# Inspection of local authority arrangements for the protection of children

## London Borough of Sutton

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**Inspection dates:** **13-22 May 2013**
**Lead inspector:** **Wendy Ghaffar HMI**

**Age group:** All

Website: www.ofsted.gov.uk


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## The inspection judgements and what they mean

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

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|---|---|
| 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 the London Borough of Sutton 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 the London Borough of Sutton, the local authority and its partners should take the following action.

**Immediately:**

- ensure that the recording of strategy discussions and Section 47 enquiries demonstrates appropriate multi-agency information sharing to inform decision making to protect children and young people.

**Within three months:**

- ensure that all children who have been assessed as children in need have a written plan in place to enable professionals to coordinate their activity and manage risk effectively
- ensure that supervision provides opportunities to reflect and analyse case work and that this is represented in the recording of supervision
- ensure that recent improvements in the quality of assessments are consolidated so that there is consistency in practice across teams and all assessments clearly address all relevant aspects of children's needs
- ensure that all assessments are quality assured effectively by first line managers

- ensure that chronologies are up to date and are utilised effectively in decision making and in the transfer of cases

- ensure that social work reports for case conferences are shared with parents prior to the conference so that parents can effectively engage in, and contribute to, case conferences

- ensure that appropriate systems are in place to gather and analyse data and information on missing children and children at risk of sexual exploitation, so that patterns and trends can be identified and used by agencies to inform intervention, service planning and delivery

**Within six months:**

- ensure there is a sufficiently stable workforce to fully embed the improvements in practice achieved since the last inspection

- develop systems to routinely collate feedback from parents, carers and children who have been in receipt of social work interventions to inform and develop practice and service provision

# 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 (LSCB). 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) and one local authority secondee.

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

# Service information

9. The London Borough of Sutton has approximately 45,240 children and young people under the age of 19 years. This is 23.8% 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 34% of the total population, compared with 16.3% in the country as a whole. The largest minority ethnic groups are Asian/Asian British (13.5%). The proportion of pupils with English as an additional language is above the national figure.

10. At the time of the inspection, 176 children were subject to a child protection plan. Children's social care services were providing support to 1400 children and young people in total.

11. Early help and support is provided through a variety of services including 14 children's centres plus the Early Intervention and Prevention Service (EIPS), Families Matter (Sutton's response to the national Troubled Families programme), the Joint Adolescent Service and the Youth Service.

A range of commissioned targeted services also provides early help and support.

12. Initial contacts with children's social care services are managed by the recently established Multi Agency Safeguarding Hub (MASH) as well as some that go directly to the children with disabilities team. Those identified as requiring further social care assessment are transferred to one of the three referral and assessment teams. Children and young people who are assessed as requiring social care support or protection then transfer to one of the Family Support and Care Planning teams, the Joint Adolescent Service or the social work team at the Sutton Family Centre.

# Overall effectiveness

## Adequate

13. The overall effectiveness of arrangements to protect children in the London Borough of Sutton is adequate. Children who are at risk of harm are protected through effective action, and the Director of Children's Services (DCS) and senior leaders, supported by elected members, have made significant improvements to practice and service delivery since the inspection of safeguarding and looked after children services in April 2012. Service improvement has been given high priority. A wide range of audit activity has provided an extensive evidence base, which has informed the development of the improvement plan. Middle and senior managers have established a clear overview of strengths and weaknesses in practice across social work teams and are embedding a culture of high expectation, high challenge and high support. However, managers have yet to be fully and consistently successful in improving the overall quality of outcomes for all children. Senior managers have worked hard and effectively at drawing together political and other agency support for early help, for the MASH, and for external commissioning. Senior managers have set out a robust set of expectations for performance and the quality of service, with extensive, valued training and mentoring for staff, which has begun to have an impact.

14. Some frontline teams are over reliant on locum staff, which means that some children experience too many changes of social worker. The initial robust action by senior managers to ensure a motivated and able management group was essential but a recruitment and retention strategy with enhanced terms and conditions for social workers has only recently been agreed. The delays by the council in agreeing to fund this initiative have impacted on the progress of the plan to secure a stable workforce.

15. The quality of practice is improving across all teams and within child protection conferencing processes. This results in many children, young people and their families benefitting from an improved service and better outcomes. Children and young people at risk of harm are quickly identified and promptly referred to children's social care services by partner agencies. However, inspectors found examples of drift in a number of child protection cases; this is now being identified in audits and challenged in conferences, and is resulting in appropriate action to ensure that plans are progressed in a timely way. The cause of drift in cases seen by inspectors is mostly as a result of high turnover of and frequent changes of social worker, meaning that plans do not always make the progress that they should. In addition, some children in need plans are not being agreed and implemented in a timely way.

