in line with what inspectors found in individual children's cases sampled. Inspectors found that assessments that conclude with no further action are linked to the insufficient detail found in referrals from partner agencies.

23. The vast majority of partner agencies' attendance at child protection and core group meetings is good. Police attendance at initial child protection conferences is particularly low (44%), although the police do provide written reports. Child protection chairs use the local authority's recently implemented model of social work. This is helping children and family members to engage better with professionals, to understand the seriousness of concerns and to

contribute to their own plans. However, few children attend their conferences. Advocacy is not provided to children effectively to give them the time and space to talk to someone about their situation, independent of their social worker and outside of their family. Last year, only a very small number of children benefited from advocacy support.

24. Overall, the quality of child protection and child in need plans requires strengthening so that they are child-centred and have realistic and measurable outcomes. Due to delays in the completion of child protection conference and core group minutes, some parents do not receive a timely record of what they need to do. In the event of circumstances changing, contingency planning is generic, with statements of seeking legal advice, rather than being specific about exactly what the outcome might be if a plan is not successful.

25. Neglect is a major factor for children in Walsall, and 70% of children are subject to a child protection plan under this category. Social workers are not yet intervening effectively at an early enough stage. Consequently, some children are not getting the vital support and protection they need. Senior leaders have recently taken action and are training staff to equip them with the right tools to identify and respond effectively to neglect. Despite the prevalence, the local authority and the LSCB have been slow to take decisive action, and the draft neglect strategy is yet to be approved.

26. The quality of management oversight and supervision is not yet consistently good. As a result, there is sometimes drift and delay in taking action when risks increase or progress is limited or not sustained. This is more evident when social workers have experienced a constant churn of team managers and have high caseloads. The local authority's own audits have identified this shortfall in practice. In the past six months, supervision has been of a better quality. (Recommendation)

27. Managers' and social workers' understanding of private fostering regulations is inconsistent. In the cases of three of the four children deemed to be living in private fostering arrangements, the local authority had been explicit in making the arrangement. Therefore, the local authority should have made a decision to look after these children. Notifications from partner agencies are low. Safeguarding checks of identified carers are not always completed and the quality of assessments and planning for children is weak and not compliant with statutory guidance. (Recommendation)

28. Children living in families where domestic abuse is a feature are appropriately referred to multi-agency risk assessment conferences (MARACs). Partner agencies, including a senior practitioner from children's social care, regularly attend MARACs to share information and consider risk. Specialist services, such as perpetrator programmes and drug and alcohol programmes, help parents to keep their children safe from harm. Inspectors who sampled children's cases where domestic abuse was a significant factor found that some actions agreed at MARAC had not been followed up, resulting in a less-than-good service for some children.

29. Work to protect children at risk of or experiencing sexual exploitation is not rigorous enough. Risk assessments are evident but vary in quality, with limited analysis or safety planning. An independent reviewing officer (IRO) has been appointed to chair all multi-agency sexual exploitation (MASE) meetings, and this is beginning to improve the quality of information sharing and action planning. However, decisions are not always translated into written safety plans. Consequently, risks to some children continue to increase. (Recommendation)

30. When children return home having gone missing, a commissioned service undertakes return home interviews to gain information about their reasons for going missing. The timeliness and quality of return interviews is variable, with only 53% of interviews completed within 72 hours (January–March 2017). Inspectors sampled a number of interview records and found that some important information had not been explored sufficiently, so that subsequent plans to reduce risks could be more effective. There are significant delays in administrators uploading return home interviews onto the electronic social care record. In some cases, these delays can be up to three months. This means that information from interviews is not always readily available to social workers and the emergency duty team. This limits subsequent planning and risk management. Senior leaders have already taken action to remedy this, but it is too early to demonstrate impact.

31. Good arrangements are in place to monitor children who are electively home educated and those who go missing from education. The designated teacher is in contact with all of the families of children who are electively home educated and carries out regular and comprehensive reviews to track each child's progress. A new Fair Access panel ensures that school placements are found quickly and children experience smooth transitions. Children in alternative provision are monitored effectively to ensure that they receive a good education.

32. Walsall is a tier 2 'Prevent' duty priority area and has a full-time 'Prevent' duty coordinator. The local authority and partners respond well to children at risk of radicalisation. A 'Prevent' duty action plan is in place, and a senior officer in the local authority oversees and chairs the 'Channel' panel, which is well attended by partner agencies. Awareness of, and the response to children at risk of radicalisation are well established and effective. Inspectors saw good examples of assessments and developing plans to respond to identified risks. The local authority and partners respond appropriately to trafficked children. This includes the appropriate use of the national referral mechanism to notify the national crime agency of children at risk of trafficking.

33. Multi-agency awareness raising of the risk of female genital mutilation has taken place. Increased knowledge has led to seven referrals since February 2017. However, assessments are not yet rigorous enough, and there is an over-reliance on parents' self-reporting rather than more in-depth assessments of risk, such as the likelihood of parents returning to home countries.

34. Good arrangements are in place for young people aged 16 to 17 years who become homeless. Assessments take place swiftly and, if young people are unable to return home, lead to appropriate accommodation, including host family arrangements. When necessary, homeless young people become looked after by the local authority.

35. The designated officer manages and responds effectively to allegations regarding adults in a position of trust. The role of the designated officer is understood by referring agencies and thresholds for referrals are well applied. The designated officer coordinates investigations efficiently to make sure that children are protected.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

The vast majority of children looked after live in good-quality foster homes. Efforts to support children to remain with their birth families are not always successful, as the local authority does not have an accurate overview of the effectiveness of the edge of care service. Consequently, a small number of children remain on the edge of care for too long, delaying their opportunities to secure timely permanence.

Some children experience delays in becoming looked after when the threshold for care has been met. As a result, a small number of children remain living with their birth families when they should be looked after by the local authority.

