Inspection of local authority arrangements for the protection of children

Staffordshire

Inspection dates: **5 November to 14 November 2012**
Lead inspector **Nicholas McMullen**

Age group: All

Website: www.ofsted.gov.uk

Further copies of this report are obtainable from the local authority or at www.ofsted.gov.uk

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 8

The quality of practice 11

Leadership and governance 14

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 Staffordshire is judged to be adequate.

Areas for improvement

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

Immediately:

- ensure that assessments and reports clearly reflect the views and experiences of children
- ensure that management oversight of cases is well recorded and is effective in progressing casework.

Within three months:

- eliminate the current backlog of overdue assessments and ensure that future assessments are completed within an acceptable timescale
- ensure that all children with child protection plans are seen at a frequency that matches their specific child protection needs and that records clearly establish whether they have been seen alone or not
- ensure that the common assessment framework is used more consistently and effectively to improve outcomes for children receiving targeted early intervention support
- ensure social care case records are sufficiently comprehensive and up to date, include chronologies, and that each child's case file includes all relevant documents.

Within six months:

- reduce average caseloads within the busiest specialist safeguarding units and ensure that all workers and managers have manageable workloads
- develop processes to ensure the views and experiences of children, young people and their families positively influence the development of child protection services
- improve systems for inputting and accessing case records for children receiving services from the local support teams
- continue its workforce development programme for early intervention services to ensure all workers and managers have appropriate skills in assessment, case planning and evaluating outcomes.

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 six 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. Staffordshire has approximately 171,000 children and young people under the age of 18 years. This is close to 20% of the total population. The proportion entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for approximately 9% of the total population, compared with 16.3% in England as a whole. The largest minority ethnic groups are Pakistani, Indian and mixed White and Afro-Caribbean. The proportion of pupils with English as an additional language is below the national figure.

10. Over the last 12-18 months services for vulnerable children in Staffordshire have been re-configured through its Families First programme. Referrals of potential children in need are made to a centralised first response team (FRT), co-located with a multi-agency safeguarding hub (MASH) which includes health and police. Referrals which may need targeted early intervention services can be directed to one of 18 local support teams (LSTs) or 54 children's centres. Referrals of children who may be at risk and require a child in need assessment are transferred to one of 18 locally based specialist safeguarding units (SSUs) for an initial or core assessment or to undertake section 47 enquiries.

These units also provide longer term support through child protection and children in need plans. Four specialist teams provide services for disabled children including assessment and support for disabled children who are at risk of harm.

Overall effectiveness

Adequate

11. The overall effectiveness of local authority arrangements to protect children in Staffordshire is adequate. Since the unannounced inspection of contact, referral and assessment services in July 2011 substantial improvements have been achieved and the issues identified by that inspection as needing priority action have been fully and effectively addressed. In this relatively short period significant improvements have also been delivered in all aspects of core child protection work and a major re-configuration of the local authority's early intervention services has left it better positioned to provide early support for children and young people at risk and has improved joint working between targeted services and specialist safeguarding provision. These improvements have had strong corporate and political support, been driven by intelligent, robust and energetic leadership and delivered through an increasingly skilled workforce. A commitment to supporting Staffordshire's most vulnerable children is evident throughout. However, some significant issues remain outstanding, such as the poor timeliness and incomplete recording of many child in need assessments, the fact that social workers' caseloads are too high to enable them to complete all the tasks required, and the need to ensure that support provided through early targeted intervention is of a consistently high standard with an adequate quality of recording.

12. The local authority has prioritised maintaining a good range of targeted early intervention services and acted to improve their efficiency and effectiveness by integrating these services into multi-disciplinary local support teams either co-located or located close to its specialist safeguarding units. As a result, access routes into these services are clear and consistent. Most children are receiving the right level of support and can move appropriately and, where necessary, quickly between targeted and specialist provision. These processes are supported by detailed but clear threshold criteria which have been recently updated. The re-configuration of services through the Families First programme has been accomplished through careful and considered change management with a clear sense of direction and ambition. Creating the LSTs required bringing together a range of professional cultures, working styles and management arrangements and whilst there is general enthusiasm for an integrated approach the teams are still at a relatively early stage of development. Consequently more work is needed to get the best out of different approaches, ensure more consistent assessment, planning and recording practice, equip workers with the necessary skills and so ensure that children and families receive reliably good quality, timely and effective support.