16. Rapid progress is being made in the functioning of the LSCB since the appointment of the new chair in 2012, with evidence of a sharper focus on core child protection practice. For example, the development of a multi-agency reporting data set is now underway, enabling members of the Board to challenge and hold partners to account. New tools are under development to consider qualitative monitoring of work and reporting, working toward an outcome-based approach. Learning from the most recently published serious case review has been effectively disseminated, with evidence of improvements in practice.

17. The early intervention strategy is in place but is at an early stage of implementation. The Early Intervention and Prevention Service and Integrated Services for Children and Young People provide clear early support targeted through a joint resource panel; a wide range of early help provision including children's centres is available. However the council recognises that there is more work to be done. Outcome data in relation to the common assessment framework (CAF) is not currently collated and used to target services. The need for more targeted services is recognised by the council, with the first stage of plans to develop a locality model of early intervention provision and targeted preventative services due to be implemented later this year.

18. Performance management and some aspects of quality assurance are now well established in the council, with regular reporting of performance to senior leaders and elected members. In addition, the DCS, senior managers and the Chief Executive undertake audit activity and case file scrutiny to examine the quality of a wide range of aspects of practice. Team managers and social workers spoken to during the inspection welcomed this level of scrutiny and recognised that there are high expectations in relation to their practice. All of these activities combine to give the council and senior managers a good understanding of areas of strength and areas for development. However, feedback from children, young people and their families is not routinely collated so there is little evidence of their views informing service delivery and design.

19. Management oversight in some areas of the service is variable in quality, with evidence seen by inspectors of assistant team managers signing off assessments that were insufficiently analytical and that did not address all aspects of children's needs. This results in a small number of cases where interventions are not sufficiently well focused, allowing the potential for drift and delay.

20. The council has taken action to improve the quality of supervision since the last inspection. Social workers receive regular supervision and report that managers are available and accessible for support and advice. The quality of supervision is adequate overall but remains an area for further development. Most examples seen by inspectors focused on case

discussion and direction, although there were examples of supervision that was reflective, analytical and challenging for staff.

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

### Adequate

21. The effectiveness of the help and protection provided to children, young people and their families and carers is adequate. Effective action is taken to protect children at risk of harm and there are examples of parents and children benefiting from early help provision, for example through children's centres. Whilst there is a range of valued early help services, the early intervention strategy is at an early stage of implementation. Plans are in place to develop more localised pathways for referral into early help services through the establishment of a locality model of early intervention provision and targeted preventative services. The first pilot for this model of working is due to begin in September 2013.

22. The quality of CAFs sampled by inspectors was adequate. The CAF is embedded across services, with engagement from a range of partners including health, children's centres, education and the voluntary and community sector (VCS). However, a recently commissioned independent review of the use of CAF found that further training to develop the process as a sharper assessment tool is required. The recommendations of the review are currently being implemented by the council. A CAF impact tool has recently been piloted and the results from this pilot demonstrate improved outcomes for most children and young people. This impact tool is being rolled out to all providers using CAFs, with appropriate support for its implementation. However, there is not as yet a systematic or consistent approach to the collection and analysis of outcome data in relation to CAFs across all services. Senior managers are aware of this and are working on improvements to ensure that this data is collated and used to target services through, for example, the services for the first locality area to be established.

23. In the last year, a number of services have been reviewed to improve their effectiveness. For example, there has been a fundamental review of Child and Adolescent Mental Health Services (CAMHS) to ensure clearer pathways for referrals into this service and this has been effective in reducing the waiting time for children and young people to receive a service. Commissioning arrangements with the VCS have been reviewed to ensure that services are commissioned and targeted appropriately to meet local need. Early help for older children and young people is increasingly being set in the context of continuing support in order to reduce barriers to achievement. The local authority is leading on training and supporting

Emotional Literacy Support Assistants in Sutton schools. This increases the capacity of schools to minimise the impact of emotional difficulties within the school context. Help for young people is available through services such as such as the 'You Think' programme led by the Youth Offending Team. An example of the impact of this service is a reduction in the number of young people becoming first time entrants to the criminal justice system following targeted work with them and their families.

