City of Wolverhampton

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]

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

[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

Senior managers, leaders, and elected members are systematically driving improvements in services for children and families. Corporate leadership is strong and effective. With a clear sense of vision and purpose, and by focusing on key priorities, senior managers, leaders and elected members are using performance management information to monitor and track performance, and deliver better outcomes for children across a range of different areas.

Early help services have been reconfigured in such a way as to bring together strengthening family workers with health visitors, midwives and social workers in eight community-based hubs. Although it is too early to evaluate the full impact of this new service model, parents told inspectors that it is making a difference to them and their families and that, increasingly, they are able to get the right help, in the right way, at the right time.

The multi-agency safeguarding hub (MASH) provides a robust and effective service at the first point of contact. With good links to the emergency duty team, timely information-sharing and robust management oversight, the MASH ensures that appropriate action is taken to safeguard and protect children and young people, including those who go missing and/or are at risk of being sexually exploited.

Good and sustained improvements have been made across the whole range of services for children looked after. Edge-of-care services are targeted effectively to prevent avoidable family breakdown. As a result, children only become looked after when it is right that they should.

Most children come into care in a planned way. Permanence planning starts early. The number of children looked after has been significantly reduced without compromising children's safety. A strong and effective virtual school is delivering positive outcomes for children looked after. Most children are living in stable placements.

The local authority takes its responsibilities as a corporate parent very seriously. The Children in Care Council and the care leavers' forum have been influential in shaping the way in which services are developed and delivered.

Good use is made of adoption to achieve permanence for those children for whom it is the right solution. This includes older children and those with complex needs, regardless of their ethnic identity. The timeliness of legal proceedings, and of matching and placing children with adoptive families, is improving.

Care leavers receive a good, individualised service, which prepares them well for independence. They say that they feel valued and are listened to. Too many care leavers are not in education, employment or training, but appropriate action is being taken and the position is improving. All care leavers live in suitable accommodation.

However, the help and protection which children and young people receive require improvement to be good. The quality of analysis, assessments and plans, including child in need and child protection plans, is variable. The child's voice is not given sufficient prominence or consistently clearly articulated in case files. The level of critical challenge provided by frontline managers is not consistently robust. Some children are not getting the help and support that they need quickly enough.

The local authority has recognised the need to rationalise its performance management information and make sure that the balanced scorecard provides a clear line of sight on all aspects of frontline practice. Further work is also required to embed fully the quality assurance framework.

Contents

Executive summary 2

The local authority 5

Information about this local authority area 5

Recommendations 7

Summary for children and young people 8

The experiences and progress of children who need help and protection 9

The experiences and progress of children looked after and achieving permanence 15

Leadership, management and governance 26

The Local Safeguarding Children Board (LSCB) 31

Executive summary 31

Recommendations 32

Inspection findings – the Local Safeguarding Children Board 32

Information about this inspection 36

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates one registered short-break children's home, which was inspected in November 2016 and judged as requires improvement.
- The last inspection of the local authority's arrangements for the protection of children was in June 2011. The local authority was judged to be adequate.
- The last inspection of the local authority's services for children looked after was also in June 2011. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since January 2015.
- The DCS is also responsible for adult services and public health, though not directly for education.
- The chair of the Local Safeguarding Children Board has been in post since February 2013.

Children living in this area

- Approximately 58,167 children and young people under the age of 18 years live in Wolverhampton. This is 22.9% of the total population in the area.
- Approximately 30% of the local authority's children are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 20.5% (the national average is 14.5%)
  - in secondary schools is 19.7% (the national average is 13.2%).
- Children and young people from minority ethnic groups account for 41.6% of all children living in the area, compared to 21.5% in the country.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British, followed by Mixed (20.6% and 11.3% respectively).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 27.2% (the national average is 20.1%)
  - in secondary schools is 22.5% (the national average is 15.7%).

[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.

- Wolverhampton is very diverse and has the second-highest Sikh population in the country.

Child protection in this area

- At 30 September 2016, 354 children and young people per 10,000 population (2,042) had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from both 403 per 10,000 (2,341) at 31 March 2016 and 489 per 10,000 (2,017) at 31 March 2015.
- At 30 September 2016, 36 children and young people per 10,000 (209) were the subject of a child protection plan. This is an increase from 26 per 10,000 (152) at 31 March 2016, but a decrease from 50 per 10,000 population (290) at 31 March 2015.
- At 30 September 2016, the number of children living in a privately arranged fostering placement was suppressed due to the very low numbers.
- Between the last inspection in 2011 and 30 September 2016, 11 serious incident notifications were submitted to Ofsted and six serious case reviews (SCRs) completed. Two SCRs were ongoing at the time of this inspection.

Children looked after in this area

- At 30 September 2016, 626 children were being looked after by the local authority (a rate of 109 per 10,000). This is a reduction from 655 (112 per 10,000) at 31 March 2016 and 780 (135 per 10,000) at 31 March 2015. Of this number:
  - 369 (or 59%) live outside the local authority area
  - 31 live in residential children's homes, of whom 71% live out of the authority area
  - 495 live with foster families, of whom 59% live out of the authority area
  - 36 live with parents, of whom 14% live out of the authority area
  - there were four unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 40 adoptions
  - 10 children became subject of special guardianship orders
  - 229 children ceased to be looked after, of whom 3.9% subsequently returned to be looked after
  - 38 children and young people ceased to be looked after and moved on to independent living
  - no children and young people who ceased to be looked after are living in houses in multiple occupation.

Recommendations

1. Ensure that management oversight at the frontline is appropriately challenging and consistent, and that frontline managers are able to use the new case file audit tool effectively.

2. Strengthen the line of sight which senior managers, leaders and elected members have on frontline practice, by including detailed information about children in need whose cases are being held by team managers, or managed on duty, prior to being allocated to a named social worker.

3. Ensure that children looked after who are living at a distance from Wolverhampton receive the same high level of health and educational support as children living closer to home.

4. Ensure that, when children and young people are placed with family and friends, social workers are clear about what actions must be completed to assess and formalise those arrangements in line with placement regulations.

5. Ensure that all assessments include a consistently robust analysis of risks and protective factors, resulting in child in need and child protection plans which are specific, measurable and easy for children and parents to understand.

6. Ensure that greater prominence is given in case files to the thoughts, wishes and feelings of children and young people, so that the child's voice is clearly recorded and understood.

7. Strengthen advocacy arrangements to ensure that children in need of help and protection and their parents, and children looked after, are enabled to make a meaningful contribution to child in need and child protection processes, and children looked after reviews.

8. Ensure that children looked after who would benefit from one have access to an independent visitor.

9. Ensure that all personal education plans are specific, measurable and easy for children and young people to understand.

10. Ensure that all pathway plans include targets which are specific, measurable and written in such a way that there is no room for ambiguity about who needs to do what, by when, to ensure that care leavers are able to make a successful transition to independence.

11. Ensure that once children are placed with adoptive families there is no unnecessary delay in applying for an adoption order.