The local authority continues to work hard to ensure that children looked after achieve permanence. Children who have a plan for adoption are swiftly identified, matched and placed with their adoptive families. More children could benefit through foster to adopt arrangements. Brothers and sisters live together successfully in long-term homes.

There are continuing efforts to support foster carers to seek alternative orders, resulting in a number of children leaving care appropriately. The local authority needs to assure itself that all children, including children at risk of, or subject to sexual exploitation, who should be looked after, are identified swiftly to reduce drift and delay.

Children looked after are seen regularly and they are seen alone by their social workers. Some children experience too many changes in social workers. These changes do not provide children with the stability that they need to understand their circumstances. Care plans are updated at children looked after reviews. However, they are rarely informed by assessments. As a result, social workers and carers cannot always be assured that children's needs are fully understood and met. Many children know their IROs well, and this provides valuable continuity. Children do not always fully understand why they are looked after, as life story work is not routinely completed.

Personal education plans are not consistently challenging, specific and understood by children and their carers. These plans are not supporting all children to improve their educational outcomes.

Pathway plans do not support care leavers in developing important skills for their independence, training or employment. A high number of young people do not have a clear view of their emotional and physical health needs or their health histories.

Inspection findings

36. Some children experience delays in becoming looked after when the threshold for care has been met. As a result, a small number of children remain living with their birth families when they should be looked after by the local authority. Additionally, a small number of children who are already looked after experience drift in permanence planning due to delays in initiating care proceedings. The recent addition of the permanence coordinator role is now providing the local authority with an improved oversight of children who are subject to pre-proceedings. However, a small number of children continue to experience drift and delay, including children at risk of, or subject to, child sexual exploitation. (Recommendation)

37. The edge of care service provides good support to a small number of children, enabling them to remain with their birth families. Supported by the edge of care service, safe and sustainable arrangements are in place for children who return home, including those for whom care orders are discharged. This positive work has resulted in the number of children who return to care reducing from 9% to 4% in the last year. However, the number of children coming into care continues to rise, and the local authority does not yet have an accurate overview of the overall effectiveness of the edge of care service. Consequently, the local authority cannot assure itself that all children are benefiting as they should. Senior leaders have recognised the need for improvements, and a new model for edge of care services is being developed.

38. Legal advice and support are available to practitioners. However, some social workers and their managers are unsure of the local authority's family and friends policy. This means that a small number of children live in arrangements that are insufficiently assessed and the necessary safeguarding checks are not completed. As a result, family and friends carers do not always have the right level of assessment and support when children first become looked after. This leaves some children who are unable to live with their parents without the right level of protection through a formal arrangement. (Recommendation)

39. Senior leaders have established a strong culture of early permanence and parallel planning with family and friends carers. Many are supported to apply for alternative court orders, such as special guardianship orders. Outcomes for children are good, and there are a very low number of disruptions. The local authority positively supports children who become subject to special guardianship, by securing their financial leaving care entitlements, thus providing additional support as they enter adulthood.

40. Care proceedings are, on average, completed within the 26-week timeframe. For children who have plans for adoption, timescales are often as short as 14 weeks, supporting timely adoption planning. The local authority has positive relationships with the judiciary and the Child and Family Court Advisory and Support Service (Cafcass). Care proceedings work is of good quality. Parenting assessments and viability assessments are of sufficient quality to assist with

decision-making. However, for a small number of children, social work evidence does not secure the support of the court, and this results in unnecessary delay or changes in care plans.

41. The number of children looked after under section 20 of the Children Act 1989 (voluntary agreements with parents), is significantly lower than the national average. Despite this positive position, the local authority has reviewed the appropriateness of all section 20 arrangements. This review has resulted in care orders being sought for a small number of children. Seven per cent of children subject to care orders live with their parents. A strategic drive to discharge these care orders safely is under way, and there is evidence of good outcomes.

42. The permanence panel is responsible for tracking the progress for children still waiting for permanence. For some children, permanence is achieved by default and not as a result of care planning driven by children looked after reviews and the permanence panel. For other children, who are living in their permanent homes, there has been significant drift to secure formal approval from the permanence panel. The local authority acknowledges that more children will benefit from living in permanent care arrangements. Plans are under way to formally match a number of children to their foster carers. This means that a greater number of children now have the opportunity to achieve psychological permanence.

43. The majority of children are seen alone by their social workers and, in many cases, more often than statutory requirements. Social work visits routinely include direct work with children. Social workers use a range of interactive tools. Well-written later life letters are provided for some children in long-term foster care. However, not enough children with a plan other than adoption benefit from life story work, despite training for social workers being completed. (Recommendation)

44. When children looked after are at risk of child sexual exploitation, the response to risk is not always effective. For a very small minority of children in care, arrangements to reduce the risks of sexual exploitation are not robust enough. In a small number of examples raised with the local authority during the inspection, children had suffered significant harm. Children who are placed in secure accommodation respond well to the care they receive, and risks of harm are reduced. Very few children looked after come to the attention of the police and youth offending services.

45. When children go missing from care, return home interviews do not always sufficiently consider risks. For example, when experimentation with drugs is recorded, there is a lack of follow-up, in order to respond to, and thus seek to, reduce the risk. The completion and impact of return home interviews for children looked after are not sufficiently tracked by the local authority. Consequently, risk factors are not fully understood.

46. Children who have specialist needs benefit from a wide range of support, which includes interventions to tackle gang affiliation. The implementation of the fostering, looked-after and adoption supporting hub (FLASH) is a strength. While it is too early to identify any direct impact for children, inspectors saw evidence of effective work with foster carers and adopters to support placement stability. However, not all foster carers are aware of the service. Access to other emotional health services can be delayed, and there is a typical wait of eight weeks for an initial appointment following assessment. This means that children are waiting too long to have their emotional health and well-being needs assessed and met.