24. The basis of the early help offer is the council's Early Intervention Strategy, which provides the vision and aims for the service. Targeted support is developed through a multi-agency resource panel and is based on analysis of need using a range of measurable indicators and other data. This includes an increasing role for children's centres as a hub for support within localities, and providing specialist roles in health, parenting and child development. The panel enables good coordination of services between agencies to ensure that children and young people receive a service early in the emergence of a problem. Services offered to families are proportionate to risk and partner agencies report that the panel is resulting in a more timely and coordinated response from agencies in meeting the needs of children and young people.

25. Children's centre managers and head teachers report that children's centres and schools are now more involved in child protection work; for example, child protection plans include the monitoring and attendance at children's centres, where relevant.

26. Since the inspection in 2012, there has been a very clear drive by the DCS and his senior management team to ensure that help given to children and families is proportionate to risk, and that in those cases where drift is identified, children's needs, including the need for protection, are re-assessed. Following the 2012 inspection, an external agency was commissioned to audit all child protection cases and looked after children cases and an audit was undertaken of a sample of child in need cases. As a result of this focused work, the number of children subject to child protection plans has reduced as some have been stepped down to child in need plans and others have progressed appropriately to become looked after children. During the inspection no children were identified who were unnecessarily subject to child protection intervention.

27. In most cases seen by inspectors where children were the subject of a child protection plan, there was evidence of regular activity to ensure that outcomes improved. However, there is still evidence of drift in a small number of child protection cases, although this is being robustly challenged in child protection conferences. The cause of drift in those cases seen by inspectors is mostly as a result of high turnover of staff in the family support and care planning team, where frequent changes of social worker are negatively impacting on the timely progress of some plans. There is evidence of robust child in need planning in some areas of

the service. For example, most children receiving support from the family centre and the joint adolescent service benefit from services that are well planned, reviewed and responsive to their needs. However, practice is too variable across the wider service, with a small number of cases seen by inspectors where child in need plans were not completed in a timely manner. The council is aware of the issue of variable practice and has recently employed a worker to drive improvements in practice in this area of work.

28. Whilst most parents spoken to during the inspection were positive about the help they receive, a small number had concerns about frequent changes in social worker related to high staff turnover. This was impacting on parents' and children's ability to form effective working relationships in a small number of cases. Most parents who spoke to inspectors during the inspection reported that they understood the purpose of interventions and plans, even in situations when there was disagreement about the decisions to make their child subject to a child protection plans, and they understood the potential consequence should plans not be adhered to.

29. Some child protection investigations, assessments and social work interventions demonstrated good and sensitive work, where issues of culture, religion and gender were addressed well. Inspectors found examples within the children with disabilities team of social work practice which demonstrated an understanding of children's individual needs with regard to their culture, identity and disability; social workers employed creative ways to engage and communicate with children, with positive outcomes.

30. Most children and young people at risk of harm are quickly identified and promptly referred by partner agencies. They are robustly screened within the MASH, which includes an education adviser to provide specific guidance on referrals from schools, as well as representatives from health, the police, probation, early help and the VCS. The establishment of the MASH team has led to an improvement in the response to contacts and the support for appropriate screening. Partner agencies comment positively on the introduction of the MASH; for example school and children's centre partners note the improved access to advice and support on safeguarding issues with the introduction of this service. The MASH operates to strict timescales for information gathering in order to assist with decision making and is clear about the type of information required from partner agencies. There has been a rise in the overall number of referrals to children's social care in 2012/13, although this is still slightly below the target set by the local authority; the majority of referrals are appropriate. Conversion of referrals into initial and core assessments in 2012/13 has increased compared to the previous year, indicating more effective screening. Multi agency risk assessment conferences (MARACs) are well established and embedded within the Borough and there is good participation from a range of agencies.

31. Appropriate systems are in place for tracking children who are missing from education and supporting those who are educated at home. Clear procedures are in place for the management of children who go missing from home and care. Notifications are sent to senior managers when young people in care are missing, and inspectors saw evidence that the DCS will track individual cases. Children who go missing are referred to Sutton Young Runaways Project and those at risk of child sexual exploitation currently receive a service from Barnardo's. Whilst there are two multi-agency groups overseeing child sexual exploitation, and training for partners on child sexual exploitation has taken place, there is little evidence of an effective coordinated multi agency strategic approach to mapping trends and patterns of children missing and/or at risk of child sexual exploitation in order to drive improvements in service planning and delivery.

