

Inspection of local authority arrangements for the protection of children

Devon County Council

Inspection dates: 15 - 24 April 2013
Lead inspector Richard Nash

Age group: All

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Contents

Inspection of local authority arrangements for the protection of children	2
The inspection judgements and what they mean	2
Overall effectiveness	2
Areas for improvement	2
About this inspection	4
Service information	4
Overall effectiveness	6
The effectiveness of the help and protection provided to children, young people, families and carers	7
The quality of practice	10
Leadership and governance	15
Record of main findings	17

Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

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

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

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Devon is judged to be inadequate.

Areas for improvement

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

Immediately:

- ensure that effective risk assessment and analysis informs decision making and management oversight is fully in place for all child protection work
- ensure that risk is effectively identified, communicated and managed in all early help work
- ensure that the experiences of the child are identified and considered in all help, protection and decision making concerning vulnerable children and young people
- ensure that the individual needs of children as defined by their race, culture, language, ethnicity and religion are actively considered in all work.

Within three months:

- ensure that an effective quality assurance system is in place that enables the council to understand and accurately manage and improve the impact of services delivered
- ensure that feedback from service users, including complaints, and views of children and young people are used to inform training and service development.

Within six months:

- ensure that the early help offer is reviewed, evaluated and an action plan to address areas of weakness is put in place.

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 local authority 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 five of Her Majesty's Inspectors (HMI).
8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Devon has approximately 141,000 children and young people (0-17 years old) who reside within the authority. The 0-17 population accounts for around 18.9% of the resident population, a proportion lower than both regional and national averages. The proportion entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for 5.9% of the total Devon schools population, of which 1.1% are Eastern European. The proportion of pupils with English as an additional language is significantly below the national figure.
10. Early help for children and families in Devon is delivered through both provided and commissioned services of the local authority in partnership with other organisations, including the voluntary sector.
11. Four locality social work teams, four multi-agency locality forums and a range of settings and services are in place to support early help arrangements. These include 43 children's centres; an intensive family support team; over 30 school employed Parent Support Advisors, voluntary and community settings and young people's services. Early help

is also delivered via partnership arrangements with, for example, children's and adult mental health services and substance misuse services; and where children's social work staff have direct involvement with particular families. Devon is a pathfinder for improving services to children with Special Educational Needs and Disabilities, is rolling out a new single assessment process to replace the Common Assessment Framework (CAF) and after successfully implementing year one of the Troubled Families initiative, is rolling this Programme out across Devon to further impact on early help for children and families and the offer of preventative services.

12. Local authority child protection services in Devon are delivered initially through one countrywide referral team, the multi-agency safeguarding hub (MASH), where all enquiries (contacts) on new cases are made and, where appropriate, are referred onwards to four assessment teams covering the county. The assessment teams undertake initial assessments, strategy discussions and section 47 enquiries before transferring cases to one of 25 locality teams, where child protection cases and children in need cases are held. These teams are supported by the Family Intervention Service, the Child and Parent Assessment Service and the Family Group Conference Service. At the time of the inspection, over 5,000 children were in receipt of a social work service of which 450 children were subject to child protection plans and 684 were in care.

Overall effectiveness

13. The overall effectiveness of child protection services in Devon is **inadequate**. There are systemic weaknesses in managerial oversight and quality assurance that enable inconsistent and ineffective practice to go unchallenged and as a consequence some children and young people are exposed to unnecessary risk of significant harm. Inspectors found significant weaknesses in relation to the quality of assessments and the robustness of the professional decision making of managers. Quality assurance and performance management systems, including those used by child protection case conference chairs and managers at all levels, have been ineffective at both identifying areas of weakness and addressing known shortfalls in service delivery. Some recent improvements in relation to ensuring all cases are promptly allocated and the timeliness of some assessments have been made. However, concerns previously identified by the local authority over the last twelve months relating to the effectiveness of children's plans, the lack of analysis in assessments and high re-referral rates have not been sufficiently addressed, leaving some children and young people inadequately protected from significant harm.
14. The MASH provides effective opportunities for information sharing in relation to concerns raised about the welfare of vulnerable children and young people in Devon. Despite this the professional judgements made by social care managers in the service are of variable quality and are not subject to effective quality assurance arrangements. The experience of the child is not sufficiently taken into account and the rationale for decisions not recorded. Consequently, some children and young people do not receive an appropriate response in relation to their child protection needs leaving them at risk of further unnecessary harm. Inspectors identified cases where the management decision was incorrect including cases where statutory social work intervention was required but where the MASH decision had been for a common assessment framework (CAF) assessment to take place, or in other cases no further action was taken
15. Assessments, including CAFs, are variable in quality with too many having insufficient emphasis upon risk, the analysis of risk and the specific protection needs of the child or young person. Whilst the views of children and young people are usually recorded in case files insufficient attention is given to their experiences the impact of the specific events in their life or their individual needs. Case files seen by inspectors indicate that case records are generally up to date. However, the management of how case records are maintained is ineffective and key information such as the record of visits to children and young people is not kept in a uniform way. Consequently it is hard for managers to have clear oversight of work undertaken and for accurate management information to be produced.
16. The Devon Safeguarding Children Board (DSCB) has not been effective in driving forward improvements to services for vulnerable children and their