47. Appropriate arrangements are established to offer initial and review health assessments. Improvements in timely completion of health assessments have been sustained. Support for emotional health and well-being are not always available. While strength and difficulties questionnaires are now completed for most children, inspectors saw limited evidence that they are used to inform children's care and health reviews.

48. Care plans do not always reflect the current arrangements for the child, and children are not always clear about what their care plans mean. Contingency plans lack detail. Care plans completed in the corporate parenting service are stronger and they are routinely updated for looked after reviews. However, assessments are not routinely completed for children looked after to fully understand children's changing needs. As a result, care plans are not fully reflective of the current situation.

49. The vast majority of children live in settled homes with foster carers who are well supported and well trained. Most children live within a 20-mile radius of their family home. Social workers consider carefully diversity issues, including children's culture, beliefs and backgrounds, to promote positive matches to their foster carers. Children placed outside of the council area have access to advocacy services but are not always able to access local mental health services in a timely way.

50. Brothers and sisters live together routinely and are only placed apart when this in their best interests. Family contact plans are carefully thought out, and contact is a positive experience for children, who benefit greatly.

51. Most children experience stability with their foster carers. A very small number of children have a number of unplanned moves. As a result, these children do not have the opportunity to build stable and enduring relationships with their carers. Decisions to move children are not routinely informed by assessments. Consequently, the local authority cannot always evidence whether placement moves are in the child's best interest.

52. Foster carer recruitment is a key priority for the local authority. A dedicated recruitment manager is working hard to increase the availability of carers, particularly for brothers and sisters, for older children and for children who have complex needs. Foster carers receive good support and they have access

to a wide range of training. The local fostering association is very active and contributes effectively to the development of the fostering service.

53. The virtual school knows its children well. The head of the virtual school knows the current progress and achievements of each child looked after. The pupil premium is used effectively. Teachers have funded after-school clubs, one-to-one support and resources for use at home to help with reading.

54. The quality of personal education plans needs to improve to be more consistent. Social workers, schoolteachers and the virtual school do not always ensure that all targets in these plans are challenging, specific and understood by the child and their carers.

55. The vast majority of children looked after attend schools judged to be good or better. Decisions about moving a child whose school is judged to be less than good are made on an individual basis with the child and carers involved.

56. School attendance for children looked after is good. Educational attainment at key stage 1 has improved significantly during the last year and is better than that of other children looked after in England. Children at key stage 2 do not perform as well. The provisional results for this year show an improvement. Educational attainment for children at key stage 4 needs to improve, as children on average achieve one grade lower than expected.

57. Children are encouraged to access a wide range of leisure activities and they are supported to maintain positive links with their friendship groups. No children have changed school as a result of becoming looked after during the last 12 months.

58. Children are given information about their rights and entitlements when they become looked after, including how to make a complaint. Young people have access to advocacy through a commissioned arrangement. Forty-four children looked after and care leavers have accessed advocacy in the last year. This has supported children to influence important decisions about their lives.

59. The vast majority of children participate in their looked-after reviews or have their views represented. IROs maintain positive relationships with a small number of children who have experienced a number of changes of social worker, helping them to maintain their progress. Inspectors saw many examples of robust challenge by IROs. However, for a small number of children, despite challenge, there continues to be drift and delay in the progress of their care plans. (Recommendation)

60. Children looked after regularly meet with elected members and senior leaders. The chair of the corporate parenting board is ambitious for children looked after and care leavers. There are a number of initiatives in place to champion children looked after and care leavers. However, the corporate parenting board has yet to demonstrate the effective challenge of partners to improve outcomes for all children looked after and care leavers.

The graded judgement for adoption performance is that it is good

61. Securing permanence through adoption for children in Walsall is a key priority for the local authority. Resources have been strengthened to support this priority by the new post of a permanence coordinator, and an additional family finder based in the adoption service. Improved systems and processes identify children for whom adoption might be the plan sooner; these include the effective use of early alerts raised by IROs during initial children looked after reviews. Additionally, the permanence coordinator attends the PLO panels to ensure swift identification of potential adoption plans. As a result, the adoption service has a strong oversight of children who may benefit from permanence through adoption. Consequently, they are able to plan at an early stage for children, prior to their placement order being granted.

62. The adoption managers have a good knowledge of their service. They understand service strengths, priorities and the areas for improvement. Managers acknowledge that permanence planning was previously not managed with the urgency and pace required. To remedy this, the permanence panel was introduced in January 2016. The panel has been effective and has increased the pace of children matched to their adopters.

63. Social work practice in the adoption service is good. Direct work with children is child-centred, focuses on meeting needs and is undertaken at the child's pace. Matching considers the child's needs, age and understanding. This is supported by a stable and knowledgeable adoption workforce, which works hard to secure adoptive homes. Inspectors saw evidence of tenacious practice for harder-to-place children and a clear senior leadership direction that recognises that 'doing the right thing' for children is a priority for the service.

64. Although timeliness in achieving adoption is above the government threshold, it is an improving picture. The local authority has a strong commitment to realising adoption plans. This can take longer to achieve for some children. The local authority knows the reasons for these delays, and every child is tracked closely to make sure that they do not wait longer than is necessary to be adopted. The service has set an ambitious target of 53 adoptions for 2017–18 and is on track to achieve this.

65. During 2015–16, 60 children had a plan for adoption. This is a significant increase from 25 children in 2014–15. Of these, the majority were matched and placed within six months of their adoption decision. All 60 children have achieved adoption, and only two children waited for longer than 12 months. This good performance demonstrates the persistence and tenacity of the local authority to identify prospective adopters. A small number of children and adopters are waiting for adoption. Inspectors sampled some of these cases and confirmed that these children were not waiting unnecessarily, and that

the local authority is giving careful consideration to matching, ensuring effective outcomes.