32. The low number of children subject to private fostering arrangements is recognised by the local authority, which is taking steps to address this matter through revised policies and procedures, and a rolling programme of multi-agency training and awareness raising for staff. It is too early to assess the impact of these recent developments. Most children subject to private fostering arrangements receive visits in accordance with statutory guidance.

## The quality of practice

### Adequate

33. The quality of practice is adequate. There has been substantial activity and improvement work undertaken across the local authority since the inspection in April 2012. The quality of practice across all teams and within child protection conferencing processes has improved, with evidence that many children, young people and their families are benefitting from positive outcomes. However, some inconsistencies remain in the quality of practice and management oversight in a small number of cases held in two core social work teams.

34. Locally agreed thresholds for access to children's social care are understood by agencies, including those providing early help, with the majority feeling confident in their decision making regarding levels of risk and concern for children. Advice is available from qualified social workers and dedicated professionals from other agencies within the MASH to support professionals with referral decisions. In response to a lack of clarity in some of the contacts from partner agencies, the local authority has recently implemented a new referral form. This has been shared at meetings and workshops with other agencies, although it is not yet being consistently used by all partner agencies.

35. In the majority of cases, decision making regarding thresholds for assessment within children's social care services is being consistently and appropriately applied in a timely way within the newly established MASH. Domestic abuse notifications are appropriately screened by the police and most contact decisions are based upon relevant information from both the family history and agency involvement. Response to children and young people at immediate risk of harm is swift and effective. There are appropriate arrangements in place for the management of contacts and child protection concerns out of hours and there is adequate communication between the day time and out of hours service.

36. Staff within the MASH liaise effectively with the children with disabilities team to ensure the needs of disabled children are met effectively. However, the children with disabilities team currently operates a second point of contact for professionals to children's social care services which means that the MASH contact information is not currently reflective of the local authority as a whole.

37. Whilst appropriate agency checks are undertaken in most cases, the majority of strategy discussions are completed as telephone conversations between an assistant team manager and a police colleague from the Child Abuse and Investigation Team. The recording of strategy discussions does not routinely include the views of the multi-professional group working with the child and young person and therefore records do not always evidence that all relevant information has been shared to inform decision making. Detailed planning such as clear actions for individual agencies are not always evident in the recording of strategy discussions.

38. Section 47 enquiries are conducted by qualified workers and are timely, and outcomes in relation to safeguarding are clear. However, the quality of section 47 enquiry records is variable. For the majority, although the outcome is adequate and appropriate, the records lack a detailed overview of the social worker's findings from the investigation. Additionally, despite having been signed off by managers, some lack evidence of full liaison with other agencies and analysis of risk is not always sufficiently well-recorded.

39. The majority of assessments are timely and result in a direct offer of help. There is evidence of effective engagement of fathers and significant males, including grandfathers, in assessment work. However, the quality of assessments varies from inadequate to good. Examples of good assessments seen by inspectors include consideration and identification of risk and protective factors and evidence of detailed and thoughtful consideration of the child's views, wishes, feelings and experiences. However, inspectors also saw a small number of assessments that lacked detail and which were insufficiently analytical and therefore of limited help in determining where and how interventions should be focused. This results in some cases where aspects of children's needs are not being fully

met. However, there is no evidence that the poor quality of some assessments is placing children at risk of significant harm.

40. The quality of case recording is variable. There are many good examples of case recording which reflect thoughtful, direct work with children and young people, which are timely and clear. However, in some cases seen during the inspection, the voice of the child is not sufficiently evident within case records. In these cases, records are too focused upon the adults within the family rather than the child; this was an issue identified in the Safeguarding and Looked After Children inspection in 2012. Chronologies are not being used routinely to inform decision making for children and young people. As a result, in a small number of cases seen by inspectors, the full history of families is not being considered when reaching decisions regarding thresholds for intervention.

41. The majority of child protection planning for children and young people is adequate. Plans have clear actions, including actions for parents and multi-agency professionals, and measurable targets and the plans are regularly reviewed. In the majority of plans, contingency actions are also recorded. This provides evidence of significant improvement in practice since the last inspection. However, there are still some issues to address in order to produce good plans for children and their families; most plans do not identify actions for children and young people themselves where appropriate and there is little evidence of children and young people contributing to their plans.