13. The FRT provides a clear and accessible single point of contact for professionals and members of the public who have concerns about a child.

Contacts are swiftly and thoroughly evaluated with assistance from other agencies co-located within the MASH. As a result children at risk are identified and receive prompt attention and protection. Strategy discussions support well planned and thorough section 47 enquiries which in turn lead to clear and well-judged outcomes. These processes ensure robust identification of children requiring protection through a multi-agency child protection plan.

14. Children subject to multi-agency child protection plans usually benefit from sound and analytical social work assessments although their views and wishes are not always clearly captured in these assessments. Children are visited and seen in line with the local authority's minimum three weekly standard and these visits are usually well recorded although it is not always clear whether a child has been seen alone or not. Outcomes for most children subject to plans improve with good attention given both to reducing risk factors and enhancing resilience through, for example, improved school attendance.

15. Children who do not meet the threshold for section 47 enquiries but do require an assessment as potential children in need are referred promptly and appropriately by the FRT to their local SSU. While most of these children are then visited and seen reasonably promptly a large number experience delays in their assessment being completed. Social workers and managers in a number of the SSUs find it difficult to give sufficient priority to this work given the size and demands of their caseloads. Similarly once work has been undertaken there are often considerable delays in it being fully written up in case records. These problems are compounded by the current electronic case recording system which is cumbersome and does not easily provide reliable or timely information on on-going assessment work. The local authority is well aware of these issues and is addressing them on a number of fronts but not yet with sufficient impact.

16. Performance management within the local authority, although hampered by data reliability issues, is generally well developed with attention given to both quantitative and qualitative information. This has enabled the local authority to establish a strong self-awareness and understanding of its performance and to drive through improvements in many but not all of its key areas requiring such improvement. There is evidence of the authority learning from a range of sources and welcoming both internal and external challenge. Key issues and themes from serious case reviews are well understood by managers and staff and this learning has had a clear impact on prioritisation and service improvement.

17. Staffordshire Safeguarding Children Board has ensured a comprehensive training programme and set of policy documents are in place and contributed to some service improvements such as robust arrangements for responding to missing children. Overall, however, it has until recently

lacked clear priorities and not provided strong leadership or been sufficiently challenging. This has changed with the appointment of a new independent Chair in January 2012 and a new performance framework and improvement plan for the Board are being developed and implemented. Members of the Board report that it is now much more, and appropriately, focused.

18. Workforce planning has been effective in reducing social work vacancies and turnover and staff spoken to felt well supported. The regularity and quality of supervision has improved with more staff now benefiting from opportunities for reflective supervision although this remains inconsistent and for some workers supervision remains dominated by casework updates, some of which, given the size of caseload, can only give cursory attention to some cases. Workers can access a good range of development opportunities clearly linked to service priorities and its improvement agenda.

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

Adequate

19. The effectiveness of the help and protection provided to children, young people, and their families and carers is adequate. Children and young people at risk of harm are appropriately identified and provided with effective protection. Improvements in the functioning of the multi-agency safeguarding hub (MASH) and first response team (FRT) mean that new referrals now consistently receive a timely and effective response, with good attention to current and historical information in evaluating risk and reaching decisions. Management decisions are clearly recorded with explicit rationales. These arrangements ensure children who may be in need of additional help are initially directed to the most appropriate service for further assessment. This includes children who may be at risk from abuse for whom section 47 enquiries are carried out in a timely way and for clear, evidence-based reasons. Children who are the subject of section 47 investigations are routinely seen and, when appropriate, seen alone. In almost all cases, risks are explicitly identified and evaluated enabling sound decision making regarding the outcome of section 47 enquiries and next steps. Decisions are clearly recorded with specific actions established for follow-up to ensure children are kept safe.