families. This has been recognised by the local authority and in January 2013 action has been taken to address this through the creation of regional sub-boards to encourage more emphasis on service improvement. It is not yet known what impact these changes have made. The child protection case conference chairs do not provide robust challenge to poor and inadequate practice and do not contribute to quality assurance. The local authority has recognised the need to address deficits in service delivery and intend to secure extra resources to assist with robust auditing of casework.

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

Inadequate

17. The effectiveness of the help and protection provided to children, young people and their families and carers is **inadequate**. Children and young people are not sufficiently protected as risks are not consistently identified or effectively managed. Too many enquiries into the MASH are directed to early help services even when it is clear statutory intervention is required to protect children.
18. Inspectors found inconsistent decision-making in the application of child in need and child protection thresholds. In some cases, a timely and effective response to ensure risks are fully assessed was not evident. Additionally, some case recording lacked clarity regarding decisions and actions being taken, with insufficient account being taken of historical information. As a result it was not always possible to track the rationale for some decisions and actions or to readily determine that children or young people were being helped at the right level. In a number of cases seen by inspectors there was undue delay in children and young people receiving services and others where the assessment of risk was not sufficiently robust. This resulted in some cases being closed inappropriately or assessed as children in need when child protection processes should be applied. During the inspection the council were asked to review a significant proportion of the cases seen as part of the inspection and confirm that children and young people were currently safe and were receiving the correct services.
19. Monthly family profile meetings held within the MASH provide an effective multi-agency timeline and written profiles of families; enabling clear coordinated partnership action plans to be developed. The families presented are either subject to a high number of repeat MASH enquires, requiring early help or children and young people who regularly go missing. However, in the family profile meeting observed by inspectors two of the three cases discussed were inappropriately referred. The

decision to refer these cases to the monthly family profile meeting meant there was significant delay in addressing the child protection needs of these children. Both cases had child protection concerns and required urgent action to ensure that the children involved were safe and appropriately protected.

20. The council are currently developing a strategy for early help. However, in the absence of a strategy the delivery of early help is inconsistent. Consequently not all children and families who would benefit from early help and support receive a service. There is variability in the quality of CAFs and there is no tangible quality assurance process applied to this work. Too many families are being passed repeatedly and inappropriately between early intervention services and children's social care. Furthermore the commitment of professionals to undertake CAFs and to take on the lead professional role is too variable, with a number reluctant to become fully involved. There is no current monitoring or evaluation of the impact of early help by the council.
21. Inspectors did see some individual examples of effective early intervention services through resources accessed by schools and parenting support advisors who lead on CAFs. However, children and young people are not consistently in receipt of timely specialist services to meet their assessed needs. In some cases seen there were lengthy delays in accessing the child and adolescent mental health services (CAMHS). Families experiencing domestic violence are well supported by programmes such as Stop Abuse for Everyone (SAFE), Survivors Empowering and Educating Domestic Abuse Services (SEEDS) and Resolve to End Perpetration of Abuse in Relationships (REPAIR). Direct work by the council's own domestic abuse social workers and family intervention workers effectively support families. This includes one-to-one work to raise self-esteem and promote awareness around children and young people in keeping them safe.
22. Commissioned services by the council for children missing from education and elected home educated children are tracked and monitored robustly. These services have clear service specifications setting out their purpose and intended outcomes and they generally achieve positive outcomes. Privately fostered children and young people and their carers are receiving a responsive service which supports placements well, promoting stability and positive outcomes for children, in particular those attending language schools, good attention is given to their family circumstances, religious and cultural needs.
23. The current arrangements to respond to the needs of children and young people who are at risk of child sexual exploitation (CSE) and missing children are not sufficiently robust. Inspectors identified a number of cases where the risks of CSE had not been considered or identified; consequently children and young people are not adequately protected.