66. Children are placed successfully with their brothers and sisters where it is in their best interests. The local authority offers a strong response to children who have additional or complex needs. Despite this, a very small number of disabled children have a plan of adoption. The local authority has interrogated the reasons for this and has satisfied itself that all children, where appropriate, are considered for adoption.

67. The process and systems for family finding are clear and effective. As soon as family finding staff are made aware of a plan for adoption, the child's social worker and the family finder meet to discuss the plan. Monthly family finding meetings make sure that adoption social workers are provided with up-to-date profiles of children and adopters. The local authority has systematically considered prospective adopters for the majority of these children, including those who have not yet completed care proceedings. The Black Country consortium and the national register are used for those children who cannot be suitably matched to Walsall adopters. Adopters are referred to the adoption register within timescales.

68. The adoption service has targeted the recruitment of adopters specifically to increase adopters for brothers and sisters, older children and children who have complex needs. The local authority is becoming increasingly successful in recruiting a range of adopters who reflect the diversity of the local community. Black and minority ethnic adopters account for 13% of adopters recruited in 2015–16, providing increased opportunities for matching.

69. Children's profiles are very well prepared and are used to support the identification of adopters, providing the best opportunity for matching children to the right adopters. Regular activity days successfully provide the adoption services with the opportunity to match children to prospective adopters who may not have been considered.

70. The local authority does not yet routinely support children to live with their adopters at the earliest opportunity through foster to adopt arrangements. The local authority knows that this is an area of development and acknowledges that the option of foster to adopt should be explored in greater detail with adopters during their assessment. (Recommendation)

71. Good-quality direct work prepares children well for adoption. This work is sensitive and thoughtful. Inspectors saw good examples of children being prepared for placement, including a child who had experienced previous unsuccessful introductions to adopters. Children who are placed for adoption have every opportunity to understand their family history and identity through timely and carefully considered life story work.

72. Children who are adopted experience family stability. In the last three years, there has been only one adoption disruption. This demonstrates that matching is robust and children's needs are very carefully considered.

73. Adopters told inspectors that, overall, they have, and continue to have, positive help from the adoption service, including 'excellent' guidance from the adoption support service. They described 'timely, respectful, insightful' recruitment, training and assessment, swift matching and placing of children, and effective move-on arrangements from foster carers.

74. The adoption panel is chaired well. Appropriate processes are in place to consider recommendations for approval and matching. The panel membership includes people from diverse sections of the community in terms of gender, age and ethnicity, as well as adopters, adoptees and an elected member. As part of its quality assurance remit, the panel closely scrutinises adopter assessments and matching documents. From this scrutiny, the panel has identified that the quality of child permanence reports needs to improve. In response, the local authority has held child permanence training for social workers, which has improved the quality of many child permanence reports. Agency decisions are appropriate and timely.

75. Adoptive families are informed about their adoption entitlements and they are offered an annual post-adoption review. The recommendations leading from adoption support assessments are clear. A good range of support, including therapeutic support, group work for teenagers and adoptive fathers, and therapeutic life story work is available. Good use is made of the adoption support fund. There is a wide range of timely services available to support adoptive families, including the FLASH service both pre-placement and post-adoption.

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

76. The vast majority of care leavers feel safe in their homes. When young people state that they do not feel safe, the local authority takes action to ensure their safety and well-being. Personal advisers provide good support to the small number of care leavers who are in prison and help them to prepare for their release. Managers and personal advisers are aware of children looked after who may be at risk of child sexual exploitation. The local authority has commissioned a service that offers a weekly drop-in service for care leavers to discuss and tackle drug and alcohol concerns. Personal advisers support care leavers who are pregnant through teenage parents' services and referrals to early help services.

77. Personal advisers, social workers and young people do not use pathway planning effectively to support care leavers to develop important skills for their independence, training or employment. Some personal advisers do not set challenging enough targets for care leavers, and this causes them to make slow progress. For example, an adviser will highlight a need for a young person to improve their budgeting skills but does not set out clear actions as to how this can be achieved. The local authority is aware that pathway plans are not popular with young people and it is looking at alternatives that are more appropriate. (Recommendation)

78. The health provision for care leavers needs to improve. Most care leavers have a doctor, dentist and optician, but not all do. Significant gaps in the health provision for care leavers last year, due to the health adviser not being available, have resulted in a large number of young people who do not have a clear view of their health needs and their health histories.

79. The children looked after nurse is also working with 13 care leavers in addition to her own duties. The local authority knows that more care leavers require health guidance and support. There are plans to open a drop-in service for care leavers soon.

80. The local authority, in conjunction with the Healthcare Trust, has recently launched a health booklet to document care leavers' health histories. However, only a few young people have these and, therefore, many do not have a clear understanding of their health histories. Personal advisers support young people well to obtain their passports, birth certificates and other important documents. Young people cannot easily access mental health services. Managers recognise a need for a more coordinated approach, especially for care leavers who are 17 years old and over and who cannot routinely access emotional health and well-being services. (Recommendation)

81. Young people have good relationships with their personal advisers, although they have a varied experience when trying to contact them. Inspectors highlighted this shortfall during the inspection. The local authority took immediate action to ensure that all care leavers had the contact details of their personal advisers. In addition, the telephone system in the care leavers' hub has been improved to ensure that care leavers receive a timely response when they need support.

82. Care leavers are engaged in shaping the service through the New Belongings group and other forums. Young people are proud of the care leavers' service; they are pleased that it is now in a new building and have plans for its renovation. Managers and personal advisers listen and discuss ideas with their young people, and these are resulting in positive service developments for care leavers.

83. Personal advisers support young people to gain independence with varying degrees of success. The local authority has plans to widen the skills and

knowledge base of all personal advisers, so that all young people receive a consistent and holistic leaving care offer.