42. There have been significant improvements in the management of child protection conferences since the last inspection. Case conferences observed by inspectors effectively analysed risk and protective factors for children and young people, identify robust plans and ensure the family and all professionals are clear about what needs to change to reduce risk for the child. In the majority of cases, there is good evidence of inter-agency attendance at core groups and child protection conferences. Colleagues from across the multi-agency group routinely provide reports for conferences and attendees at conferences are enabled to participate fully in the meeting discussion. Core groups and child protection conferences have a clear focus on the needs of children and young people and are achieving positive change. A number of children and young people have experienced drift in child protection planning. However, this is being effectively challenged and addressed in current child protection conferences. Reports to conference are not always shared with parents prior to the conference and this is impacting, in some cases, in parents' ability to prepare for the conference and to make a fully informed and effective contribution.

43. There is good evidence of information sharing between agencies within the formal settings of child protection conferences and core groups and when contacts are received by the MASH. However, in a small number of

cases, the effectiveness of information sharing is compromised by the frequent change in social worker and this can delay the progress of plans for some children. Partners describe a sense of stop/start with new social workers coming into post and this can cause delays in the timely sharing of information.

44. The quality of operational management oversight has improved since the last inspection in 2012. Management oversight is of a consistently better quality within the teams that have a more stable workforce. Quality assurance of a small number of assessments was less robust in teams with higher numbers of agency staff. Good case management directions are routinely provided to workers at the point of allocation of new referrals within the referral and assessment service and are well recorded. These contain information relating to the reason for the referral and also include direction for direct work with children and young people to ascertain their views, wishes and feelings. Case management directions at the point of transfer between workers are not routinely recorded, which is a weakness, particularly given the high turnover of staff in some parts of the service.

45. Staff within children's social care services, including members of the out of hours team, are suitably qualified. Where recently qualified social workers are working with a child subject to a child protection plan, co-working arrangements are in place with their assistant team manager to provide oversight of cases and support for the new worker. In high risk cases, systems are in place to ensure managers across all levels within the organisation, including the DCS and legal services, are appropriately taking decisions regarding the progress and planning for these children and young people.

46. The majority of children and young people receive regular visits from their social worker in accordance with their plan. In most cases, there is evidence of recording of children being seen, and seen alone as appropriate. There are a number of examples of good practice where social workers engage meaningfully with children and young people, building a positive relationship that keeps the child's views, wishes and feelings at the centre of their provision of help and protection. For a small minority of children, they have not seen their social worker according to the frequency outlined in their plan. In these cases, delay in implementing plans in a timely way was also observed.

47. There are currently low levels of participation by children and young people in case conferences. The council recognises this to be an issue and has developed a children and young people's participation project, known as the young people's LSCB, which is involving young people in developing leaflets and consultation material to support participation in case conferences.

# Leadership and governance

## Adequate

48. Leadership and governance are adequate. The council and its partners are working to a comprehensive and detailed improvement plan. The improvement plan clearly identifies the areas for development, with rigorous reporting to a variety of governance groups. The improvement plan has reasonably timely outcomes for over 90% of targets. There has been some slippage with respect to actions for the LSCB, but this is now being addressed since the appointment of the new LSCB chair. The terms of reference for the improvement board demonstrate a clear focus on three key building blocks, summarised as quality of social work practice, partnerships and the impact of the LSCB, and quality assurance and performance management. The approach is evidence based and supported by a comprehensive evidence bank.

49. Following the adverse inspection findings in 2012, the DCS and local senior managers have worked to good effect in ensuring priority has been given to service recovery and improvement. They have sought, and secured, some essential additional investment as a contribution toward addressing the legacy of poor practice and the previously unmet safeguarding and protection needs of children, with increased practitioner and first line manager staffing levels. Protection of most of the core budget, and making provision for access to additional one-off funds, have been helpful in this process.

50. The impact of the investment and focus on improving performance have not been fully evident in one of the most critical of areas: establishing and maintaining a stable, workforce. Although vacant posts are covered by locum staff, workforce instability adversely impacts upon achieving consistency of practice in some cases. For example, there were a small number of cases seen during the inspection where changes of social worker had impacted on the progress of child protection plans. However there were no cases identified during the inspection where children were left at risk of significant harm. The high use of agency staff is also resulting in higher costs to the local authority.