20. Social work reports to child protection conferences provide effective analysis of current and historical factors. This enables the development of a clear picture of the child's experience and its impact. Child protection plans vary from adequate to good; weaker plans do not include specific and measurable objectives or appropriate contingency planning. However, the introduction of a new template with a more explicit focus on risk and outcomes is delivering improvements in plans that enable families to be

clear about what needs to change. Review child protection conferences explicitly consider progress in reducing risk and improving outcomes. Practitioners are held to account by conference chairs and there is an emphasis on outcomes that has led to discernible improvements for children and young people. Examples include improved protective factors such as regular school attendance. In most cases seen by inspectors, decision-making at child protection conferences is appropriate. The county applies guidance that child protection plans under the category of neglect should not normally end at the first review conference. This allows for improvements made to be monitored over a longer period to ensure that they are maintained. However, in a small number of cases seen plans ended too soon to allow for the demonstration of sustained improvement.

21. Overall, child protection services are well-coordinated and operate effectively through a combination of a clear focus on identifying and reducing risk, skilled practice by social workers, effective family and parenting support services and good operational partnerships. This enables the achievement of positive and sustainable outcomes for children. Where sufficient change is not being achieved within a child centred time, timescale planning moves on to consider alternative care arrangements for children, supported if necessary by legal action. There are strong multi-agency arrangements for responding to children who go missing and for those who may be at risk of child sexual exploitation. Children receiving elective home education are well monitored with the council working pro-actively with parents and carers including those from minority ethnic groups. Staff are alert to safeguarding issues and appropriate action is taken when concerns arise.

22. Effective screening by the FRT means that children in need of protection and those in need of further assessment for Section 17 provision are clearly identified. However, upon transfer to the SSUs, children in need of Section 17 help do not receive a consistently timely and assured response. While such children are, in most cases, seen promptly, in a very large number of cases, assessments have not been completed and recorded on the child's case file. In a significant number of cases, assessments have been outstanding for many weeks. In a large number of these cases assessments have been undertaken but not fully written up, but in others, assessments have not been completed. In consequence, children and families are experiencing delays in the provision of services to meet need. Such delays also limit the scope for recognising and evaluating information when subsequent referrals are made, for example out of hours, as records are not comprehensive.

23. Most parents and carers feel that the help, support and protection provided by children's social care and its partners are beneficial. The positive findings of the council's own survey of parental experiences of child protection services are reflected in the observations of inspectors, in that most parents feel they have been helped and outcomes for their

children have improved as a result of the services provided. Parents and carers feel that social workers, family and parent support workers and other front line staff treat them with respect and are good listeners. They understand why help has been provided and value highly the help received. Parents and carers of children on child protection plans say that they know what needs to change, though not all are clear about how much progress professionals believe they have made.

24. The degree to which the help and protection provided to children, young people and their families respond fully to issues of equality and diversity is variable. The basic requirements of recording ethnicity, disability and communication needs are largely in place, with most files containing relevant information and use made of interpreters and translators when necessary. However, the extent to which assessments and interventions reflect cultural and other needs is too variable. Some good examples were seen. For example, inspectors saw examples of the sensitive exploration with young people of their experiences of moving to the United Kingdom and the careful use of research into forced marriage and female genital mutilation to inform their interventions. As a result, children and young people were protected from harm in a way that enabled them to retain important cultural and religious links. However, in most cases, the consideration of culture is much more limited, including for White British children. Factors such as the impact on children of growing up in a white working class culture with high levels of worklessness are not routinely explored in assessments. The council has recognised some of these limitations and is taking action, for example through the use of action learning sets, to improve responses to issues of culture, race and identity.

25. A well-considered offer of early help and support for families has been developed through 18 multi-disciplinary local support teams (LSTs) across the county. Early help incorporates a range of services that work well together and with the SSUs to provide effective oversight of families whose needs are below the threshold for statutory social care intervention. However, as yet health professionals are not fully incorporated in the LSTs. Increasing numbers of families are being engaged by LSTs and there are emerging signs that early help may be starting to lead to a reduction in referrals to statutory services. Where children require more intensive help, or when their needs lessen, arrangements to step-up and step-down support are in place and appropriate. Children's centres contribute satisfactorily to the early help offer in the area.

