Inspection of local authority arrangements for the protection of children

Somerset County Council

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

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The inspection judgements and what they mean

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

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

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Somerset County Council 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 Somerset, the local authority and its partners should take the following action.

Immediately:

- Review all children on child protection plans to ensure that the measures being taken to protect them are sufficient and effective. Review all children whose child protection plans have ceased in the last three months to ensure that the decision was appropriate and that subsequent child in need arrangements are sufficient
- ensure that there is routine and recorded management oversight of cases by front-line and more senior managers so that the quality and effectiveness of work done to meet needs and protect children is understood and where necessary improved
- senior managers should sample child in need work across the county to ensure that risk indicators are not being missed and that children's safety is assured.

Within three months:

- Improve the quality of assessments, ensuring clear analysis of all relevant information including historical and parental factors, so that services provided to children are targeted effectively on needs and risks

- ensure that child protection and other plans include specific improvement objectives with timescales so that progress is known and where insufficient, alternative action can be taken

- ensure that child in need work is guided by good quality plans with specific objectives and progress measures

- ensure that thresholds for early help and social care services are clearly defined and widely understood so that children and their families benefit from the right help at the right time

- initiate action to resolve delays for vulnerable children in accessing child and adolescent mental health (CAMHS) provision

- ensure that children on child protection plans are regularly visited and seen alone by a consistent, allocated social worker. Ensure that the quality of supervision, and its recording, is sufficient and provides challenges and opportunities for reflective learning.

Within six months:

- Ensure that early help provision is coordinated, operates to clearly defined thresholds and aligns with social care services to enable children and their families to get help at the right level, and to move between the different levels of help as their circumstances change

- ensure that the common assessment framework (CAF) is routinely used to guide early help and support prompt access to children's social care services when necessary.

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

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

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

Service information

9. Somerset has approximately 115,600 children and young people under the age of 19 years. This accounts for 22% of the total population. Some 14.9% of those under 16 are estimated to be living in poverty. The proportion of school pupils entitled to free school meals is below the national average at 11.4%. Census 2011 data indicates that children and young people from minority ethnic groups account for 6.3% of the total population, compared with 16.3% in the country as a whole. The largest minority ethnic group in Somerset is White Other, with significant local Gypsy-Roma-Traveller population and a rising number of people from Eastern Europe, particularly Poland. The proportion of school pupils with English as an additional language is below the national figure of 16%.

10. Early help is provided in Somerset by a range of services including 41 children's centres and third sector youth organsiations such as Promise. There has been a shift towards greater targeting in early help, and a new early help strategy will be launched later in 2013 that aims to create a better coordinated offer, with improved evaluation and alignment with children's social care.

11. Initial contacts with children's social care services are managed by the Somerset Direct, and those identified as requiring further social care assessment and intervention are transferred to a team (known as a 'pod') based in one of the Council's four areas. An emergency duty team responds to children and young people who require support or protection out of normal office hours.

Overall effectiveness

12. The overall effectiveness of arrangements to protect children in Somerset is **inadequate**. Most children who are at risk of harm are identified and receive help to protect them. However inspectors also found a number of cases where not enough was done to protect children, and where the risk of harm remained present for too long. New referrals to children's social care services normally receive a prompt and proportionate response, but there is a lack of clarity among the different agencies about thresholds for children's social care involvement. Somerset Direct staff are not always assertive enough in pushing cases back to referrers where a social care response is not needed. As a result, some children and families receive help that is disproportionate to their needs.

13. When children transfer to district teams for further assessment and intervention, too many experience delays in having their needs met. There are some good assessments, particularly those carried out under the recently introduced 'Signs of Safety' approach to child protection work. However, the quality of assessments overall is poor, with weak analysis of the information that has been gathered. This means that the child's experience is not fully understood and subsequent planning is compromised. Few assessments pay sufficient attention to significant historical factors or parental factors such as domestic abuse and drug and alcohol misuse. The absence of key-event chronologies from most case files means that significant risk indicators have been missed in some cases. The Signs of Safety approach is as yet not embedded across the council, but social workers using it have demonstrated its potential to support improved practice. Some children receiving child protection help experience delays in accessing child and adolescent mental health services (CAMHS) and this can limit the effectiveness of other work.

