Inspection of local authority arrangements for the protection of children

Walsall Metropolitan Borough Council

Inspection dates: **24 June – 3 July 2013**
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Age group: All

Website: www.ofsted.gov.uk

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Contents

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The inspection judgements and what they mean

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

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

Overall effectiveness

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

Areas for improvement

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

Immediately:

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

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

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

Within three months:

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

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

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

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

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

Within six months:

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

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

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

About this inspection

4. This inspection was unannounced.

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

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

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

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

Service information

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

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

Overall effectiveness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The quality of practice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Leadership and governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Record of main findings

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