26. In the best examples of early help, families are supported well in times of crisis and over time they achieve good outcomes, such as improved mental health, stable housing and improved school attendance and attainment. Family relationships improve and parenting skills are enhanced. Staff develop good relationships with families and build trust with them well. However, there is too much inconsistency in the quality of

early help. The common assessment framework (CAF) is not used consistently and when it is used the quality of assessment and planning is too variable. Some are well completed with useful contextual information and insight into the needs of children and their families. Too often, though, recording lacks coherence and a clear assessment and it is not always clear what outcomes are being focused on for improvement. The views of children are often not well recorded. Planning does not always reflect the current needs of families and in a few cases seen the services offered did not match the level of need that was evident. Inspectors also saw examples where agencies were slow to respond when improvements in outcomes were not being achieved.

The quality of practice

Adequate

27. The quality of practice is adequate. External agencies make appropriate referrals to the FRT, which is the single point of contact for all referrals from across the county. Professionals from other agencies also have good access to social work expertise and advice via this team. Thresholds for access to services have been reviewed and agreed recently by the Staffordshire Safeguarding Children Board. The thresholds are understood well and applied effectively; with nearly all decisions for accepting referrals viewed as appropriate by the receiving SSUs. Additionally, effective systems are in place for social workers from the SSUs to provide advice and if necessary carry out joint visits with workers from the local support teams, to determine whether the referral threshold for statutory services is met in particular cases. The co-location of SSUs with local support teams is enabling a more coordinated approach for cases that need to move into or out of statutory services.

28. Referrals consistently receive a prompt and appropriate response from the FRT, which is based within the MASH. Pertinent and detailed information is gathered and recorded, and risks and protective factors are identified clearly. Historical information is well presented and considered and is taken into account in evaluating risks and reaching decisions. Cases requiring a child protection response are prioritised and passed on promptly to the SSUs. Children's social care, the police, health and local support teams are well coordinated through the MASH to ensure timely and consistent responses in cases of domestic violence, including involvement with multi-agency risk assessment conferences (MARAC) when necessary. All incoming cases to the FRT that were seen by inspectors included clear evidence of management oversight, with decisions recorded and tasks set.

29. Referrals that are received out of hours are handled effectively by the emergency duty service. The service is based with partner agencies at the MASH, which facilitates good joint working. The extended hours operated

by the MASH during the early evening and at weekends enable the emergency duty service to benefit from the same level of multi-agency support as the day time service. There is good liaison between the emergency duty service and day time services, with overlapping working time at the beginning and end of each shift.

30. On receipt of referrals, team managers identify the action required and most cases are allocated promptly. Where appropriate, professionals ensure that they receive consent from families to contact other agencies for information. Priority is given to cases where children are, or may be, at risk of significant harm. The majority of section 47 enquiries seen by inspectors demonstrate good practice. All section 47 enquiries are carried out by qualified social workers. Agencies work together well in strategy discussions and meetings to ensure that an effective plan is in place for the child protection enquiry. Decisions made are appropriate to risk. In most cases seen, strategy discussions are clearly recorded, enquiries are thorough and interventions are timely. When cases do not proceed to an initial child protection conference, the reasons are clearly explained. Practitioners also have good access to legal advice.

31. Social workers' reports for child protection conferences that were seen by inspectors are comprehensive and benefit from clear analysis and evaluation. Reports are shared well in advance with parents and carers, and written information about child protection arrangements is provided, so that they can be well informed. Child protection conferences are well chaired and appropriately challenging. Conferences are usually well attended and good efforts are made to engage families. Decision-making within child protection conferences is clearly recorded, and risks and strengths are summarised well. Child protection planning is effective but the thoroughness and quality of written child protection plans is too variable, although all those seen by inspectors were at least adequate. The template for recording child protection plans has been updated recently. The revised template requires a more focused approach to risk and the impact on the child, and to the desired outcomes. Multi-agency core groups are well attended by partner agencies and by families, and detailed reports are provided on the children's progress. Core groups observed by inspectors were clearly focused on the daily life experience of the children and young people, the development of the child protection plan and the importance of improving outcomes.