Summary for children and young people

- Senior managers, leaders and elected members are working well together, and in partnership with the Children in Care Council and the care leavers' forum, to improve services for children and young people who need help and protection, children who are looked after and care leavers.
- The new strengthening families hubs are making it easier for children and families to get the help and support that they need in the right way and at the right time.
- Senior managers and leaders are working well with their partners to make sure that children who are at risk of harm are safeguarded and protected.
- When children go missing and/or are at risk of being sexually exploited, partners and professionals know what they need to do and work well together to manage and reduce the risks.
- When families are struggling, the intensive support that they are given helps to prevent family breakdown.
- Some children who are not at immediate risk have to wait for the help and support that they need. Senior managers, leaders and elected members know about this and are already doing something about it.
- Child protection conference chairs and independent reviewing officers are good at making sure that children and young people get the right help, support and protection.
- Senior managers and leaders are taking action to make sure that children and young people are properly involved in social work assessments, and that plans take full account of what children and young people think and feel.
- Senior managers are making sure that only those children who need to be looked after come into care.
- There are far fewer children being looked after now than there were two years ago. Most children looked after are living in settled and stable placements.
- When children are not able to live safely with their birth families, adoption is carefully considered for all children, including older children and children with complex needs.
- Although some children still wait too long to be adopted, this is getting better.
- Care leavers are getting good support to prepare them for independence.
- All care leavers are living in suitable accommodation and are given good information about their rights and things that they are entitled to.
- Although too many care leavers are not in education, employment or training, action is being taken to address this and it is getting better.

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

Summary

Early help services have been reconfigured to ensure that children and families have effective help when needs and/or concerns are first identified. As well as improving the quality and timeliness of information-sharing and increasing opportunities for joint working, these new arrangements mean that cases can be stepped up or down quickly in response to changing circumstances. Parents talk very positively about the help and support that they receive and are able to describe the difference that this makes to them and their families.

Good partnership working and effective management oversight in the multi-agency safeguarding hub ensure a timely and effective response to contacts and referrals about children. Thresholds are applied appropriately. Proportionate and effective action is taken to safeguard and protect children who are at risk of significant harm. Strategy meetings and child protection investigations are timely and thorough. The emergency duty team provides an effective out-of-hours service.

In the majority of cases seen, partner agencies work well together to protect children who are the subject of child protection plans. Child protection conferences and core groups are effective. Child protection chairs provide an appropriate level of scrutiny and critical challenge. Arrangements to safeguard and protect children who go missing or are at risk of sexual exploitation are robust and well coordinated. Multi-agency responses consistently improve outcomes for children and young people.

An increase in referrals since the start of 2016 means that some children in need, including children with disabilities, are having to wait for their needs to be fully assessed. Senior managers are aware of this and have taken action to increase the capacity of the multi-agency enquiry team to enable it to carry out all initial assessments of need, as well as child protection enquiries.

The local authority is taking appropriate action to improve the quality and consistency of social work practice, including the quality of analysis, assessments and plans, while at the same time giving greater prominence to the voice of the child in case records. The quality of frontline management, which is not yet consistently robust, is also being strengthened

Intensive family support, targeted at children on the edge of care, is effective in preventing avoidable family breakdown. Good use is made of family group conferences to enable families to understand the needs of their children better and identify strategies to improve parenting.

Inspection findings

12. Family support workers, referred to as 'strengthening family workers', are making a real difference in the lives of children and families. The local authority has recently reconfigured its early intervention services to create eight locality-based strengthening families hubs. With strengthening family workers sitting alongside social workers, under the same roof as health visitors and midwives and, in one case, a police officer, the quality and timeliness of information-sharing have improved. As well as increasing opportunities for joint working, the hubs are helping to create a real sense of synergy. Although it is too soon to evaluate the full impact of these new arrangements, the early help and support that children and families receive is, in most cases, timely.

13. The quality of early help assessments is variable. All are at least adequate, and some are good. Early help plans are well targeted, set out clear expectations of parents and professionals, and provide clear timescales. Parents talked enthusiastically about the help and support that they receive. In addition to practical assistance and emotional support, the parents value being helped to navigate their way through complex legal and other systems and supported to access services which otherwise they would not have known about. They particularly appreciate the fact that 'as you get more confident, the support gradually gets less'. A young person, whose mother had escaped from a life of domestic abuse, said: 'They [the hubs] are very important; you can't knock them.'

14. The co-location of strengthening families and safeguarding teams means that as risks and/or needs increase or decrease, cases are swiftly stepped up or down between early help and children's social care. Local partnership managers, each of whom is responsible for managing two strengthening families hubs, chair regular weekly, face-to-face meetings of early intervention and social work unit managers. Thresholds for escalating cases from early help to social care are well understood and consistently applied.

15. Good partnership working means that children who are at risk of significant harm are promptly identified. Decisive action is taken to safeguard and protect them. Established 12 months ago, the multi-agency safeguarding hub provides an effective single point of contact. Partners are generally clear about thresholds for access to children's social care services and understand the referral pathways, including those involving children who go missing or are at risk of sexual exploitation. The quality of referrals to the MASH is appropriate in most cases. Robust management oversight ensures that decision-making in the MASH is timely. The percentage of repeat referrals has fallen significantly, demonstrating that the local authority is getting better at responding well first time to the needs of children and families.

16. The emergency duty team is well resourced and responds effectively to the needs of children and families out of hours and at weekends. The interface

between the out-of-hours service and daytime social work teams is strong. Information is shared effectively.

17. Child protection investigations carried out by the multi-agency enquiry team (MAET) are thorough. Strategy discussions and meetings are timely, share information effectively and ensure that initial enquiries are completed without delay. Although the rationale for decisions taken or action agreed is not always clearly recorded, the local authority and its partners work well together to ensure that children are safe.

18. Most children who meet the threshold for statutory intervention receive a timely response, but a small minority of children in need, including children with disabilities, have to wait before being seen. An increase in the number of contacts and referrals since the start of last year is putting pressure on social work teams. Senior managers, leaders and elected members are aware of this and have taken action to double the size of the MAET so that it has the capacity to complete all initial assessments of children in need, as well as child protection enquiries. In the short term, social work unit managers in the strengthening families hubs are having to hold some child in need cases themselves and/or manage them on duty. Inspectors did not find any evidence to indicate that any of the children and families that are waiting for help and support are at immediate risk. (Recommendation)

19. Most assessments are detailed and comprehensive, but the quality of analysis is variable. Although risks and protective factors are identified, their impact is not always clearly articulated. This has the potential to blunt the effectiveness of the help and protection provided. (Recommendation)

20. The timeliness of initial child protection conferences (ICPCs) is good, and the local authority's own figures show that a high proportion of ICPCs now result in a child protection plan. Most conferences are well attended and information is shared effectively. In most cases, child protection conference chairs provide effective critical challenge. Core groups meetings are also well attended and are effective in keeping children safe.

21. The local authority recognises the need to increase the level of advocacy support available to enable parents and children to engage meaningfully in child protection conferences. In those cases when advocates are used, children's views are well represented, giving them and their parents greater influence over key decisions that affect them. (Recommendation)

22. The quality of child in need and child protection plans is variable. Although inspectors saw some good examples of intelligent and effective plans, the weaker examples are not sufficiently specific or outcome focused, and are inclined to focus on the adults rather than the children. Contingency plans are not well developed and this makes it difficult for parents to understand fully what they need to do, by when, and the consequences of not doing so.

23. Thresholds for stepping cases up or down are well understood and are applied appropriately in most cases. However, in a small minority of cases, once children have been stepped down from child protection to child in need plans, arrangements for monitoring sustained improvement are not sufficiently robust. Management oversight of decisions to dispense with a child protection plan after the first review child protection conference has recently been strengthened to ensure that children are not exposed unnecessarily to risk.