Peninsula-wide procedures have been developed and a local multi-agency forum has been established to strengthen joint working to help children in need of protection. The council have taken positive steps with the appointment of a specialist team; which will be co-located with the police exploitation team. This team will take forward the implementation of the peninsula-wide protocol for CSE to identify young people at risk. However, this initiative is relatively new and will not be fully operational until 1 July 2013.

24. There have been some positive outcomes for families involved with family group conferences (FGC). The council have implemented early help and domestic abuse FGC models across the county. Parents spoken to reported positively in respect of their understanding and the support they have received from the service. This service has not yet been evaluated by the local authority.
25. The quality of both children in need and child protection plans is variable with too many seen being of poor quality. Most plans seen were too generic, not written in a user friendly style and were neither outcome focused nor timescale specific. Child protection plans lacked case specific contingency plans indicating a lack of understanding of both the individual needs of the child and the specific risks to their well-being. In some cases, the lack of effective monitoring and review has led to risk factors going unrecognised and drift in cases.
26. Inspectors saw a high number of cases where weak planning and a lack of rigour in management oversight had led to drift and delay in meeting the needs of children and young people. This is supported by the local authority's own thematic audits where 32% of cases did not have evidence of management oversight. The basic requirements for recording the ethnicity, religion and language of children, young people and their families' are, in the majority of cases, routinely recorded at the referral stage by the MASH. However, insufficient consideration is given in assessment and planning about the way diversity impacts on the ability of parents to protect their children from harm which means that for some children needs are not being identified or met. For example, where inter-generational domestic violence has occurred professionals make little consideration of the impact of this when assessing a parent's ability to protect their children or on the prognosis of parents ceasing this behaviour. Access to interpreters is readily available for children, young people and their families for whom English is not their first language.
27. Children and young people's views are not consistently taken into account or used well to inform assessments and planning. Although the local authority's own audit activity identified that the voice of the child was evident in case recording and assessment it is not then used to inform case planning or the outcome of assessments. Children and young people have access to advocacy services and examples were seen where this has

been effective in supporting attendance at child protection case conferences. However, the attendance of children and young people at child protection conferences is not fully embedded in practice.

28. There is a clear commitment by practitioners and managers to working in partnership with parents. In some cases this leads to effective outcomes enabling children to remain at home with their parents. However in other cases seen, this has led to a lack of focus on the experience of the child. In too many cases assessment, intervention and planning are predominantly focused on supporting the adult rather than focusing on the experience and needs of the child. Some parents spoken to by inspectors reported that they have understood the reasons for intervention and found the support and help offered effective. However, other parents are not engaged in child protection processes sufficiently and the lack of specific and measurable child protection plans contributes to a reduction in understanding about how to keep children safe.

The quality of practice

Inadequate

29. The quality of practice is **inadequate**. Inspectors found too many cases where the professional judgement exercised by social workers and managers did not reflect the known or potential risks to children and young people. Consequently, the level of protection offered to vulnerable children and their families was often ineffective. The local authority has been aware through their own audit activity of some of the shortfalls in practice and has plans to address these. However, at the time of the inspection insufficient progress had been made to address weaknesses in child protection services.
30. The multi-agency safeguarding hub (MASH) is well established and is an efficient process for sharing information between agencies. Key agencies are represented within the MASH with other agencies contributing to information sharing through virtual arrangements. The hub is staffed by qualified social workers and practice managers who receive and make decisions about enquiries and how they should be responded to. In the majority of cases referred to the MASH, the single enquiry form is being used by agencies, thus supporting a more consistent approach to making enquiries. The appropriateness of enquiries being made by universal services was evidenced within cases seen by inspectors.
31. During the inspection, some decisions within the MASH were found to be inappropriate. For example, management decisions to refer a case for CAF or no further action where the threshold for statutory social work input was met. This indicates that too high thresholds for children's social care assessment and interventions are being applied. In some cases, risks are not being sufficiently identified resulting in decisions which failed to provide timely and appropriate protection to children.