32. Most children on child protection plans are visited by social workers at least every three weeks, in accordance with council policy. This was the standard set and adhered to in nearly all cases seen by inspectors and so it was not clear how well or often visiting frequency was adjusted and increased to meet the needs of individual children. Inspectors saw evidence of social workers building effective relationships with children and young people. Records of visits do not consistently make clear whether children are being seen alone, if appropriate. Child in need plans

that were seen by inspectors were at least adequate and multi-agency meetings were taking place regularly to progress the plan.

33. The timeliness of initial assessments in child in need cases is inconsistent across the county and in some areas substantial numbers of these assessments remain incomplete many weeks after the referral was received. While monitoring by senior managers indicates that almost all children are seen soon after referral and key decisions regarding the outcome of an assessment are usually made and placed on record these decisions are being based on verbal discussions rather than management consideration of a written and complete assessment. This limits effective quality assurance. The majority of core assessments in 2011/12 were also completed outside of the timescales set out in statutory guidance, although core assessments required as part of child protection enquiries are prioritised. When initial and core assessments are completed they are mostly of good quality. They identify risks and protective factors, are child focused and proportionate, and the quality of analysis is high. School attendance and academic progress are routinely considered for school aged-children, and health needs are identified. However, assessments are still not consistent enough in capturing the child's voice. The council is aware of this and some areas are piloting an activity pack which workers report is helping to achieve more active engagement. Managers' comments that were seen by inspectors on assessments and on social workers' reports to child protection conferences are well considered and add value to the work being undertaken.

34. The quality and timeliness of case recording is too variable, and in some offices there are significant delays in scanning external documents onto the system. In a number of cases of sibling groups, meeting notes and assessments had not been copied across to all siblings' case files. The majority of cases seen by inspectors did not include up to date chronologies making it more difficult to identify patterns of behaviour and draw out risk and protective factors.

35. Decision-making within children's social care services is undertaken by suitably qualified managers. The recording of management oversight on open cases is variable across teams and less well recorded in areas where caseloads are high, although staff report that they feel well supported. Key decision sheets are used to record decision making on open cases, although many of these seen by inspectors reflect a brief description of the current position rather than continuous review and planning.

36. Supervision is provided regularly to staff and frequency is closely monitored by senior managers. Supervision files are audited and findings of recent audits indicate improvements in quality and increasing evidence of reflective supervision. Supervision files seen by inspectors show some good use of reflective practice, with examples of impact on learning, but this is not consistent across all specialist safeguarding units. Most

supervision appears to be primarily task based, although attention is also paid to the health and well-being and personal development of staff. Some supervision files of workers who have high numbers of incomplete assessments do not consistently demonstrate effective and persistent management challenge and support to ensure that work is completed in a timely way. Newly qualified social workers report that they receive good levels of support from managers and additionally from joint working with more experienced social workers.

Leadership and governance

Adequate

37. Leadership and governance are adequate. The council has embarked on an ambitious improvement agenda coordinated through a single improvement plan (SIP). The plan sets clear priorities informed both by external scrutiny, including that provided by inspections and peer reviews, and by the council's own strong self-awareness. Actions to improve service performance are clear, focused and regularly monitored and reviewed. Progress against the plan is overseen by the Children's Improvement Board which includes all key players with an additional element of independent challenge and expertise provided by the Director of Children's Services (DCS) of a neighbouring local authority. Key priorities have included addressing the priority action and areas of development from the unannounced inspection of contact, referral and assessment services conducted in July 2011, improving the consistency and quality of core child protection services and integrating local authority services providing targeted early intervention. Significant, and in some cases, swift progress has been achieved in all these areas through the Families First programme.

38. Insufficient progress has been made in improving the timeliness of section 17 child in need assessment work and performance in completing initial and core assessments remains poor. Senior managers are seeking to address this weakness and have taken steps to mitigate its impact by ensuring that children and young people are seen in a timely way and that managers have sufficient oversight to ensure that those at risk of harm are protected. The current backlog of incomplete assessments, however, remains sizeable, leading to delays in getting services to some children and young people, poor or incomplete recording and significant inefficiencies in how resources are being deployed. Current electronic recording systems in social care and targeted services are slow and cumbersome creating additional inefficiencies both in inputting and accessing information. Senior managers are fully aware of these difficulties and a clear plan is in place to commission and develop a new system but this will not come into operation before January 2014.