24. Most case records seen are up to date, but case records do not always make it clear that children have been seen alone, even when they have been. While in most cases the child's age, ethnicity and gender are recorded, case records do not always give a clear sense of what life is like for the child or provide a clear sense of the child's unique identity. Chronologies and genograms are evident in most case files, but their quality varies. Although social workers know children well, the voice of the child is not consistently given due prominence. Recognising this, senior managers are in the process of rolling out a preferred social work model to make sure that in future children are always at the centre of assessment and planning processes. (Recommendation)

25. The quality and rigour of management oversight at the frontline is not consistently good. Inspectors saw examples of purposeful and effective management scrutiny leading to improved outcomes for children, but not all frontline managers are sufficiently robust in monitoring progress or challenging the quality of social work practice. (Recommendation)

26. Staff turnover, which has been relatively high, has improved and is now less of an issue. Fewer changes of personnel mean that children are more likely to be able to establish meaningful relationships with their social workers. Some social workers are making good use of direct work tools to find out what children think and feel.

27. Partner agencies work well together to ensure that the risks associated with children who are exposed to domestic violence are identified and assessed. Multi-agency risk assessment conferences (MARAC) arrangements are robust and well embedded. Information is shared effectively and thresholds applied appropriately. However, representatives from adult services are not always able to attend. This has the potential to undermine the effectiveness of the MARAC process. Effective multi-agency public protection arrangements ensure that offenders who are living in the community are appropriately supervised and that potential risks to children are closely monitored.

28. Arrangements to monitor the welfare of children who are living with parents who are experiencing problems with their mental health, misusing drugs or alcohol, or when domestic violence is an issue are generally robust. Effective collaboration between partner agencies ensures that in most cases children are appropriately safeguarded. Children experiencing neglect are mostly well

monitored and cases are escalated in a timely manner, as and when necessary.

29. Young people aged 16 and 17 who present as homeless are being well served. A clear and effective joint protocol ensures that these young people's needs are carefully assessed and suitable accommodation offered, if appropriate.

30. At times of crisis, when families are really struggling and there is a danger that children may end up having to come into care, high-quality intensive family support is provided to try to prevent avoidable family breakdown. Good use is made of family group conferences to help parents and children better understand the impact of their behaviour on each other, build resilience and mobilise support from the wider family network. Children and parents receive timely and well-targeted outreach support, which includes a short-break service if necessary. Sixty-three families (104 children) are currently being supported in this way. In the vast majority of cases, this imaginative and creative response results in improved outcomes for children and families.

31. Working closely with the police, the local authority has strengthened its response to children who go missing from home, school or care. Information and intelligence are shared effectively between children's social care and the police. The local authority's dedicated missing return officer, who is responsible for completing return home interviews (RHIs) living within a 20-mile radius of Wolverhampton, sits alongside behaviour and attendance officers and the elective home education officer. Whenever an RHI is undertaken, the child sexual exploitation screening tool is also completed. Completed RHIs are routinely uploaded to the electronic case recording system. The number and quality of RHIs have improved significantly. In October 2016, 93% of missing episodes resulted in an RHI, of which 87% were completed within 72 hours.

32. Robust strategic and operational arrangements are in place to identify, manage and reduce the risks associated with child sexual exploitation. Multi-agency sexual exploitation (MASE) meetings focus on individual children, and support is provided to ensure that, whenever possible, they and their parents are able to participate in the MASE meetings and be involved in co-producing risk management plans. With high levels of awareness, good use of the child sexual exploitation screening tool and a dedicated child sexual exploitation coordinator, the emphasis is on early intervention. Although the number of children identified as being at risk of child sexual exploitation has increased, the local authority and its partners are able to demonstrate their success in preventing the escalation, and successfully reducing, the level of risks.

33. Children who are electively home educated are monitored effectively. The local authority is in touch with all of these families and carries out regular reviews to track children's progress. The progress and attainment of children in alternative provision are also rigorously monitored to ensure that children receive a good education.

34. With training for professionals and clear protocols in place, there is a high level of awareness of female genital mutilation. Girls who are identified as being at potential risk receive a timely, protective response.

35. Although Wolverhampton is not a 'Prevent' priority area, robust arrangements are in place to meet the challenge of, and manage the risks associated with, radicalisation. With clear links to both the Children and Adult Safeguarding Boards, radicalisation is recognised as an integral part of safeguarding. Good levels of awareness and effective coordination ensure that activity is purposeful and targeted, and that young people who are considered to be at risk are identified.

36. It is too soon to evaluate the impact of recent activity to raise awareness of private fostering. Although a multi-agency private fostering forum has been established, currently there are only two recognised private fostering arrangements in Wolverhampton. This means that the local authority and its partners cannot be confident that they are effectively safeguarding all children and young people who are living with adults to whom they are not related.

37. The local authority and its partners take allegations of the abuse of children and young people by professionals very seriously. 'Position of trust' meetings are well chaired and result in effective, well-coordinated and well-managed responses, ensuring that children are appropriately safeguarded and protected. The designated officer has been proactive in meeting with a range of professionals and community leaders to ensure that they understand his role and function, and are clear about their safeguarding responsibilities.

The experiences and progress of children looked after and achieving permanence	Good

Summary

Wolverhampton has adopted a very child-centred approach to children looked after. With a clear strategic vision, robust arrangements to monitor and track progress, and some very sensitive and thoughtful work with individual children, the local authority is delivering improved outcomes for children and young people.

The vast majority of children looked after live in secure and stable homes and, when appropriate, have well-supported contact with their families. A combination of clear permanence plans and good-quality direct work help children and young people to make sense of their history and experiences. The attainment of children is good. In Wolverhampton, children looked after outperform their peers.

The number of children looked after has been safely reduced. Only those children who need it become looked after. Effective management oversight ensures that most children come into care in a planned way, rather than in an emergency. When children return home to their birth families, this is also well planned, and appropriate support is provided to ensure that children are safe.

Some aspects of the service are particularly impressive, including the strength of the local authority's partnership with the Children in Care Council, the stable influence and expert guidance provided by independent reviewing officers, the widespread positive impact of the virtual school, and the work that is being undertaken to reduce offending and re-offending behaviour. The individual needs of children are carefully considered. Permanence planning is a real strength.

Further work is required to ensure greater consistency in the quality of care plans and assessments. The local authority also needs to ensure that children placed at a distance receive a consistently good service and that more children are supported by an advocate or an independent visitor.

Adoption is carefully considered for a broad range of children. The number of children placed for adoption is relatively high. Effective management oversight means that timeliness, in relation to all aspects of the adoption scorecard, is improving. Adopter recruitment is timely. Adopters value the support provided both before and after children have been placed. Disruptions rarely occur.

Transition planning starts early. Young people's advisers provide effective all-round support for care leavers to prepare them for independence. Care leavers, all of whom are living in suitable accommodation, talk very positively of the help and advice that they receive. They understand their rights and entitlements, and feel listened to. Although not enough care leavers are in education, employment or training, effective action means that the position is improving.

Inspection findings

38. Children are listened to. Their voices are heard and acted on. Examples include: a child whose contact arrangements were safely increased as a result of what the child had told their therapist; a disruption meeting that was organised in direct response to the young person saying that they were unhappy in their placement; and the use of MOMO (Mind of my own) technology to enable a child with disabilities to express their thoughts and feelings about their recent experiences.