51. The workforce is one of relatively high experience, with most staff ranging from four to 15 years' post qualification experience. Staff report that they feel supported, challenged and motivated. Inspectors found that staff reported positively on many of the changes brought about as a result of the improvement plan and valued the practitioner workshops provided by the Executive Head, Safeguarding which they saw as improving standards of practice. Robust and appropriate action has taken place to address the legacy of poor performance of some staff, and senior managers are committed to only employing staff who can meet the high standards

expected. Political leaders fully accept the impact of staff turnover on the ability of the council to ensure consistency in standards of practice. The Chief Executive brought forward the date for the implementation of a package of measures aimed at securing a stable staff group as a direct result of concerns raised in the inspection. This includes a recruitment campaign for frontline staff with external support to secure the recruitment of team managers and an offer of permanent posts to temporary staff who are able to meet the expected standards of practice.

52. An extensive range of qualitative and compliance audit activity has provided a solid platform for understanding the nature and scale of improvement required in social care. Senior managers personally scrutinise and audit practice on a regular basis. As a result of this there is now much evidence of a sustained focus on driving up performance; for example improvements in the quality of child protection plans and significant improvements in the performance of child protection chairs, to the extent that the chairing of all of the child protection conferences observed by inspectors was judged to be good.

53. Providers, including the voluntary and community sector, report improved engagement with senior managers. For example, the DCS undertakes briefings with partner agencies and the Executive Head, Education and Early Intervention provides a regular blog to keep staff updated on developments.

54. Senior managers are clearly determined to improve practice to a high standard. Much of the focus has necessarily been on ensuring that statutory child protection requirements are met. Links between the Children and Young People's Plan, commissioning and early intervention strategies, are yet to be fully developed and the early intervention strategy is in place but is at an early stage of implementation.

55. The Chief Executive is well informed, engaged and knowledgeable about the service, and committed to driving improvements in the quality of frontline practice. He undertakes monthly audits of cases and meets regularly with frontline staff to consult with them. The Chief Executive, the lead member for children's services and the council leader all receive performance and other reports on child protection as a matter of routine. Regular and frequent meetings are held between senior officers and elected members at which performance is reviewed and the DCS held to account**.** Arrangements are in place to inform the members of the Children, Family and Education Committee and the Audit Committee of the performance of the service, although there is limited evidence that data and other information are systematically used to support and challenge senior officers about performance.

56. The LSCB has recently been effective in improving the quality of practice across the system and all key partners are committed to its work. For

example, the extensive action plan for the most recent serious case review is being implemented effectively. Messages and learning have already begun to be disseminated across staff groups, with action plans being produced appropriately.

57. The recently appointed LSCB chair has been robust in his approach to supporting and holding all partner agencies to account in the delivery of individual, joint and collective responsibilities. The LSCB has a much clearer focus in engaging partners, such as children's centres, more effectively and partners report a clearer definition of roles and responsibilities of LSCB membership. A focus of recent LSCB work was the analysis of outcome data to develop improvement strategies, which has led to a greater understanding of challenges in driving service improvement.

58. There are significant areas of work still to be developed by the LSCB, for example in ensuring effective joint understanding and a strategic response to the risks of child sexual exploitation and raising awareness of private fostering arrangements.

59. Quality assurance is supported by weekly provision of data to operational managers and substantial improvements have been achieved in applying managerial oversight, which was evident in many cases seen by inspectors. However, in some cases seen, managers had made decisions and signed off assessments that were of poor quality and that did not sufficiently evidence a thorough assessment of all aspects of risk and need. The quality of management oversight therefore does not consistently lead to improved outcomes and service provision to children, and this remains an area for development. Most social workers and managers receive regular supervision and they acknowledge that this is, at times, reflective in nature. However, supervision records are highly variable in quality and content, exacerbated by the high turnover among first line managers.

60. The voice of children and young people is only more recently beginning to be sought, identified and acted upon on both on an individual as well as an aggregated basis. The local agencies have established a range of strategies designed to place children and families closer to the centre of casework and service planning, and while much of this is clear and ambitious, it remained an aspiration.

61. Consultation takes place on a regular basis with front line social care staff and managers, with senior managers 'walking the floor' as well as directly engaging in audit activity. However, the benefits from these activities are diminished due to the high turnover of staff, currently running at an annual rate of 20% at the time of the inspection.

62. Operational staff welcome the accessible and highly valued training opportunities available, from formal post qualifying awards to targeted

development and mentoring for first line managers and child protection chairs. The current workforce is sufficiently experienced to meet the demands of the workload. However, additional pressures and demand are developing due to a combination of the legacy of previously unmet need, the changing demographic profile, and the area taking more assertive action to protect children, including seeking safe and permanent upbringing outside of birth families for a higher number of children. Managers are aware of the need for continuous review of the capacity and capability of the workforce.

# 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 |