39. Political support for protecting vulnerable children in Staffordshire is strong. Child protection services are accorded the highest corporate priority and this is reflected in the council's resource allocation meaning that in a challenging financial climate, budgets for safeguarding services have been protected and where necessary augmented. Lead politicians have a good understanding of service issues and pressures and work hard to keep their knowledge up to date through regular briefing meetings with senior managers and visits to front line services. Managers value both the support and constructive challenge politicians provide.

40. The appointment of an independent Chair to the Staffordshire Safeguarding Children Board (SSCB) in January 2012 has sharpened both the focus and accountability of the Board and as a result it is providing a more constructive challenge and having more impact in key areas. The Chair is suitably experienced and has appropriate access to senior managers and politicians. Respective roles, responsibilities and accountabilities are now both clear and clearly understood. A good range of multi-agency safeguarding training is provided through the Board. This training is valued by partner agencies and the Board is beginning to develop more robust processes for evaluating its impact. Appropriate and up to date policies and practice guidance are in place for all key areas of child protection activity and the Board has developed and overseen improvements in multi-agency responses in some important areas such as missing children and child sexual exploitation. The Board has recognised the need to review its performance management arrangements to ensure partners are held more fully to account particularly in identifying and addressing areas requiring improvement.

41. The recent changes in Staffordshire have required careful and considered workforce planning. Strong partnerships within the council have enabled significant numbers of staff from a variety of professional backgrounds to be co-located within LST's and work to a single skill set and competency base. Robust needs analysis of the local community in Staffordshire has enabled resources to be shaped to local need. The council recognises that more work is needed to get the best out of the different cultures, approaches and working arrangements which went into the LSTs and to assure the quality of the services that are being delivered to children and families.

42. Managers are provided with monthly performance information that is timely, specific and focused with an appropriate balance of national and local performance indicators. Performance management is hampered by data reliability issues but managers are aware of these and work hard to overcome them and overall managers do have a good understanding of service pressures and performance. This is shown, for example, by improvements in the timeliness of section 47 enquiries and child protection conferences and the reduction in child protection plans in operation for two years or more. However, while performance

management data has been used to monitor the impact of incomplete and overdue section 17 assessments, insufficient progress has been made in addressing the underlying causes of this poor performance. Improvements in quantitative performance in other areas have been accompanied by improvements in service quality. For example staff supervision is not only taking place more regularly but is also more likely to include opportunities for critical reflection. Robust case auditing including both regular and thematic auditing and re-auditing has helped drive these improvements. However the local authority recognises that more work is required to fully embed regular auditing and to complement its own auditing with multi-agency case auditing.

43. The local authority has undertaken a number of key consultations with children, young people and their families, including consultation in relation to the Families First programme developments, the experiences of children who go missing and SSCB consultation that has resulted in the creation of Youthbox, an online resource offering help and advice to young people. A survey of parents' experiences of child protection processes produced a relatively high response and provided useful feedback. Its findings have been used to improve services by, for example, ensuring social work reports are shared with families in good time before a child protection conference. There is much less evidence of the views and experiences of children and young people being collected and used directly to inform improvement of child protection services.

44. Workforce data in respect of social work staff indicates low vacancy rates and relatively low use of agency staff, although recruitment of additional experienced workers remains a challenge. Recent turnover of social workers and managers is low and workers who spoke to inspectors showed enthusiasm and commitment to working for Staffordshire, despite the considerable workload pressures some of them were experiencing. Caseloads in SSUs differ significantly and range from the manageable to extremely demanding. Overall, while some progress has been made to reduce caseloads they remain too high and as a result, despite working long hours, some staff are unable to adequately complete some of their child in need work.

45. Training programmes designed as part of workforce development include a strong focus on learning and continuous improvement and are having a positive impact on service quality. Discussions with staff seen by inspectors demonstrated the impact of learning from serious case reviews through, for example, the emphasis on the importance of assessments being analytical and focused on risk. Key learning was also reflected in practice examined by inspectors. Good practice is supported by intelligently designed tools and forms such as those developed for conference reports and child protection plans.

Record of main findings

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