39. Thresholds to care are well understood and consistently applied, ensuring that only children who need to become looked after do so. Since March 2015, when 780 children were being looked after, the local authority has managed to achieve a significant reduction in the size of the care population without compromising children's safety. At the time of this inspection, 635 children were being looked after. When children no longer need to be looked after, the local authority provides an appropriate level of intervention and support to ensure that they are able to return home safely to their birth families. Very few children return to care. Of the current care population, only five children have become looked after for a second or subsequent time.

40. Most children come into care in a planned way. The local authority is working well with families and the courts to ensure that the majority of children become looked after as a result of formal legal proceedings rather than in an emergency. This allows more time to engage in meaningful work with children and families, and to make sure that they understand what is happening and why. Voluntary accommodation is rarely used, except when this is the most appropriate option.

41. Management oversight has been strengthened to ensure that permanency planning starts early for children looked after. Senior managers are directly involved in the weekly admission to care panel and the management oversight panel, which monitors and reviews plans for individual children to avoid drift or delay. As a permanent member of the admission to care panel, the adoption team manager has a clear line of sight on new entrants to the care system. While inspectors observed a degree of variability in frontline management oversight, this was generally stronger for the children most recently looked after, and was present for the majority of children.

42. The local authority has taken decisive action to address the high number of children who previously were living at home with parents while still the subject of full care orders. The placement with parents team works with children and families to ensure that the level of intervention and support is appropriate, and that children are safe and secure. When care orders are revoked, children and families continue to receive help and support, either as children in need or through early intervention, as appropriate. The vast majority of children whose orders have been revoked have remained in the

care of their parents. Two years ago, 89 children were living at home on care orders. Now there are only 36.

43. The quality and timeliness of court work has improved significantly as a result of concerted action by the local authority. Applications to court, court statements and letters before proceedings are generally of a consistently good quality. Court work seen was well evidenced and analytical. The timeliness of care proceedings has improved considerably. The majority of recent proceedings have been completed within 26 weeks. However, legacy issues continue to have an impact on performance.

44. When it is not safe for children to remain with their birth families, every effort is made to find out whether it is possible for them to live with extended family members or friends, if it is in children's best interest to do so. Viability assessments are of a high quality, and are analytical, comprehensive and respectful of the individual circumstances of family members. This commitment to explore wider family options has resulted in a very small number of children living with family and friends for a considerable period of time before their placements have been properly assessed or formalised. The local authority recognises that it needs to revise its permanence policy to make sure that it provides a clear and unambiguous explanation of the process, and what is expected and required in such situations. (Recommendation)

45. Positive working relationships with Children and Family Court Advisory and Support Service and the local judiciary facilitate open and flexible discussion of complex practice issues. Well supported by its legal team, the local authority rigorously tracks its use of the Public Law Outline and monitors the progress of all court-related work to avoid unnecessary delay. As evidence of the effective grip that it has on court work, the local authority is rarely called to account for their practice at compliance court meetings with the local judiciary.

46. Children looked after have regular visits from their social workers, who routinely see them alone. As at November 2016, 90% of visits to children looked after were competed on time. Improved stability in the workforce also means that children looked after are experiencing few changes of social worker. This has been confirmed by the Children in Care Council (CiCC), the foster carer group and the corporate parenting board. Workforce stability makes it easier for children to come to know and trust their social workers.

47. Children looked after benefit from the dedicated support provided by the child and adolescent mental health services. This includes direct work with children and young people, as well as advice and guidance for their carers and social workers. There is also a good range of local services specifically to support children and young people with issues relating to drugs or alcohol.

48. Independent reviewing officers (IROs) are effective in driving improvements in practice and performance, leading to better outcomes for children looked after. A stable and experienced team of IROs has been given additional resources, including a dedicated foster carer reviewing officer, to ensure that IROs are able to continue to deliver a high-quality service. At the time of this inspection, 90% of reviews had been completed on time. Children and young people are well engaged in the review process, and 92% of them participate in their reviews. Although there is still some variability in practice, the majority of care plans are clear, concise, up to date and outcome-focused.

49. Children looked after do as well or better than their Wolverhampton peers in terms of educational outcomes and, at key stage 2, significantly better than the national average for children looked after. This is an impressive achievement and reflects the work of a well-resourced and well-led virtual school. With only a very few exceptions, children looked after have good school attendance records, and for most this is 90% or above. However, children looked after who are living outside of the city's boundaries are doing less well. The virtual head has put additional resources in place to address this.

50. Eighty per cent of children looked after attend schools that are judged as good or outstanding. Decisions about whether or not to move a child whose school is rated as less than good are made on an individual case-by-case basis. Almost one fifth of children looked after achieve five GCSEs A* to C including English and mathematics. Although similar to last year, this is below the national average for all pupils. The virtual school has identified additional resources to support children this year. At the point at which they leave school, nearly half of children looked after do so with some GCSEs or equivalent qualifications, and at that point 90% of them progress into further education, employment or training.

51. Most children looked after have a personal education plan (PEP). However, while PEPs ensure that pupils receive appropriate help and support, they are not consistently child-centred. PEP targets are not always written in a way that makes them easy for children or their carers to understand. Further work is required to strengthen the quality assurance process to ensure that PEPs are appropriately ambitious and accessible. (Recommendation)

52. The pupil premium is used effectively to support children looked after to achieve their academic potential and promote their social and emotional well-being. The use of the pupil premium is systematically reviewed as part of the PEP planning process. Currently, 86 children looked after have education, health and care plans, which are also reviewed during PEP visits.

53. Children looked after are actively encouraged to pursue higher education. A programme targeted at Year 7 students is designed to raise the aspirations of young people. Although still relatively new, the early indications are that this is having the desired effect and that more children looked after are expressing

an interest in going to university. Good information-sharing arrangements with local further education establishments ensure that young people are well supported. The average level of attainment of children looked after who attend the local college is better than their peers.

54. Alternative education provision is used appropriately to re-engage young people until a long-term educational solution is found. The local authority carries out regular quality assurance visits to ensure that providers meet the required standards.

55. Work is ongoing to try to make sure that children, including children looked after, understand how to keep themselves safe when accessing social media. E-safety and bullying, including cyber bullying, are addressed as part of an initiative involving schools, the local authority and virtual school staff.

56. With a suitable range of placement options available, most children looked after live in secure and settled homes. Placement stability is good and improving (71% of children looked after have had the same placement for more than two-and-a-half years). In the case of those children who have experienced a number of moves, the local authority's response has been appropriate.

57. The Wolverhampton Children and Young People Sufficiency Strategy 2017–2020 clearly sets out the challenges faced and the priorities agreed by children's social care. A targeted recruitment plan means that the local authority has a sufficient number of suitably trained foster carers to meet the needs of children looked after. It also has a good range of in-house and independently provided emergency options. The range of supported accommodation services for vulnerable 16- and 17-year-olds has been enhanced. Foster carers talk very positively about the quality and flexibility of the support that they receive, which is supplemented by a 'buddy' system and a men's group for male carers. Foster carers also comment favourably on the advice and support that they are given to help them to manage contact arrangements successfully.

58. Children's needs for permanence are carefully considered at an early stage. In the vast majority of cases, permanence plans are in place following the second looked after review. The local authority makes effective use of a number of different tracker tools to avoid drift or delay in achieving permanence for children and young people through adoption, a special guardianship order (SGO) or long-term fostering. Children, families and carers are given a clear picture of what will happen and when.

59. When permanency is achieved by way of an SGO, this is based on a thorough analytical assessment, a comprehensive support plan, and an appropriate period of training and support prior to the application to court. The quality of this work is good. Although the number of SGOs is still relatively low, progress

is being driven by two dedicated SGO workers and a long-term fostering worker as part of a targeted improvement plan.