84. Too many care leavers are not in education, employment or training. This is recognised by managers as an area for improvement. Impact workers have been employed recently to support young people to make sure that they understand the importance of being in education, employment or training. A not in education, employment or training (NEET) action group meets monthly to discuss each young person, to ensure that plans are in place and personal advisers, through providing information, advice and guidance, are supporting the young people effectively. (Recommendation)

85. The local authority has provided work experience placements within the council for 20 care leavers this year. This is a good example of the corporate commitment to care leavers. Additionally, the local authority has one apprentice, and two care leavers are in the process of securing full-time employment with the council. A number of local authority full-time staff are care leavers. Managers are working hard to increase the number of work experience and apprenticeship places for these young people in the local area, as these are extremely low. The local authority successfully ran the annual 'take-over' day in 2016, providing care leavers with further opportunities to experience the workplace.

86. Seven young people are at university and 10 more are hoping to start in September. Care leavers at university receive good support. Thirty-one young people are in further education; but more young people need to be encouraged into education, training and employment to prepare them for their futures.

87. The vast majority of care leavers live in suitable accommodation, providing them with safe and stable homes. The care leavers' service does not use houses of multiple occupancy or bed and breakfast accommodation. Managers and personal advisers have recruited host families from a variety of diverse backgrounds. Personal advisers use these families effectively to ensure that care leavers have good access to an appropriate and supportive home environment. Twenty-one young people are living with their foster carers in 'staying put' arrangements, and a large majority of young people are successfully living independently.

88. Personal advisers support young people effectively when their tenancies are at risk. No care leaver has had a tenancy breakdown or eviction this year; this is good practice.

89. Care leavers know about their entitlements. Personal advisers give each care leaver a booklet, which details their entitlements. They also spend time with them to help them to access the support they require. Young people who met with inspectors gave examples of support, such as birthday money, starting-up grants, staying-put grants and support financially when going to university.

90. With support from personal advisers, care leavers organise an annual celebration event. This year, it will take place at a venue chosen by children looked after and care leavers. Personal advisers, managers and elected members join together to celebrate young people's successes in academic achievements, overcoming personal obstacles, such as taking medication regularly, and sporting achievements. Children looked after and care leavers value this event, and are very complimentary about the support they receive for this.

91. The care leaver service has gone through significant change in the last three months. Both of the leaving care managers know their service extremely well and are working to a clear action plan for improvement. However, many of these plans are new and are not yet fully established within the service. Consequently, good services and support are not yet in place for all care leavers.

Leadership, management and governance	Requires improvement

Summary

Senior leaders and elected members have committed time, energy and investment to improve the lives of vulnerable children and families. The DCS and the senior management team's leadership are influencing positive services and improving outcomes for many children. Ambitious investment in the workforce and a clear action plan of improvement are positively influencing the quality of decisions and provision of help to children and young people in some parts of the service.

However, there are some key areas where there is insufficient evidence of sustained and positive change. These include the application of thresholds at every stage of the child's journey, the understanding and use of the private fostering regulations, the response to child sexual exploitation and the support to care leavers who are not in education, training or employment. Although caseloads have reduced overall, caseloads are still too high in some parts of the service. Good-quality staff supervision is not yet consistently practised across all teams.

The local authority engages well with the Health and Wellbeing Board. This has helped to ensure a strong focus on vulnerable children in the overarching Walsall plan. Consequently, strategies such as the Walsall Children and Young People's Mental Health and Wellbeing Strategy Transformation Action Plan for 2016–2021 and domestic violence services have been developed. The placement sufficiency strategy is regularly updated to ensure sufficient resources to meet children's needs.

A pragmatic and concerted approach to reviewing services systematically is resulting in positive changes. However, challenges in the turnover of social workers and first-line managers continue to impact negatively on the continuity of services to children. The local authority has a good understanding of this and has comprehensive arrangements to improve the stability of its workforce. A recent restructuring of the safeguarding and family support teams, and the introduction of a social work model of managing risk, have enhanced the quality of work undertaken. Plans are in place to establish the model of social work practice across all social work services. The social work and early help academy is a notable strength to develop social workers.

Despite having access to reports and data, elected members do not have a strong enough understanding of service quality and the impact for children. The corporate parenting board has been relaunched, but does not yet have sufficient overview. Arrangements for enabling children to have an influential voice in service development and improvement need to be strengthened.

Inspection findings

92. Senior leaders and elected members provide visible leadership, which is focused on improving children's services and the lives of vulnerable children and families in Walsall. Good communication, supported by detailed operational and strategic plans, feeds into the overarching strategic Walsall plan. This plan is well coordinated, bringing together the activity of seven boards. Together, supported by an annual partnership event, boards ensure a well-resourced and ambitious focus on service improvement.

93. Improvements are clearly evident in adoption, where services are good. Other service areas are improving. These include early help, the MASH, assessment timeliness, children being seen and their views being understood, and reviews of children looked after. Increasing momentum is enhancing the workforce and improving service quality through the children's services 'practice uplift' initiative. Restructuring to smaller teams with lower supervision ratios, along with manageable caseloads, is starting to support improved social work practice. Leaders, including elected members, are fully engaged and well informed, sharing a strong and committed focus on prioritising services to improve the lives of vulnerable children and families.

94. However, there are key areas that have not yet achieved sufficient impact on service quality. These include the application of thresholds, private fostering, the response to child sexual exploitation and the support to care leavers who are not in education, training or employment.

95. Management oversight through supervision has improved, especially over the past six months. Inspectors saw some case supervision which critically evaluated progress; it was challenging and detailed, with purposeful actions. However, in many cases, management oversight is too brief and the rationale for decision-making is not always evident on children's files. This means that it is not always possible to track key events and identify evidence for decisions made. Good-quality staff supervision is not yet consistently practised across all teams. (Recommendation)

96. The local authority has made effective use of detailed information about its local communities, including children looked after, care leavers and those in need of help, care and protection. The DCS is well engaged with the Health and Wellbeing Board, which has prioritised vulnerable children and families, resulting in increased resources. Membership and governance changes have ensured senior membership across statutory agencies as well as the voluntary sector, resulting in commissioning plans aligning with other agency plans.