14. Child protection conferences are mostly effective in ensuring that information is shared and in identifying risk. However, there is little evidence of child protection conference chairs carrying out a substantive quality assurance role in between conferences, which is a missed opportunity to apply additional oversight. Very few child protection plans are sufficiently specific. They do not give clear indications of what needs to change and by when, and so do not support the monitoring and review of progress by core groups and review child protection conferences. As a result, decision-making about reduced risk is not always sound, and some child protection plans have ended too soon. Assessment and planning for children in need, including those stepping down from child protection plans, is particularly weak. Work is not routinely guided by a clear, or indeed any plan, and so is too often unfocused and short-lived, with premature case closure in some cases.

15. Management oversight of cases is not robust. It is not always clear that assessments and plans have been seen and signed off by managers, and

there is little evidence of managers using supervision to challenge social workers or encourage them to think critically about their cases to improve understanding. As a result, neither poor nor good practice is routinely identified by managers. This inhibits individual and organisational capacity to learn and improve. This weak management oversight has been compounded by a lack of routine senior-level case file auditing. This is now being remedied by the Council and Somerset Safeguarding Children Board (SSCB), and findings are beginning to be used to brief staff about improvements, but it is not fully embedded and its impact remains to be seen.

16. While inspectors saw examples of good work by social workers and team leaders, with clear benefits and improved outcomes for the children concerned, such cases are largely the result of skilled and knowledgeable individuals rather than robust quality assurance and performance management. Nevertheless, it does illustrate that there is the potential within Somerset to deliver high quality work.

17. At lower levels of need, there is an adequate range of early help provision, some of which provides a good service aimed at supporting children and their families. However, these early help services are not supported by a coherent early help framework. Nor are they clearly aligned through agreed and well-understood thresholds with children's social care. This lack of coordination means that there are gaps in provision, for example geographically, and that not all services are accessible for all children and families across Somerset. Inspectors heard of cases where timely and local access to parenting programmes was not available, which compromised parents' ability to make the required changes.

18. The council has recognised that too many aspects of its children's social care services are not of sufficient quality and effectiveness. Identifying a failure to improve since the last inspection, particularly in the quality of assessments, children's plans and performance management, the council has very recently brought in a new and largely interim senior leadership team. There is now a much sharper focus on performance, with an appropriate initial prioritisation of compliance with statutory guidance. Improvements are already evident, for example in the timeliness of visits to children on child protection plans. However, as the council acknowledges, the changes are too recent to have had a widespread impact on quality and effectiveness of practice. Work has now begun to address quality issues, with the appropriate initial priorities of analysis and planning. This will be supported by the continuing implementation of Signs of Safety with the intention of widening the improvements this has already brought.

19. SSCB has until recently been ineffective, but under new leadership and structures it is now beginning to meet its statutory duties, though there have been delays in completing Section 11 audits among partner

agencies. The most significant improvement so far has been the in the engagement of partner agencies, with a greater recognition of agency and collective responsibilities for safeguarding and protecting children. There is evidence that individual agencies have been robustly held to account for their actions. A programme of multi-agency case auditing is now underway, and this will contribute to a better understanding of what good looks like across the partnership.

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

Inadequate

20. The effectiveness of the help and protection provided to children, young people and families is **inadequate.** Risks and needs are not consistently assessed or effectively managed. Inspectors had to ask the Council to re-examine too many cases where records did not show clearly that sufficient protective action had been taken.

21. There is an adequate range of early help provision in the county, some of which is very effective in meeting needs and improving lives. For example, inspectors saw and heard evidence of purposeful work by children's centres, schools-based Parent and Family Support Advisers (PFSAs) to improve parenting skills, and effective work by the Pathways to Independence (P2I) service to support vulnerable young people. However, this provision is fragmented, uncoordinated and not evaluated within a consistent framework. In consequence, the ability of children, young people and families to get the help they need at the right level, right time and right place is not assured. Although assessments are undertaken with children identified as needing early help, there is no single agreed assessment tool. The common assessment framework (CAF) is not widely used by the local authority or other agencies, resulting in some children being subject to unnecessary multiple assessments.