32. Advice and guidance for professionals and agencies is available from designated qualified staff within the MASH. Agencies told inspectors that this was helpful and the quality of the advice and guidance provided was good. However, some professionals expressed their frustration to inspectors about getting the MASH to accept cases where work had been on-going with a family for a long time but the situation was deteriorating. In these circumstances, cases were not being accepted unless there was a specific trigger for intervention regardless of whether the deterioration in a child's circumstances had led to them requiring statutory social work intervention.
33. Good quality information sharing opportunities exist within the MASH to inform decision making. However, the quality of the police reports can be difficult to read and analyse due to the way they are written. The red, amber, green (rag) rating determination for cases helps to identify and prioritise cases for information sharing responses and decisions making. However, the application of this rating system can build in delays of up to three days prior to an initial assessment being started and children being seen. Additionally, where a case has been red rag rated – the highest and most urgent response time set for sharing information within four hours, some agencies do not respond, taking the view that information will be sought from them through a section 47 enquiry or an initial assessment. As a result, the effectiveness of sharing the fullest information at this first opportunity can be reduced. Use of the risk identification matrix within the MASH process is not consistent and, as a result, can be misleading to the receiving manager in the local area assessment team. The practice of referring a case to a local area manager under the category of initial assessment where there is a clear child protection concern and the threshold for a section 47 enquiry is met is very poor practice
34. Across child protection services within the council, the rationale for decisions taken is not always sufficiently clear with variability in quality ranging from insufficient rationale to ones which clearly set this out. Overall, the decision making does not evidence sufficient attention being given to understanding the child's experience and the impact on them of their circumstances. This leads to overly positive analysis of risk in some cases, a lack of healthy scepticism of information provided and delays in going out and seeing children to ensure that they are safe.
35. The rate of re-referrals remains high and too many referrals leading to initial assessments are inappropriately closed down after the assessment. The council is aware of this and has recently completed an audit of initial assessments which were subsequently closed. This audit identified that out of 34 files, five were inappropriately deemed to be no further action, three did not require an initial assessment, 14 had inadequate recording, chronologies and genograms. Only three cases were judged good.

36. Where child protection risks are recognised child protection strategy discussions and meetings are held, although these are not always timely.. Where meetings are held, these are well attended by relevant agencies. However, actions arising from these meetings are not always clearly recorded nor is it clear whether the notes of the meeting have been sent out to professionals. Section 47 child protection enquiries are carried out routinely by qualified social workers and completed promptly. However, the enquiries are often more of a wider assessment rather than a sharply focused piece of work on which to form an opinion about the concerns originally expressed. The recording does not always demonstrate enquiries being undertaken with all relevant professionals nor is there always clear evidence of all the issues of concern being rigorously explored. Within the children with additional needs team, evidence was seen on cases where section 47 child protection enquiries are initiated appropriately with strategy discussions being well recorded.
37. The quality of assessments including common assessment is too variable ranging from inadequate to at least adequate. In most assessments seen, the reason for the assessment is clear. The voice and views of the child and parents are clearly recorded in most cases. However, information from other agencies is not evidenced routinely within assessments. Where professionals have contributed, this is not clearly recorded. In some assessments, fathers have not been included, even where there is a clear need for them to be assessed in order to determine the safety of a child.
38. Core group meetings are taking place regularly. There is limited evidence that core groups are being used to develop the outline plan into an effective working tool. However, one family spoken to during the inspection viewed the core group meetings as being helpful with the plan being clear and changed to reflect changing need. Core groups are mostly well attended, however attendance by GPs and adult mental health services are consistently poor. As a result, the development of well-coordinated services to children and young people and their families is potentially impaired.
39. Child protection case conferences are mostly well attended, particularly by the police. In one conference observed, the outline plan resulted in a protection plan that was specific and outcome focused, with appropriate timescales and clarity of professional responsibility. However, the section 47 enquiry prior to the conference had not recognised or addressed all the key areas of risk and consequently the outline child protection plan was unlikely to be effective.
40. The council has recently introduced the 'signs of safety' approach to child protection conferences and this is reported by conference chairs to be engaging families and professionals more effectively. This model, is predicated on social workers visiting the family at least five days prior to

conference to outline concerns and expectations. There is no systematic monitoring as to whether this is being achieved.

41. Case recording is generally up to date. However, the quality is variable with some being poor and not sufficiently clear for the purpose of the visit or addressing known issues or concerns. The accessibility of the recording system to the designated domestic abuse social workers who can insert their own recording on case files improves communication through the system, leading to more comprehensive recording of events. The completion of chronologies is also variable, affected by the lack of functionality in the electronic case records to automatically populate a chronology. Overall, the current case recording system does not easily show the journey of the child as there is no uniform approach to recording that ensures, for example, that records of visits to children and young people are always recorded in the same place.
42. Written analysis of risk and protective factors is often not sufficiently focused. However, in case practice observations, social workers were often able to articulate the concerns, risks and protective factors with more clarity than that in their written assessments. Timeliness in completion of assessments is a clear area for further improvement with some overdue assessments being unacceptably delayed. In addition, pre-birth assessments are not routinely completed in a timeframe that reflects the pre-birth protocol, the risk or expected birth date of the unborn child.
43. In the majority of the CAFs reviewed, the assessments included a good description of the children and their circumstances. However, action planning in CAFs is variable. Some cases had poor or non-existent actions or plans whilst others were clearly set out. In some, it was not clear exactly what actions would be taken to help and protect the child or the timescale for achieving this. Overall, in a third of cases seen, CAFs were timely and resulted in a direct offer of help. In only one of these was it possible to evidence good outcomes for the child. This was not clear in the others. Three cases were deemed inadequate due to a lack of clarity as to whether safeguarding concerns had been acted upon and these were referred straight back to the council. On one of these, it has been accepted that the MASH decision was not appropriate.
44. The child and parent assessment service offers a comprehensive and robust assessment of parenting capacity and associated risk and protective factors which enables children to remain in the care of their parents where possible. Assessments completed by this service result in high quality analysis and viability recommendations enabling the social worker to plan effectively for permanence for children and young people. The work of the service has been praised by the judiciary. Clearly defined criteria for referrals are in place and the service is managed separately from mainstream social care services to retain an appropriate level of independence. However, evidence seen during this inspection combined

with feedback from services, particularly in relation to unborn children, indicates that more is needed to be done to promote a consistent and timely referral mechanism.

45. In most instances cases are allocated promptly to social workers. However, there is little evidence on the case recording that the allocated social worker receives clear instructions from their line manager as to what they are expected to do along with required timescales. Social workers report they receive regular supervision and that their managers are approachable and supportive. Inspectors saw evidence of supervision being held regularly and recorded. However, there is an absence of reflective supervision being evidenced within the records with supervision generally being task orientated and not evidencing challenge.
46. Performance management within supervision is not generally given rigorous attention, especially where there are clearly known areas of weakness, for example the lack of robust analysis of risk in assessments. Up to date appraisals were not routinely found on individual supervision files. Supervision records lack evidence that child protection plans are subject to rigorous supervision oversight and challenge nor is tracking of statutory visits routinely undertaken. Supervision records seen by inspectors do not evidence any audit activity on cases or discussions about issues arising from this.
47. Inspectors saw evidence in most cases of children being seen and seen alone when appropriate. In some cases, good working relationships were built up between the social worker and the young person and this was clearly supporting improved outcomes. However, in too many cases, children were not being seen soon enough where concerns had been referred to the MASH and then referred onwards to local teams.
48. Robust arrangements are in place to visit and monitor children and young people who are privately fostered. Such young people are being seen regularly, on their own as appropriate, with timely assessments of arrangements in most cases. Their views of their placement are given good attention as are their cultural and religious needs. The family group conference service provides a high quality service, engaging parents and members of the extended family in focusing on working together to resolve issues of concern. Observation of a conference demonstrated a sensitive, effective and child focused approach, well presented information which clearly set out the issues to be considered combined with the absolute focus to ensure the child was going to be safe. The family group conference service and private fostering arrangements both have effective quality assurance mechanisms in place and have a track record of making a positive difference for children and young people.
49. The out of hours emergency duty team provides a responsive service with flexibility to increase the staffing complement to meet anticipated

demand. Full access to both the children's social care electronic records and the MASH records enables decisions to be made on the fullest available information. However, the rationale for actions and decisions along with an increased focus on the experiences of the child and identification of risk factors to determine responses and decisions is an area for development acknowledged by the service. There is no formal senior manager cover rota for out of hours although informal arrangements are in place for contacting the relevant senior manager. Access to out of hours legal advice, with the exception of bank holiday periods, is also absent. The activity and quality of the work undertaken by the emergency duty team does not feature in audit activity nor is there a routine reporting mechanism of activity to senior managers.

Leadership and governance

Inadequate

50. Leadership and governance are inadequate. The strategic priorities for children and young people are insufficiently explicit about the need to safeguard and protect vulnerable children. During the inspection too many children and young people were identified as not being effectively protected from harm. In addition, management oversight and quality assurance systems are insufficiently robust and have failed to fully identify and address the variability of practice across the county. This variability of practice relating to assessment, planning and risk management means that changing needs and escalating risk are not always identified in a timely manner.
51. The council has recently started to address some areas of poor performance. The peer review, which reported in October 2012, identified a significant amount of unallocated work across the county. Senior managers have ensured that all work is currently allocated but have made much less progress in relation to other key performance areas. Whilst some activity has taken place in relation to, for example high re-referral rates, this has not resulted in any significant or clear improvements. Senior leaders have made insufficient progress in tackling known deficits in practice post the peer review. Concerns exist in meeting all child protection performance targets which are consistently below that of national and statistical neighbour averages. For example, high re-referral rates to the MASH, statutory child protection visits are not evidenced as being undertaken within statutory timescales and the timeliness and quality of assessments is poor. There is an absence of effective quality assurance and performance management systems across the statutory social work teams which senior managers have not addressed. This enables poor and ineffective practice to exist unchallenged for significant periods of time.

52. The Chief Executive of the Council has regular interaction with the Lead Member for Children and the Strategic Director for People where there is a focus on performance, although primarily in relation to compliance issues rather than qualitative aspects of the work. The scrutiny process by elected members has not resulted in effective challenge of senior officers in relation to service improvement. Senior leaders are aware of the need to improve the impact of the Devon Safeguarding Children Board (DSCB). Three regional sub-groups of the DSCB have been set up to improve the focus on improving outcomes for children and young people. This new model has been in place since January 2013 and there is not yet evidence of impact on practice. The LSCB independent chair acknowledges that more could have been achieved by the LSCB in relation to raising standards of practice and challenging poor performance.
53. Performance management and quality assurance arrangements for children's social care are inadequate. There is no overarching quality assurance framework and current quality assurance activity has had a very limited impact on improving services to children and young people. Whilst there is increasing evidence of the use of management information to improve performance the focus of this is primarily on compliance and is dependent on case recording by social workers which is already accepted by the council as not always reliable. While there exists a wealth of performance information available, there has been insufficient grip and understanding of performance management and quality assurance, with poor tracking, monitoring and delivery of actions emanating from audit and training.
54. Management information is not sufficiently focused on the experiences of children and young people, current risks, and the difference intervention makes. The council has undertaken a limited number of thematic audits of child protection services. These audits have highlighted a number of areas of poor performance such as the lack of analysis in assessments and the generic nature of child protection plans. The council has not made any significant progress in addressing these areas of weakness or making improvements to service delivery. Senior managers have recognised the need to improve services and are in the process of creating a new team structure and are aware of the need to improve quality assurance processes.
55. Independent safeguarding reviewing officers do not routinely contribute to quality assurance processes and there is inconsistency in their response to the identification of poor practice, such as insufficient core group activity to progress child protection plans. Although the manager of this service now produces a quarterly report for the consideration of the senior management team there is limited evidence on how this is improving practice. The DSCB has not been effective in driving forward improvements to child protection conferences or core groups.

56. Since April 2012 responsibility for the statutory complaints process for children's social care was incorporated into a single customer services team for both adult and children's services. The local authority recognises that more work is required to identify learning from complaints and to incorporate a feedback cycle into the quality assurance framework. Managers also recognise the need to ensure feedback from children and young people influences service development and staff training.
57. The workforce reflects the local population. There is a coherent recruitment and retention strategy in place which includes a number of incentives for new starters. The council has implemented a strategy to address the reliance on agency staff in some area teams. This has resulted in a more stable and consistent workforce with reducing numbers of agency staff.
58. There is evidence of a commitment to training with a number of staff having been supported to complete social work degrees as well as management training and leadership development. Additional support is given to newly qualified social workers including reduced caseloads, mentoring and innovative scenario based training. Training for more experienced social workers is more limited and workers expressed difficulties in accessing training given commitments to casework. Although there is a training programme in place this is not robustly linked to shortfalls in practice, for example quality assessments.

Record of main findings

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