97. The joint strategic needs assessment (JSNA) includes detailed assessments that are used to inform commissioning plans and priorities. For example, the range of services has increased for those experiencing domestic violence, and the children's and adolescents' mental health transformation strategy has been established. Service reviews are up to date and subject to regular annual review. The placement sufficiency strategy is updated annually. Gaps in

service are clearly identified, resulting in plans to address them, such as the recruitment of more local foster carers.

98. The partnership and services are not yet delivering an effective enough operational response to child sexual exploitation. Progress has not been sufficient, following the July 2016 Local Government Association (LGA) child sexual exploitation peer review. Inspectors saw a small number of children, including children looked after, for whom risks have escalated. There is not yet an effective visible operational lead ensuring outcomes or good practice regarding child sexual exploitation. (Recommendation)

99. The scrutiny committee, while challenging of process and compliance, does not sufficiently understand and challenge the quality of services for children effectively. For example, scrutiny of early help focuses on service provision rather than quality and outcomes for children. (Recommendation)

100. The local authority recognises that the corporate parenting board, while functioning, has not yet achieved its priorities. Membership is representative of the wider partnership. Of particular note, a young person is vice-chair of the board. Although young people are represented, their number has been low and the local authority recognises the need to improve young people's participation. The board is not yet evidencing the impact of its focus and challenge and cannot demonstrate how its work is influencing service delivery and outcomes for children. (Recommendation)

101. Senior leaders have developed comprehensive monitoring of performance and service quality. They know where performance is meeting its standards and where it needs to be developed. For example, the DCS recognised the need to improve supervision and management oversight. Compliance has now improved substantially. A monthly performance board systematically considers data. Key themes arising from performance data are cascaded via regular engagement with staff, using a range of communication. A triangulated approach, which includes a comprehensive audit programme, a practice improvement forum, learning from complaints and compliments, celebration events and walking the floor by senior leaders, ensures an effective understanding of service quality.

102. The local authority can demonstrate that the vast majority of children are seen regularly and in accordance with their plans. Direct work with children is a strength, and this good practice is well established in many areas. However, performance information available to frontline managers is not yet consistently used across the service. Without this level of assurance at the service front line, the local authority cannot be assured that it has an accurate overview of every child's circumstances. (Recommendation)

103. While performance data shows improvements in compliance in areas such as assessment timeliness, children seen and case supervision, the local authority's own audits have reflected levels of service quality found during this inspection. Local authority audits have highlighted the need to develop

practice further, to improve management oversight and case direction, and to understand and apply thresholds consistently. Additionally, audits have shown that risk analysis, including child sexual exploitation and episodes of going missing, and the quality of care planning, including planning for young people leaving care, all need to be improved.

104. The local authority has established clear practice standards and, where issues have been identified, undertaken a series of robust service reviews. Of particular note is the review of 1,000 early help cases, which confirmed to the local authority and partners that children are benefiting effectively from early help and prevention services. There are well-advanced action plans to address the findings of the children in need review and the review of the care leavers' service. As a result, senior leaders are well informed about areas of the service which do not yet meet their practice standards.

105. There are still areas for improvement. The local authority has taken strong action to rectify these, for example by a significant investment in more staff, reducing caseloads, addressing individual performance issues effectively, staff development and support, and action planning to improve practice. Further examples include the introduction of a well-coordinated early help offer with most children receiving the right support. Inspectors saw evidence of outcome-based projects, which are delivering positive impact, such as the teens and toddlers and mellow parenting offers.

106. Senior leaders, with corporate support, have responded promptly, effectively and with rigour to tackle critical issues, such as the creation of an additional social work team to respond to an increase in referrals and the creation of a specialist team to respond to an ongoing complex investigation.

107. The local authority has invested significantly in workforce development, resulting in a comprehensive approach to the recruitment, development and retention of staff. The local authority has increased the number of social work posts to increase the sufficiency of staff. Thirty-one additional staff have been recruited, and these are planned to take up their posts in September. In the meantime, the local authority has a number of interim and agency staff to help ease capacity challenges.

108. Although caseloads have reduced overall, in some parts of the service caseloads are still too high. Staff turnover remains a challenge, partly as a result of the local authority positively addressing individual performance issues and increasing staff capacity. While inspectors saw proficient social work practice and decision-making for some children, particularly in more recent records, the scale of change required means that some children have experienced drift as a result of changes in social worker and an absence of quality supervision, which has not always sufficiently progressed children's plans.

109. The local authority is developing into a learning organisation. It has created a positive culture. Its academy of social work and early interventionis a strength

for developing its own social workers. Positive investment in evidence-based tools, such as the graded neglect tool and analytical chronologies to support good practice, is beginning to show impact but is not yet sufficiently applied and practised across the service. Social workers are benefiting from high-quality training, which they report is beneficial and improving the quality of their work with children and families. While there is a clear commitment to upskilling staff and frontline managers, staff turnover and workload priorities mean that this is not yet fully implemented.

110. Learning from complaints is taken up through training, supervision and unit meetings, as well as practice forums and staff briefings. Analysis of themes and issues identified in complaints is increasingly detailed and has led to service improvements, such as the introduction of a pocket money and savings policy for foster carers.