60. A clear policy commitment ensures that foster-to-adopt placements are increasingly being used to good effect to provide continuity and, at the same time, minimise delay for children in need of permanence. Since November 2015, seven children, including brothers and sisters and, in one case, an older child, have benefited from foster-to-adopt placements. This is particularly impressive.

61. Advocacy is provided through a commissioned service but, although its use is routinely considered, the number of children looked after who are receiving advocacy support is low, and there is a waiting list for children requiring an independent visitor. At the time of this inspection, 16 children looked after had an advocate. Nine children had an independent visitor, with a further 11 children on the waiting list. (Recommendation)

62. The individual and separate needs of brothers and sisters are carefully considered and assessed. A high proportion of brothers and sisters are living together in permanent placements, including, for example, a group of five siblings. This means that, whenever possible, children are enabled to grow up together, safe in their shared family identities. When, because of their assessed needs, brothers and sisters end up living apart, they have the same IRO and great care is taken to ensure that contact is maintained at the right level for them, regardless of the distance involved.

63. Child permanence reports appropriately assess and analyse children's needs for lifelong security, provide a strong sense of each child's unique identity, and clearly reflect children's wishes and feelings. Other assessments of children's needs are more variable, though always of an adequate standard. Although social workers know children well and are clearly able to articulate their needs, not every child has an up-to-date assessment. (Recommendation)

64. While considerable effort is being made to ensure that the needs of children looked after who are living out of the local area are met, this is not always the case. Although children living locally receive good health support, the looked after children steering group and the corporate parenting board are focusing on the need to improve health outcomes for children placed at a distance. This is particularly relevant in the case of the 80 children looked after who are living in placements more than 50 miles away from Wolverhampton. While these children are appropriately placed and are well served by the virtual school, their overall experiences are more variable, ranging from an outstanding service to one which requires improvement. (Recommendation)

65. The local authority's engagement with the CiCC is anything but tokenistic. Participation is strong. An impressive, well-integrated and influential group of young people, the CiCC is able to provide tangible evidence of its impact. As well as running 'total respect' training courses for social workers, councillors

and social work students, members are involved as a matter of course in the recruitment and selection of social work managers and staff. Reports to the corporate parenting board are routinely scrutinised and agreed by the CiCC before they are presented to the board. The authors of those reports are required to attend the CiCC in person and, on a number of occasions, have had to amend their reports in line with feedback from the CiCC. When inspectors met with members of the CiCC, every young person said that they felt that they had been listened to.

The graded judgement for adoption performance is that it is good

66. The local authority uses performance information well to monitor and track prospective adopters and children through their adoption journeys. Comprehensive monthly performance management reports, which include an adoption pipeline and permanency tracker, provide detailed information on progress and timeliness.

67. Good performance and positive outcomes for children are evidenced by the high number of children securing permanence through adoption. In 2015–2016, 62 children were adopted – almost a quarter of the children who left care during that period. In the 12 months prior to this inspection, 45 children were adopted. Disruptions are extremely rare.

68. Children who are older or have complex needs are successfully placed for adoption, which means that they have the opportunity to build and benefit from secure families and attachments. Wolverhampton achieves permanence through adoption for more 'harder to place' children than similar local authorities. Currently, 10 children with disabilities and 25 children over the age of five have a plan for adoption.

69. Although the average length of time taken between children becoming looked after and moving in with their adoptive families is above the national average, there is an improving picture. Children are increasingly benefiting from being placed more quickly with their prospective adoptive families.

70. The time it takes to match children with their prospective adopters is reducing steadily, although children in Wolverhampton wait comparatively longer than the national average. The local authority continues to maintain a strong focus on this. Its own, unvalidated data demonstrates continued improvement in this area.

71. The adoption team has a detailed understanding and knowledge of all of the children who have been assessed as needing to achieve permanence through adoption. The team undertakes a successful and creative range of family-finding activity. Having identified shortfalls in its ability to recruit prospective adopters to meet the needs of some children, the local authority has

developed a comprehensive marketing and recruitment strategy to address the issue.

72. The importance of planning early for permanence is well understood. Fostering to adopt is well embedded and is routinely discussed with prospective adopters. Inspectors saw examples of a number of children who were living in foster placements with prospective adopters in order to help them to develop strong and secure attachments at the earliest possible stage. Adopters talk very positively about the helpful support that they receive.

73. Recognising the importance of placing brothers and sisters together whenever possible, the local authority carefully considers the needs of brother and sister groups. Inspectors saw good evidence of brothers and sisters being placed together as a result of due weight and prominence having been given to the importance of these enduring relationships. Although the quality of 'together or apart assessments' seen by inspectors was variable, the recommendations arrived at were appropriate and consistent with the children's needs.

74. In the 12 months prior to this inspection, seven children who had had a plan for adoption had their plans rescinded. Case sampling confirmed that all of the decisions to move away from adoption were appropriate and met the children's identified needs. An immediate permanent alternative option was available for all of these children, although there was a slight delay in securing permanence for some of them with their existing carers.

75. Children and families receive good-quality post-adoption support. A wide range of relevant training is provided by adoption support social workers on subjects ranging from non-violent resistance to dyadic developmental psychotherapy and therapeutic parenting. Creative use is made of the adoption support fund to deliver bespoke packages of care. Adopters talked very positively about the training that they had received, and made it clear that they value the support and responsiveness of the adoption team.

76. Inspectors saw some particularly good examples of life-story, moving-on work and later-life letters. These were all sensitive, purposeful and child-centred, designed to help children understand and prepare for their adoption journey. Life-story books are attractively presented, include photographs and information about children's birth families, and reflect each child's unique cultural identity.

77. Children's files evidence parallel planning as well as comprehensive assessments which inform final permanence decisions. In a small number of cases, once children are placed a delay in applying for adoption orders means that legal permanence for these children and their adoptive families is not secured in a timely manner. (Recommendation)

78. The adoption team is careful to ensure that adopters are suitable and well-prepared. The majority of prospective adopters are assessed in a timely way.

However, while prospective adopter reports (PARs) seen by inspectors were of a consistently high quality, the adoption panel process has highlighted some variability in the quality of PARs. The local authority is taking appropriate action to strengthen its quality assurance process.

79. With an experienced and knowledgeable chair and an appropriately broad membership, the adoption panel provides an appropriate level of critical scrutiny, and is not afraid to challenge the quality of prospective adopter or child permanence reports. Agency decisions are appropriate and timely. The agency decision maker demonstrates a high level of knowledge and understanding of adoption work and a clear commitment to children. The local authority has plans to strengthen further the relationship between senior managers and the adoption panel.

80. The local authority is an active member of the Black Country consortium, and this adds capacity and scope to the services provided by the authority. 'After Adoption' provides appropriate and effective services on behalf of the consortium, including support to birth mothers whose children have been placed for adoption. All adopters are provided with membership of Adoption UK and are referred to the adoption register within timescales. Adopters told inspectors that they feel well supported by the local authority.

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

81. Works begins early with children looked after to help them plan and prepare for independence. The transitions team starts to build relationships with young people from the age of 14 onwards. Young people's advisers (YPAs) work alongside the child's social worker until the young person turns 16, at which point YPAs take over. This approach provides continuity and avoids young people having to re-tell their stories and/or having to come to know someone new at a critical point in their lives. Young people talk very positively about their YPAs, and about the help and support, advice and guidance which YPAs provide.

82. YPAs are in touch with all care leavers, know them well and provide an effective wrap-around service in response to young people's individual social and emotional, health and accommodation needs. When risks or needs increase, YPAs are proactive in mobilising additional support, including, for example, by referring young people to the multi-agency safeguarding hub if they go missing or are potentially at risk of being sexually exploited. Regular Friday drop-in sessions mean that care leavers are able to talk to a social worker, a YPA or the education, employment or training (EET) coordinator about issues or concerns as they arise.

83. Every care leaver has a pathway plan, although the quality of these plans is variable. Young people appreciate being involved in co-producing their pathway plans, including the time spent by YPAs in helping them to think and plan ahead, but some plans are not sufficiently specific or measurable. In the case of the weaker pathway plans, goals are defined in very general terms and do not make it clear what needs to happen or when. The local authority has recognised this and is taking action to address it. (Recommendation)

84. Every time that they meet young people, YPAs ask young people about their health, and actively encourage and support them to make and keep medical appointments. Young people have easy access to the nurse for children looked after, who attends the weekly Friday drop-ins. Health passports, developed in collaboration with members of the Children in Care Council and the care leavers' forum, ensure that care leavers have full access to their health histories.

85. Care leavers are well supported to develop the skills that they need to live independently. In addition to the support provided by their YPAs, care leavers talk positively about the independent living course, which helps them with practical tasks such as cooking and budgeting while also giving them an opportunity to mix socially with other young people who are in a similar position to themselves.

86. As the voice of care leavers, the care leavers' forum has played a significant role in shaping the way in which the care leavers' service has developed. Care leavers told inspectors that they feel valued and listened to. Evidence of their influence includes the fact that care leavers who are under 25 years of age are exempt from council tax, are given free membership of 'The Way' Youth Zone, which includes gym, dance and leisure facilities, and that if they go to university or have to move, the local authority will pay for their furniture to be put in storage.

87. Too many young people are not in education, employment or training (NEET) but there is evidence of real improvement. The education, employment and training coordinator is in regular contact with all young people who are NEET and, as a result of concerted action taken over the past 12 months, the proportion of care leavers who are NEET has fallen from 47% to 20%. Once a month, managers routinely review the position of every care leaver who is NEET to ensure that everything that can be done is being done to engage them in worthwhile activities.

88. Currently 21 young people are studying for a degree at university. The support available to these young people is good. This includes additional grants, moving-in starter kits and payment of graduation costs, as well as extra support at the local university, if needed. Good links and close working relationships with further education establishments ensure that information is shared appropriately, and young people are well supported by the college and the local authority.

89. Care leavers have good access to useful and relevant information via Facebook and/or the dedicated care leavers' website. An information pack, which includes a helpful series of pull-outs and leaflets and is given to them by their YPAs, ensures that care leavers are well aware of their rights and entitlements. As part of the pathway planning process, YPAs also make sure that they remind young people about key information as and when it becomes relevant.

90. All care leavers are living in suitable accommodation. The local authority has allocated 33 flats specifically for 16- to 18-year-olds, with a member of staff available on call at all times to support the young people. YPAs work with care leavers to help them to choose where they live and who they live with. Together, they agree plans to make sure that young people feel and are safe, and that they are able to look after themselves. Every care leaver is entitled to spend up to two weeks in an assessment flat in order to demonstrate to themselves and others that they are ready for their own tenancy. The vast majority (82%) of young people who have been prepared for independence in this way are now living successfully in unsupported accommodation

91. Twenty-one young people are living with their former foster carers as part of a 'staying put' arrangement. All of these arrangements have been assessed and agreed as being right for the young people, and their individual needs and circumstances.

92. An annual awards ceremony, organised by the local authority in partnership with the Children in Care Council and the care leavers' forum, celebrates the achievements of children looked after and care leavers. At last year's dazzling event at a local hotel, over 200 certificates were awarded in categories such as gaining independence and overcoming obstacles/challenges, as well as for educational achievements, This year's Christmas party was designed to help care leavers, some of whom had this as part of their pathway plan, to socialise and make new friends. Care leavers were particularly impressed by the fact that senior managers, leaders and elected members stayed for the whole event.

93. Care leavers are able to articulate clearly how, with the support of their YPAs, their confidence has increased. They particularly appreciate that that support will continue to be available until their 25th birthdays.

Leadership, management and governance	Good

Summary

Senior managers, leaders and elected members, who know themselves and their communities well, are driving improvements in services for children and families. Business and service plans are appropriately focused on key priority areas as part of a 'one council' approach to achieving financial stability, while at the same time delivering better outcomes for children and young people.

The multi-agency safeguarding hub provides a robust and effective response to children and families at the first point of contact. Early intervention services have been redesigned to extend their reach and promote partnership working. The number of children looked after has been significantly reduced without compromising children's safety. Edge-of-care services are strong.

Clear governance arrangements, rigorous scrutiny, and a range of effective strategic and operational partnerships mean that services are responsive to the diverse needs of children and families. Robust strategic and operational arrangements ensure that children who go missing or are at risk of being sexually exploited are identified, and that timely action is taken to safeguard and protect them.

Effective engagement with children and young people means that they are able to influence the development and delivery of services. The local authority is a good and effective corporate parent. Children looked after and care leavers told inspectors that they feel valued and are listened to.

Senior managers, leaders and elected members make good and effective use of performance management information to monitor and manage performance but the balanced scorecard, which is in the process of being refreshed, does not yet provide a direct line of sight on all aspects of frontline activity. While the local authority has made good use of audits, including externally commissioned audits, to raise practice standards, the quality assurance framework is not yet fully embedded. Currently, team managers are responsible for auditing their own team's work, and the quality of audits undertaken by them is variable.

While most social workers receive regular supervision, the quality of critical challenge provided by frontline managers is not consistently robust. Recognising this, the local authority is in the process of rolling out a new competency-based supervision and appraisal framework.

Determined to build resilience and achieve strength in depth, senior managers have succeeded in reducing staff turnover, while at the same time introducing clear career pathways which make Wolverhampton a more attractive place to work. Learning and development is given a suitably high priority.

Inspection findings

94. The local authority is ambitious, realistic and determined to achieve financial stability and improve outcomes for children and young people. Corporate leadership is strong. Senior managers and leaders are in touch with, and have a generally good understanding of, what is happening at the frontline. Robust strategic and operational arrangements to identify, manage and reduce risks of child sexual exploitation are in place, and the local authority and its partners have significantly strengthened their response to children who go missing from home, school or care.

95. An experienced, knowledgeable and highly committed group of senior managers has led children's services well through a period of significant change. Senior managers, leaders and elected members have focused on key priority areas, including safely reducing the numbers of children looked after, establishing an effective multi-agency safeguarding hub and redesigning early intervention services to extend their reach and impact. The children's transformation board is effective in driving continuous improvement. Good progress is being made in delivering better outcomes for children in most areas.

96. Governance arrangements are robust. Good communication between senior managers, leaders and elected members, as part of a 'one council' approach, ensures that there is an appropriate level of scrutiny and effective challenge. The director of children's services, the managing director, the lead member and the Local Safeguarding Children Board (LSCB) chair maintain regular formal and informal contact, and there is evidence of healthy and appropriately rigorous debate. Elected members have consistently demonstrated a willingness to invest in services for children and young people.

97. Partnership arrangements are strong. A joint-working protocol, which provides a clear overview of the role and function of the different strategic boards and their links to operational groups, helps to ensure that the various strategic initiatives are clearly aligned, avoiding duplication or overlap. The development of the MASH, and the co-location of health visitors and midwives with social workers and early intervention workers, soon to be joined by police officers, in eight locality-based strengthening families hubs, demonstrate the maturity of these relationships.

98. The Health and Wellbeing Board is appropriately focused on children and families. As part of its strategic commitment to reduce childhood obesity, an initiative involving public health practitioners working alongside children's social care staff has successfully targeted obese children who were the subject of child protection or child in need plans. Most of the children involved successfully managed to maintain their weight loss or lose more weight.

99. While the joint strategic needs assessment is being comprehensively refreshed, there is clear evidence that analysis of local needs is being used effectively to inform service developments. Effective commissioning arrangements mean that the local authority has in place a sufficient range of high-quality placements to meet the needs of children looked after. Domestic abuse services are currently under review.

100. The children and young people scrutiny panel, which enjoys good cross-party support and includes three members of the youth council, provides effective oversight of children's issues. In 2016, the panel identified child sexual exploitation as one of its key priorities, ensuring that the issue has been given a suitably high profile across all council departments. More recently, the panel has challenged, among other things, the use of pupil premium plus for children looked after.

101. The local authority is ambitious for children looked after and takes its corporate parenting responsibilities very seriously. Chaired by the lead member and with access to good quality performance management information, the corporate parenting board is influential in improving outcomes for children looked after and care leavers. Evidence of this is clearly seen in the quality of accommodation and support for care leavers, as well as the work of the virtual school, which has resulted in children looked after doing as well or better at school than their peers. The board has also been directly involved in initiatives to provide free leisure passes for children looked after and offer council tax exemptions for care leavers. All councillors are required to undertake corporate parenting and safeguarding training.

102. A strong focus on participation means that care leavers and children looked after feel involved and listened to. The lead member, who also chairs the children's trust board, is in regular contact with the Children in Care Council and the care leavers' forum. Reports to the corporate parenting board are first scrutinised then approved by the CiCC, before being presented to the board. A video on what it is like to be a child in care, produced by young people, forms part of the e-learning which all council employees are required to complete. Children's views have a clear influence on the development and delivery of services, as evidenced, for example, by their involvement in staff recruitment panels.

103. The local authority is making good use of a wealth of performance management information to monitor performance, track progress, identify service pressures and drive improvement. However, the balanced scorecard is about to be refreshed. Currently, the level of commentary and analysis provided is limited and, in the case of some key indicators, there is little in the way of comparative data against which to measure Wolverhampton's progress. Additionally, although decisive action is being taken to double the size of the multi-agency enquiry team so that children in need, including children with disabilities, do not have to wait longer than is necessary for their needs to be fully assessed, senior managers, leaders and elected members do

not receive regular reports on the number of children whose cases are being managed on duty or held by team managers before being allocated a named social worker. (Recommendation)

104. Keen to learn and open to challenge, the local authority has made good use of audit activity, including peer reviews and an externally commissioned audit of 210 case files, to review and reflect on different aspects of performance. The development and implementation of a neglect tool and the delivery of further training on domestic abuse are two examples of how audits and/or learning from serious case reviews have informed practice. Independent reviewing officers also produce quarterly reports so that issues affecting frontline practice can be responded to quickly. However, the quality assurance framework, which has recently been refreshed, is not yet fully embedded. A lack of consistency in the way in which frontline managers apply the new case file audit tool, which was introduced in September 2016, suggests that there is not yet a universally shared understanding of what 'good' looks like. (Recommendation)

105. Complaints from children and families are taken seriously, and there are robust systems in place for logging, monitoring, analysing and learning from them. Heads of service receive weekly reports on the progress of complaints. The outcome of complaints is routinely shared with staff and teams through briefing meetings and training. Young people who wish to make a complaint are offered the services of an advocate to support them. However, the take-up of advocacy support by children involved in the child protection process is low. The local authority has recognised this and has plans to address it.

106. The level of critical challenge provided by frontline managers is not consistently robust. Some are better than others at providing clear case direction, setting specific and measurable targets, recording the rationale for their decisions and making sure that the action agreed has been taken. On occasion, this leads to drift or delay. Senior managers are clearly aware of these issues and are in the process of taking action to address them, for example by rolling out a preferred social work model and introducing a competency-based supervision and appraisal framework. (Recommendation)

107. Senior managers have acted decisively to improve the quality and timeliness of court-related work to ensure that children who are waiting for critical decisions to be made are not left to wait unnecessarily. The local authority has established a very positive working relationship with the Children and Family Court Advisory and Support Service and the local judiciary, both of which comment favourably on the progress that has been, and is being, made.

108. Senior managers are rightly proud of their achievements in reducing staff turnover and increasing the stability of the workforce. Good links with local universities, increased opportunities for student social work placements, and a popular assessed and supported year in employment (ASYE) programme are all having an impact. Twenty-two of the 26 social workers who completed

their ASYE in 2014 are still in the employment of the local authority. Staff turnover has fallen from 16.7% to 15% in the past six months and, if all of the candidates who are about to be offered posts accept, then the proportion of agency staff will be down to 4.8%. A more settled and stable workforce makes it possible for children and families to develop meaningful relationships with their social workers.

109. With a robust training and workforce development strategy, the joint adult and children's social work development board and the children and young people's workforce development group ensure that social workers have access to a good range of high-quality training. This includes bespoke training provided by the child and family foundation, designed to help social workers to develop and enhance their skills in assessment, analysis and care planning. The creation of six advanced practitioner posts also reflects the local authority's commitment to building resilience and succession planning as part of a conscious 'grow your own' strategy.

110. Most social workers receive regular supervision, but the quality of that supervision is variable. Caseload size also varies. Caseloads are greatest in the safeguarding teams. Work is ongoing to ensure that average caseloads can be accurately calculated.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The board is well chaired and well led. Governance arrangements are robust. As well as strengthening the engagement of schools and health partners, the chair has successfully promoted a more joined-up approach across children and adult services.

Partner agencies are well represented on the board at a suitably senior level. Attendance at board meetings is good and a well-developed sub-group structure ensures that the board is able to deliver on its work programme, especially now that additional funding has been provided to increase the board's capacity to get things done.

The board's website, which is attractive and easy to navigate, provides a wealth of useful information, including the outcome of the two serious case reviews which have been completed in the past 12 months. Multi-agency procedures, which are regularly updated, are also available on the website. However, the board's annual report does not provide a comprehensive picture of all key areas of safeguarding practice.

The serious case review sub-group and the child death overview panel are well developed and effective. Learning from serious case and child death reviews are systematically shared with professionals and partner agencies. Robust strategic and operational arrangements are in place to safeguard and protect children and young people who go missing and/or are at risk of sexual exploitation. Links with local faith groups have been strengthened. Through the activities of the 'B-safe' group, children and young people are able to shape and influence the work and thinking of the board.

However, while the board is meeting its statutory responsibilities, it does not yet have all of the performance management information that it needs to be able to challenge and hold to account partner agencies effectively. Additionally, in the absence of a rolling programme of single and multi-agency audits, the board is not able fully to assure itself about the quality and effectiveness of frontline safeguarding practice. Without a central risk register, the board does not have a sufficiently clear or coherent overview of those risks which have the potential to have a negative impact on the ability of partner agencies to safeguard and protect children.

While the board works collaboratively to deliver an extensive range of training courses, the absence of a formal training strategy means that it is not in a position to evaluate the impact of training on frontline practice.

Recommendations

111. Further develop the board's risk register to include those risks which have the potential to have a negative impact on the ability of partner agencies to safeguard and protect children and young people effectively (para. 119).

112. Ensure that the Local Safeguarding Children Board has the right level of performance management information with which to challenge and hold to account partner agencies on the effectiveness of their safeguarding responsibilities (para. 120).

113. Develop a coherent rolling programme of single and multi-agency audits with which to quality-assure the work of partner agencies in safeguarding and protecting children, and ensure that the results of Section 11 audits are moderated effectively (paras. 121 and 122).

114. Develop a robust training strategy which incorporates a system with which to evaluate the impact of training on frontline practice (para. 129).

115. Further strengthen the annual report to ensure that it provides a clear picture of the effectiveness of partner agencies across all key safeguarding services, including the independent reviewing officer service, the work of the designated officer in managing allegations against professional and private fostering arrangements, as well as learning from serious case reviews and child deaths (para. 130).

Inspection findings – the Local Safeguarding Children Board

116. With a well-developed sub-group structure and appropriate reporting arrangements, governance arrangements are robust. The chair of the Local Safeguarding Children Board (LSCB) is in regular contact with the director of children's services and meets once a quarter with the managing director and lead member. A joint working protocol clearly defines the relationships between the different strategic boards, including the LSCB. The chair, who routinely attends the Health and Wellbeing Board, ensures that safeguarding issues are given a sufficiently high profile.

117. Experienced and assured, the LSCB chair brings rigour to the work of the board while at the same time providing effective challenge. He has used his position as chair of both the Adult and Children Safeguarding Boards effectively to promote a more joined-up approach across children and adult services, particularly at key transition points. Two of the sub-groups – the learning and development, and the communication and engagement – are shared with the Adult Safeguarding Board. Increased engagement by partner agencies, for example, has contributed to improvements in the contribution of general practitioners to child protection conferences, and both the completion and quality of return home interviews.

118. Partner agencies are well represented at an appropriately senior level on the LSCB. Attendance is good, and there is a shared commitment to delivering high-quality safeguarding services. Engagement with schools and colleges, including the independent sector, is particularly strong, as evidenced by an active and well-established headteachers' sub-group. The lay member, who is a church minister, brings a fresh and unique perspective to the board. Effective challenge across the partnership, for example in relation to the high number of children who previously were being taken into police protection, has resulted in better outcomes for children.

119. As well as maintaining a risk register in relation to the delivery of its own work programme, the board regularly discusses the impact of potential risks on partner agencies' ability to safeguard and protect children and young people. However, in the absence of a central, shared risk register, the board does not have a sufficiently clear and coherent overview of those risks, which makes it difficult for the board to ensure that they are addressed in a timely manner. (Recommendation)

120. The LSCB's multi-agency performance scorecard is not yet sufficiently well developed to enable the board to scrutinise rigorously the experience and progress of children and young people, or the work of partner agencies in safeguarding and protecting them. For example, the board's oversight of the effectiveness and impact of early help services, the quality of decision-making in the multi-agency hub and the provision of services to children in need and children looked after is not sufficiently robust. The board has recognised this and its performance scorecard is currently under review. (Recommendation)

121. Action has been taken to strengthen the board's capacity to quality assure the practice and performance of partner agencies. In 2016, the board carried out three multi-agency audits, on parental mental health, on sexual exploitation and on the use of the pre-birth checklist, and subsequently disseminated briefings on the learning from them across the partnership. However, in the absence of a coherent, rolling programme of single- and multi-agency audits, the board is not fully fulfilling its quality assurance function. (Recommendation)

122. While the headteachers' sub-group assures safeguarding practice effectively in schools and educational establishments, section 11 audits currently rely on self-reporting by agencies. To date, supporting evidence has not been scrutinised or cross-referenced against findings from multi-agency audits or other performance information. However, the newly-formed quality assurance sub-group plans to address this. (Recommendation)

123. A refreshed learning and improvement framework ensures that decisions to initiate a serious case review or, in those cases which do not meet the criteria for an SCR, a 'lessons learned' review, are appropriate. The SCR sub-group provides effective oversight, ensuring that the lessons learned from SCRs are acted on and result in improvements in service delivery and safeguarding

practice. Having completed and published two SCRs in the past 12 months, the board has been proactive in organising a number of events to disseminate the learning from them across the partnership.

124. Robust arrangements are in place to review and learn from child deaths. The Child Death Overview Panel (CDOP), shared with Walsall, is effective. Its annual report is appropriately detailed, reflects the work undertaken by CDOP to reduce infant mortality and identifies key priorities as part of its ongoing work programme. A multi-agency, multi-faceted campaign, led by public health, has been successful in reducing infant mortality. Appropriate action is being taken by CDOP to improve the quality and timeliness of the documentation produced by partner agencies which, in the past, led to a backlog of cases waiting to be reviewed. Learning from child deaths is routinely shared with partners, as appropriate.

125. Robust strategic and operational arrangements are in place to identify and safeguard children and young people who go missing and/or are at risk of sexual exploitation. The sexual exploitation, missing and trafficking (SEMT) sub-group oversees effectively the work of the child missing operational group, which focuses on perpetrators and potential hotspots, and SEMT has recently drafted a comprehensive problem profile. Good use is made of the child sexual exploitation screening tool. Training for taxi drivers and hoteliers has increased awareness of child sexual exploitation. However, although SEMT monitors performance and reports to the board at periodic intervals, the board's performance scorecard does not include any data on child sexual exploitation with which to scrutinise the contribution of partner agencies to keeping children safe.

126. The board has developed a strong local profile by running a number of successful campaigns to raise awareness of issues such as violence against women and girls, radicalisation and sexual exploitation. The Wolverhampton Safeguarding Children Board website is dynamic, easy to navigate and includes up-to-date news and blogs from the chair. Multi-agency procedures, which are regularly reviewed and updated, are clear and comprehensive. SCR reports are also available on the website

127. Children and young people are influential in the work of the board. With good links to the children in care and youth councils, members of the 'B-safe' sub-group regularly meet with the LSCB chair. As well as organising a number of initiatives to raise awareness of safeguarding issues which directly affect young people, such as bullying, alcohol misuse and sexual exploitation, this dynamic group of young people continues to shape the thinking of board members.

128. The communication and engagement sub-group has taken a lead role in developing closer links with local faith groups, working with them to develop effective safeguarding policies and practices. Undertaken in response to the findings of an SCR, this has enabled the board to extend its reach and

influence, at the same time increasing its understanding and assurance of safeguarding practice across a range of different faith communities.

129. Working in close collaboration with neighbouring safeguarding boards, the learning and development sub-group offers a comprehensive range of safeguarding courses. Many of these courses are relevant to professionals working with children or adults. This approach ensures that, irrespective of their primary focus, professionals are able to recognise and respond to safeguarding issues and concerns that have an impact on children and young people. However, although the board has strengthened its capacity to design and deliver training, it neither has a formal training strategy nor routinely evaluates the impact of training on frontline practice. (Recommendation)

130. Although the board's annual report for 2015–16 includes easy-to-understand, child-relevant data, highlights key achievements and identifies areas for development, it does not provide a rigorous assessment or analysis of the quality and effectiveness of frontline safeguarding and child protection practice across partner agencies. Neither does it provide information about learning from serious case and child death reviews, the management of allegations against professionals, the independent reviewing officer service or private fostering. (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 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 who 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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

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