22. The council acknowledges that the lack of an early help strategy and a delivery plan has impeded the coordination of early help services. A draft early help strategy is currently the subject of consultation and there is evidence of an emerging recognition of the need for better alignment of early help with children's social care and for a clear thresholds framework that supports this. However, this is very recent and has yet to deliver improvements in the coordination and evaluation of early help across Somerset.

23. Somerset Direct receives new contacts and referrals, providing an assured response in the large majority of cases. Incoming work is screened carefully with a good level management oversight. Transfer to locality teams of cases requiring further assessment is in most cases appropriate and timely. However, in a small number of cases seen by inspectors the

need for further assessment was not recognised, and these were closed inappropriately or received a lower level response than the presenting risks warranted.

24. A well-established and adequately resourced out-of-hours service links effectively with police, paediatric health services and social care day services to ensure that concerns for a child that emerge outside of normal office hours receive a prompt service, including emergency action where necessary. Strategy discussions about new child protection concerns are held with the police and sometimes other professionals. Most of these are effective in establishing how matters will be progressed.

25. When children are identified as needing help from children's social care, there is too much variability in the proportionality and effectiveness of the response they receive. While inspectors found some examples of rigorous assessment leading to effective action, in the majority of cases it was not sufficiently thorough or analytical to provide a full understanding of a child's circumstances and needs. For example, social workers do not routinely consider historical and parental factors such as drug misuse in assessing need and risk, and this limits the effectiveness of subsequent interventions. Where there is good work, it is more likely to be because of the quality of the individual practitioner and manager than robust quality assurance and performance management. Management oversight of cases is too limited in most cases seen, with work not always signed off and there is little evidence in case files of reflective consideration and challenge. Senior managers recognise these weaknesses in practice and management oversight and have very recently started to make the required changes. While there are signs that compliance with the requirements of statutory guidance and County policies has improved, for example in the timeliness of social work visits to children on child protection plans, it remains too early to see significant impact on the quality and effectiveness of services.

26. Participation of partner agencies in child protection conferences has improved from a low baseline in recent months and is now satisfactory. Child protection conferences are mostly effective in ensuring that information is shared between agencies and with children, young people and families, though the extent to which review conferences evaluate progress is too variable. Participation by key professionals in core groups remains too variable and they are not consistently effective in developing child protection plans into specific plans with clear improvement goals and progress measures. As a result, the evaluation by conferences and core groups of progress in reducing risk to the child is not reliable. However, the council is now introducing use of the 'signs of safety' model and inspectors saw a small number of recent cases where this has been used to good effect, with effective action taken against clear progress measures that were understood by parents and professionals alike.

27. While some parents of children on child protection plans had been helped by social workers to know why the local authority is concerned and what is required of them, this is not true in all cases. This reduces the scope for focused intervention and the achievement of progress. Social work reports to child protection conferences are not always shared with parents until shortly before the meeting takes place. This hampers their ability to contribute fully to discussions, planning and reviews of progress. Nevertheless, most parents seen by inspectors value their children's social workers and believe that interventions have improved their parenting and the lives of their children.

28. Case plans for children in need, including those stepping down from child protection plans, are particularly poor. Too many lack a written plan at all, and where there are plans, the large majority are not specific about the objectives of the help provided. Inspectors saw a small number of cases where an emerging need to step a case up to a child protection response was not recognised, and in consequence there was delay in securing the protection of the child. Work too often reduces and then ceases quickly after the shift from child protection to child in need arrangements, and the lack of clear plans and reviews means that effectiveness in improving children's lives is not evident. A higher than average re-referral rate in Somerset indicates that too many such cases are closed before it is clear that sustainable change has been achieved.

29. Arrangements for the identification and protection of children at risk of sexual exploitation are at an early stage of development and awareness among professionals including social workers is variable. Inspectors saw a very small number of cases social workers did not recognise indicators of sexual exploitation and so missed opportunities to protect children from the harm they were suffering. Very recent work has been undertaken to improve the response, with a multi-agency group led by police and children's social care launched in May 2013. It is too early to see evidence of its impact.

30. The council's approach to children missing from education (CME) is well developed, with active identification and monitoring. Similarly the needs and potential vulnerabilities of children educated at home are well understood by the council, with an active approach to both educational and welfare issues. Arrangements for assessing and meeting the needs of children who are privately fostered are appropriate and largely effective with some good examples of assessment and support seen. Partner agencies, such as schools, report they are aware of the need to notify the council of possible private fostering arrangements, but the numbers overall remain low.

The quality of practice

Inadequate

31. The quality of practice is **inadequate**.

32. Thresholds for referral to children's social care lack clarity and are not fully agreed and accepted by all partners. There is a perception among some partners that thresholds for children's social care have been raised and that some children who require a specialist social care intervention do not receive it quickly enough as a result. Early help is uncoordinated and the use of the CAF is barely established and not routinely used to escalate cases to social care intervention. Somerset Direct provides appropriate and timely advice to professionals in other agencies as part of its principal role to filter incoming contacts. Nonetheless, feedback about the consistency of response of other children's social care teams from professionals in other agencies varies from positive views to strong concerns about insufficient contact on open cases because of frequent social worker changes.

33. Although Somerset Direct responds and passes on the majority of child protection and child concern referrals promptly, there are often significant delays in the allocation of work in district teams, and in some of these teams cases are being held by team managers before allocation. Inspectors saw examples of delay in assessing children's needs arising from this practice.

34. Section 47 enquiries are carried by out by qualified social workers and are mostly adequate, though the risk of harm, particularly that arising from the emotional impact on children of domestic abuse, is not always correctly identified. Some child protection enquiries have not been sufficiently timely or thorough, and inspectors referred a number of cases to managers to address inadequate child protection assessment or inaction where the current risk to children and young people was unknown. In response, managers ensured that these cases were re-examined and any necessary steps taken to ensure children were protected.

35. There is a wide variation in the quality of assessments with some good examples seen, but too many are inadequate. Initial and core assessment are not consistently completed within timescales that meet the child's circumstances or the council's own targets. Most assessments lack detailed analysis of key factors in the child's life, which inhibits the development of a clear understanding of what help is needed. The council has recently moved to a simplified single assessment format which encompasses initial and core assessments. All social workers and their managers have received training in the Signs of Safety model, and good use of this assessment approach is increasingly apparent. The rate of re-referrals for the 12 month period up to the present is high and this

suggests that assessments and interventions at initial referral are too often insufficient. In most instances, assessments for child protection conferences and care proceedings are of a higher quality. However, even some of these assessments lack full consideration and analysis of relevant family history and risk. Where cultural and other diversity factors are discussed in assessments, it is mostly only superficial and does not aid understanding of the child's experience.

36. In most cases where a child is made subject of a child protection plan, interventions ensure that basic protection needs are met. However, there is sometimes a delay in receiving appropriate services, particularly from CAMHS. Most child protection and child in need plans do not establish specific improvement goals with timescales and progress measures, and as a result, success in reducing risk and need is not easily assessed. A number of parents expressed confusion about what was required to enable their children to be removed from a child protection plan. For those assessed as children in need, especially those stepping down from child protection plans, help is more limited and case involvement is often closed down too soon. The use of the CAF process is not established except as a means of accessing services to family centres. Low numbers of CAFs are completed and while there are some good quality examples too many are inadequate, with the weak analysis of information gathered.

37. The quality of visits to children and young people subject to assessment is too variable. They range from inadequate, where the visiting intervals are too long, or where children are not seen alone, through to some good examples of direct work and positive relationships with children that inform assessment and planning. Children, including some on child protection plans, are not always visited by a consistent social worker who knows them well. In some cases, visits were made by other social workers who do not know the child in order to comply with prescribed visiting requirements. This reduces the likelihood that problems will be identified. Records of visits to children subject to child protection and child in need plans do not illustrate purposeful activity or connection with the agreed plans. There is little evidence that the experiences of children and young people are routinely sought or that their views consistently shape the assessments and plans made for them. Too often the primary focus of social workers' activity is on the engagement of parents. For example in core groups observed by inspectors, much of the discussion centred on parental needs rather than the child's.

38. Management oversight and supervision are inconsistent and too often fail to identify and remedy weaknesses in practice and recording. For example, inspectors referred a number of cases with unidentified or unmet child protection concerns to the Council for urgent review to ensure children were safe. Senior managers examined these promptly and initiated appropriate remedial action. They acknowledge a range of deficits including missing assessments, delay in assessing child protection risk, a

lack of robust planning and the absence of consistent and appropriate case management and direction.

39. It is not always evident that managers have signed off assessments, and in some cases where they have, it has been without a proper consideration of risk. Management decisions often lack a clear rationale. Although social workers report that formal supervision is regular, the recorded direction on individual files is generally task-focused and lacks reflection about how to respond to the complexities of cases. Supervision records do not show evidence that practice shortcomings, for example in assessments, are challenged by managers. Case recording is largely up to date, but in a number of files seen by inspectors, assessment formats are blank or incomplete and there is no way of checking that managers have read or approved assessments. Child protection conferences and core group meeting minutes are also missing from some files. Chronologies are usually completed in those cases subject to care proceedings but are otherwise mostly absent or incomplete. Inspectors saw a small number of cases where the lack of a chronology contributed a failure to identify very significant historical risk factors. Although recorded assessments and plans are often unclear, social workers when interviewed can normally articulate the risks and next steps to move planning forward.

40. Advocacy is commissioned through the PROMISE organisation, which provides individual advocates for children including those who have child protection conferences and plans. The level of take up to support children at child protection conferences is rising, but social workers are not yet routinely referring children for advocacy or supporting young people to attend.

Leadership and governance

Inadequate

41. Leadership and governance are **inadequate**. The council and SSCB have only very recently recognised that there are significant weaknesses in children's social care services. Identifying that progress was too slow following the April 2012 safeguarding and looked after children inspection, the council employed additional interim senior management support. External consultancy was brought in from January 2013 and identified too much poor and inconsistent practice and a lack of holding to account by managers at all levels. As a result of this, the council implemented changes at senior leadership levels. An interim Director of Children's Services (DCS) took up post in April 2013 with the remit from politicians and the Chief Executive to deliver a safe and secure safeguarding service. Additional interim senior capacity has also been recruited. These steps have brought a new sense of urgency and rigour to addressing the significant long-standing weaknesses. They have enabled closer scrutiny

of key areas of children's social care business, the confirmation of a number of concerns,preliminary improvement action and coherent plans to improve the quality of practice.

42. The council is now prioritising action to improve the quality of social care practice and management so that they become fit for purpose. There is an initial emphasis on compliance with statutory and policy requirements. This has begun to show some success and is to be followed by a focus on improving quality. At the same time, there is consultation on a draft early help strategy aimed at ensuring greater alignment and coordination of the currently fragmented early help offer. While the first steps to overall improvement have been taken, the impact on practice is as yet too inconsistent and not embedded. Overall, Children's Social Care, under the current senior leadership team, is identifying the scale of the challenges and is initiating a change programme to secure the required improvements. There are already emerging signs of improvement, particularly in relation to compliance with statutory guidance and evidence that the introduction of the signs of safety approach has the potential to achieve practice improvements.However, the changes are in their infancy and are not yet delivering services for children needing help and protection that are of sufficient quality to ensure needs are met and appropriate protection afforded.

43. While there are some examples of effective collaboration, responsibility for children's welfare has too often been seen by other agencies and professionals as the preserve of children's social care services. This is now changing, and senior leaders report an increased commitment by other agencies to play their part in improvement. The component parts of a sound early help offer are in place, with some well established. However, there is a lack of coherence and strategic oversight that holds partners to account for agreed priorities. The systematic use of management and performance information in early help and preventive work is insufficiently developed, which means that some individual services and overall provision are not properly evaluated. The local authority acknowledges that it and its partners need do more to achieve greater consistency in the early help offer, and work is planned for the autumn 2013, for example, to develop and launch a core children's centre offer.

44. Accountabilities between the DCS, the Council's Chief Executive, the Children's Trust, senior political leaders and Somerset Safeguarding Children Board (SSCB) and its independent Chair are clear, with appropriate formal and informal mechanisms applied to ensure reporting and holding to account. Politicians and senior leaders are committed to supporting the necessary improvement actions.

45. The SSCB independent chair has been in role since autumn 2012. Prior to that time the board appears to have been moribund, with a high level of passivity, little holding to account and a lack of focus. Since then, there

has been demonstrable improvement, with evidence of challenge, clear expectations of agencies and individual members and better engagement. Structures have been revised to provide a greater focus and case-level analyses have been undertaken and reported on to enable lessons to be learnt. There is more use made of quality audits. However, the impact of the changes is as yet largely evident in the Board itself, with significantly better participation by partner agencies, a streamlined sub-group structure and the introduction of multi-agency auditing of files from the different partners. Significant impact in driving improvements in child protection practice across the system is not yet apparent.

46. There is now routine use of performance reports in children's social care, with reporting at all levels against a very recently introduced simplified data set. The current focus of this activity is on compliance as the first element in an overall improvement programme. Front-line managers receive weekly performance reports focusing on key indicators. They use these in their pods to ensure tasks are carried out and to challenge practitioners. Fortnightly area meetings enable middle managers to hold team leaders to account and to identify themes and trends. Similarly, there is a structured set of performance reports and meetings at senior levels, with routine scrutiny of key indicators. This has enabled consideration and review of cases, for example where children have been on child protection plans for long periods.

47. There is some evidence of improved compliance arising through performance management processes. For example, a recent deterioration in the timeliness of strategy meeting records led to management action and subsequent improvement. The focus on compliance is appropriate in achieving improvement from a low baseline. However, as the council recognises, the impact of improved performance management on the quality of work done is not yet evident. A lack of routine, systematic evaluation of practice means that the council's success in improving children's lives is unmeasured and unknown. The current leadership team has recognised this and plans are in place to remedy the deficit, but it is too early to see any resulting improvement.

48. There is no routine performance management and evaluation of early help. Overall the effectiveness of CAF and early assessments in securing interventions that lead to improvement is not known by the local authority and its partners. Improved evaluation is planned as part of the new early help strategy but is not yet in place.

49. The improved focus on performance management ensures that staff and managers now receive regular feedback on important aspects of their work, particularly in relation to compliance factors such as timescales. In some areas, inspectors saw evidence of well-received training sessions and practice discussions. Most social workers receive regular supervision and most newly qualified social workers value and benefit from

appropriate support. However, the evidence from supervision and case files is that there is very little attention paid to critical reflection, challenge over quality of work and professional development. While the council has introduced templates for recording learning from critical reflection and appraisal, these are not evident in supervision files and those asked were unaware of them. The overall picture of supervision and staff support is similar to that for practice: an organisational focus on compliance is ensuring that it is done, but not that it is done well. The quality of supervision received by social workers is too often inadequate, which means that practice is not critically evaluated and challenged.

50. There is evidence of activities aimed at securing the views of children, young people and their families to inform service development. For example, the Children's Trust Board very recently met with members of both the UK Young People's Advisory Board and Somerset Youth Parliament to consider their report about young people's priorities. These include concern about bullying, child sexual exploitation and road safety. However, it is too early to see how service development and practice will be influenced by this exercise. Parents using children's centres have taken part in some staff selection processes, and been able to attend parent focus groups about service development. At individual case level, too many assessments and plans do not reflect the voice of the child.

51. The local authority has used learning from research to begin to improve practice. In particular, the introduction of a 'signs of safety' approach was seen by inspectors to have led to good practice and outcomes in a number of cases. While it is a hopeful indicator and represents a commitment to improvement, its implementation is not complete and most children do not yet benefit. The LSSCB has delivered workshops covering the lessons from Somerset's most recent serious case review. However, most staff spoken to were not aware of the learning from this review.

52. There are enough social workers and first line managers to ensure that caseloads are largely manageable. A focus on developing support for newly qualified social workers has enabled the council to recruit to posts, and there is a significant number of more experienced social workers. The council has taken robust action to respond to poor performance and some staff and managers have left the organisation in recent months. The use of agency social workers has increased recently but remains in manageable proportions.

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