111. Senior leaders provide opportunities for the voice of children and young people to be heard, considered and acted on at all levels. The 'Respect' group for children looked after aged 11 to 18 incorporates the Children in Care Council known as 'Council for Kids' (C4K) and 'New Belongings' for care leavers over 18. While the numbers of those involved are too few, children are starting to influence improvements to services, such as training elected members. Additionally, the Respect and New Belongings groups have refreshed their pledges to children looked after and care leavers. Seventy-eight children looked after have responded to the consultation about the current corporate parenting strategy, and the C4K has challenged senior leaders about the use of jargon and complicated language in meetings.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Walsall Safeguarding Children Board (WSCB) requires improvement to be good. Historic underfunding, only recently resolved, has resulted in delays in completing all of the board's required functions. The board understands its areas of development, including a need to be able to demonstrate and understand the impact of its work. Partners are engaged with the work of the board, including chairing key sub-groups. This is ensuring responsibility and accountability for the board's performance. Through the chair, the board is active in helping to deliver the objectives of the Walsall plan in its engagement with the Health and Wellbeing Board.

The board monitors the effectiveness of some frontline practice through a programme of multi-agency audits. It does not yet have a systematic approach to ensuring that it is informed by partners' single-agency audit activity. The board has been slow to ensure that all partners complete, on a timely basis, the effective auditing of their own compliance with safeguarding processes (section 11). The board has not been able to ensure that its child death overview group completed all its processes relating to child deaths in Walsall during 2016–17.

While lessons are identified and disseminated to staff, the board has not yet ensured that there is an agreed and published neglect strategy for all partners to follow. The board has responded to a peer review of child sexual exploitation by ensuring that it does now have a clear understanding of exploitation and risk activity across Walsall, together with a child exploitation strategy. However, it does not have a clear understanding of how effectively partners work together to minimise risk in this area. The board does not have a comprehensive understanding of agency application of thresholds and the operation of the local authority's internal thresholds. The board has not reviewed the working of its own threshold for services document since 2015.

The board has established a comprehensive training offer, which is well thought of by partners. However, more work is required to ensure that the impact of training on subsequent practice is understood and taken into account in the commissioning of further training. The 2015–16 annual report does not provide a rigorous assessment of the performance and effectiveness of services. There is insufficient analysis of the board's effectiveness and impact on keeping children safe in Walsall.

Recommendations

- The board should ensure that it undertakes a review of partnership understanding and operation of thresholds for services and reviews the multi-agency threshold for services document as soon as possible.
- The board should ensure that it produces an annual report which analyses progress in safeguarding children and young people in Walsall effectively.
- Proposed developments in the evaluation of training should be put into practice as soon as possible, and learning from feedback should be used to measure impact in improving practice and in informing the commissioning process for further training.
- The board should ensure that a neglect strategy, agreed by partners, is in place quickly and that the board has an overview of the impact of practice in relation to young people at risk of child sexual exploitation and the minimisation of that risk.

Inspection findings – the Local Safeguarding Children Board

112. The board is meeting its statutory responsibilities, but there is more to do to ensure that it successfully coordinates the work of partner agencies and monitors the effectiveness of local arrangements.

113. The board has clear lines of accountability and governance. The board has appropriate membership by key agencies and, following effective action by the chair, the board is now well attended. In addition, all board sub-groups are chaired by board members across the partnership. This is ensuring greater shared responsibility and accountability for the board's performance. The board has one lay member and a member from the youth parliament, helping to provide a young person's perspective on the working of the board.

114. The chair of the board engages appropriately with the Health and Wellbeing Board. Together, the two boards are contributing well to the overarching Walsall plan. The WSCB takes a lead in the plan to safeguard vulnerable children and enabling young people to be better protected to keep themselves safe. The chair of the board also chairs the Adult Safeguarding Board and makes sure that there is a strong focus on transitional issues and joint communication through regular adult and children heads of sub-groups meetings.

115. Through a recent self-assessment and a detailed risk register, the board understands its effectiveness and the risks to its ability to maintain and enhance its overview of safeguarding in Walsall. It recognises that it does not yet understand the impact of its work sufficiently well. The board has a business plan which identifies key areas for development and improvement priorities, including those identified locally. The partnership has had an

insufficient focus on the work of the WSCB. Progress to date has been slow, particularly during 2015 and the first half of 2016. Since 2017, the WSCB has shown an increased pace to meet its priorities.

116. The working of the board, through a well-established and appropriately staffed business unit, has been challenged by inadequate funding for a significant period until the beginning of 2017. This has had a detrimental impact on the board's ability to ensure that it is complying with all of its required functions, including a fully working child death overview process and timely follow-up of board responsibilities, such as multi-agency audits and single-agency audits. Only in the last six months has the board secured additional funding from the local authority for a further two years, and for one year from the clinical commissioning group (CCG). This is now enabling the board to review its business unit functioning and ensure appropriate staffing to progress board functions.

117. The child death overview panel (CDOP) sub-group, together with the board, has not until very recently made sure that there are sufficient administrative resources so that reviews of child deaths in Walsall are completed in a timely way. Up until May 2017, there was a deteriorating situation, which saw the build-up of a backlog of at least 23 cases, including five from 2015–16, which had not been signed off by the group. This backlog is now being addressed and had been reduced by nine during the inspection, with anticipated sign-off of all outstanding cases by September 2017. While the group has been able to produce a 2015–16 annual report that includes key messages from deaths reviewed in the previous year, learning from later deaths and dissemination of that learning has been compromised by these delays. However, learning from premature deaths in 2015–16 has resulted in health programmes, such as the Walsall 'Big Mommas' and the Health in Pregnancy service.

118. There is an established programme to monitor the effectiveness of multi-agency frontline practice, with multi-agency audit activity on early help, child sexual exploitation, section 47 child protection enquiry and assessment decision-making, and domestic abuse and MASH effectiveness in the last year. These have identified action plans, which are regularly monitored for progress by the quality assurance sub-group. This programme of auditing gives the WSCB insight into the quality of practice and areas of weakness where improvement is required.

119. To supplement audit activity, the board has undertaken a wide range of assurance workshops on a number of topics, including the 'Prevent' duty, intra-familial sexual abuse, safeguarding of disabled children, and female genital mutilation. However, neither the board nor the quality assurance sub-group have established a process for being informed systematically of findings from single-agency audit activity. The board receives some agency audits on an ad hoc basis, but this is insufficient to ensure that it has a complete overview of agency performance on safeguarding practice, and this affects its ability to identify gaps in single-agency audit activity.

120. The board has a programme of section 11 multi-agency audits and, for schools, section 157/175 audits, designed to ensure that individual agencies audit their own safeguarding processes. However, the board has struggled to ensure timely completion from all agencies. More positively, the board has identified that agencies' assertions of compliance are not always supported by clear evidence. Consequently, the board has initiated challenge meetings where agencies have to present evidence to support audits. There has been a similarly slower response from schools, with 78% of schools having completed their safeguarding audits within timescales. The board is ensuring appropriate follow-up with those schools yet to comply.

121. The board has an effective learning and development framework, which is ensuring that there are clear processes for identifying and undertaking serious case reviews and management reviews, where greater understanding of practice concerning the safeguarding of children is required. The serious case review sub-group has ensured that there is appropriate analysis of issues arising, including action plans and progress on those plans. Learning from serious case and management reviews is disseminated across agencies. This includes a range of learning events and table-top exercises. The WSCB has worked to make sure that there is a level of awareness of the board and its role from local authority staff, including messages from these cases. It has not yet been able to demonstrate impact from these learning points. However, despite neglect being a central feature of a number of serious case reviews nationally, and although some agencies, including the local authority, are using 'neglect' tools to identify risk, the board is only just developing a neglect strategy. (Recommendation)

122. An LGA peer review into child sexual exploitation in July 2016 recommended that the WSCB needed to have a greater focus on the management of risk, by ensuring effective performance management, challenge and accountability across the partnership. The board has responded to these recommendations with the creation of a Walsall problem profile. This helps the board to identify problem areas, including offences, perpetrator and victim profiles and hotspots of activity. It has also developed and agreed a child sexual exploitation strategy with partners setting out a coordinated approach to how partners across Walsall will address exploitation. However, a child sexual exploitation scorecard to help evidence impact and progress in reducing risk to individual children, while under development, is not yet in place. There has been good work with faith communities, hotels and taxis on awareness raising and, in schools, the use of 'See me, Hear me' and emotional well-being and sexual health courses for young people. Take-up by schools of some of these opportunities has been low. (Recommendation)

123. The board does not yet have a comprehensive understanding of agency application of thresholds and the operation of the local authority's internal thresholds. The board's multi-agency threshold document has not been reviewed since 2015, despite the intention to do so annually. The threshold document blurs boundaries between levels three and four. Consequently, the

social care boundary for services is potentially confusing for partner agencies. The document has no direct reference to female genital mutilation and only a brief mention of radicalisation. (Recommendation)

124. The board has responded well to a key feature of many safeguarding issues, with a focus on the 'toxic trio' of alcohol and substance misuse, mental health and domestic abuse, through a dedicated sub-group. This group focuses on evidence of impact and outcomes of three commissioned services. Although a strategic partnership plan is yet to be put in place, work is being done on targeted therapeutic counselling services for children and families within the early help and social care system. The board has recognised a need to ensure appropriate skills for multi-agency staff through a commissioned best practice evidence-based training programme.

125. The board has developed a detailed performance scorecard, assisting it to identify areas of strong performance and those areas where it is weaker. As a result, the board has, for example, been aware of poor practice relating to local authority private fostering, including visits that are not timely and low numbers of identified cases. The board has been active in encouraging a number of awareness-raising initiatives, including a question about potential private fostering arrangements on school admission forms. However, these developments have had little impact on partners and the public, and the number of referrals and arrangements has remained low.

126. The board maintains a challenge log of areas of concern, which details issues where the board has sought explanation and changes of practice. It records actions taken and progress regarding response and change. These include challenging non-attendance at board meetings, use by the police of the absent category when 'missing' is more appropriate for young people, insufficient health presence in MASH, standards of care provided by a hospital trust to children, and high numbers of children at home on care orders. All these areas have subsequently been addressed by the local authority and partners.

127. The board has an established training and development framework offering a range and complexity of subjects. Courses are designed to meet the needs of a wide variety of staff, from those who require basic generalist knowledge to those who require specialist input. Courses include child sexual exploitation, domestic violence, and drug and alcohol awareness and disguised compliance. However, analysis of what courses work well and evaluation of the impact of those courses on staff practice are limited to a basic questionnaire at the end of the course. The board has plans to develop evaluations to include impact from lessons learned at the three-month point after courses end. At the time of inspection, it was too early to undertake this analysis. Lack of analysis of impact, together with no systematic gathering of agencies' views on what courses should be held, means that commissioning of training is not being undertaken on a needs-informed and planned basis. (Recommendation)

128. The 2015–16 annual report does not provide a rigorous assessment of the performance and effectiveness of services. Although the work of sub-groups is

described, it is not reader-friendly in its use of language. Children's and young people's perspectives are largely absent, as are safeguarding issues with regard to disabled children and female genital mutilation. There is little analysis and focus on outcomes for the child. (Recommendation)

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

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

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

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

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) and one Additional Inspector (AI) from Ofsted.

The inspection team

Lead inspector: Jenny Turnross HMI

Deputy lead inspector: Alison Smale HMI

Team inspectors: Linda Steele HMI, Brenda McInerney HMI, Lolly Rascagneres AI, Tracey Zimmerman HMI, Andy Waugh HMI designate, Peter McEntee HMI

Senior data analyst: Judith Swindell

Quality assurance manager: Christopher Sands Senior HMI

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk