Inspection of local authority arrangements for the protection of children

Northamptonshire

Inspection dates: **25-28 February 2013**
Lead inspector **Brendan Parkinson**

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 Northamptonshire 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 Northamptonshire, the local authority and its partners should take the following action.

Immediately:

- Ensure that effective single and multi-agency risk assessments inform decision making and management oversight and monitoring are fully in place in all cases where there are child protection concerns.
- Ensure that all risk is effectively identified, communicated and managed in the work with children and families receiving early help and preventative services.
- Review the decision-making about children and young people who have been subject to child protection enquiries not resulting in a child protection plan and all unallocated cases, and ensure all risks are fully and accurately assessed. Ensure that any necessary remedial action is taken and opportunities are taken to jointly assess any new information which may indicate an increased risk of harm to children.
- Ensure that current work within children's social care takes good account of all relevant information when delivering support within specific, measureable and time-bounded plans.
- Ensure that the experiences, wishes and feelings of children and young people are consistently, explicitly and securely at the centre of all help, protection, assessment and planning at all stages of need.

- Ensure that clear thresholds for response are understood and implemented by an out of hours service which is effective and has sufficient capacity. In particular, ensure that no child or young person is detained in police custody following charge without good reason[1] and that suitable and safe accommodation is provided whenever needed.

Within three months:

- Ensure that the pathways through which children and young people receive services are continuous and reflect the child's needs at all stages. Specifically, this should be considered in early help and prevention and in the structures that currently contribute to the increase in the number of changes of social worker children experience.

- Ensure that all children and young people who need an independent advocate, appropriate adult or supporter within the child protection system have timely access to suitably trained workers.

- Ensure that determined and effective political, professional and managerial leadership and governance are exercised within and across the public services partnerships; notably through the Local Safeguarding Children Board Northamptonshire, and that these drive continuous improvement across the whole child protection system.

- Ensure that all information regarding domestic abuse and children missing from home or care is risk assessed and communicated between key partner agencies in a timely way; and that front line practitioners fully identify those children subject to actual or potential risk of harm.

- Ensure that clear, shared and dynamic quality-based performance management and quality assurance frameworks are implemented across the partnership and within the Local Safeguarding Children Board Northamptonshire in particular, and that they are effective in identifying strengths and weaknesses, as well as in achieving, maintaining and exceeding minimum performance standards.

Within six months:

- Ensure that levels of staffing and expertise are sufficient to keep pace with need; that the right staff with the right skills and experience are in the right posts at all levels; and that these are supported by effective arrangements for workforce training, development and supervision.

[1] *In line with guidance - The Children (Secure Accomodation) Amendment (England) Regulations 2012 No. 3134*

- Ensure that children and families are routinely and effectively being consulted on service development.
- Ensure that the effective performance management framework, once in place, is used to inform all commissioning arrangements.

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 and prevention 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 two of Her Majesty's Inspectors (HMI). This followed on from a pilot inspection of a new development of the child protection methodology undertaken during January 2013 where significant concerns had been identified. That inspection included five of Her Majesty's Inspectors (HMI) and had been undertaken on a voluntary basis through written agreement with agencies in the area. It applied a methodology, framework and grade judgements in common with the current Ofsted child protection inspections.

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

Service information

9. Northamptonshire has approximately 171,200 children and young people under the age of 19 years. This is 25% of the total population in the area. While approximately 15% (25,000) of the children and young people live in the bottom fifth most deprived areas to live nationally, 33% (55,000) of children and young people live in the top fifth least deprived areas nationally. The proportion entitled to free school meals is in line with the national average.

10. Children and young people from minority ethnic groups account for 11% of the total population, compared with 16% in the country as a whole. The largest minority ethnic groups are Asian and Mixed ethnic groups. The

proportion of pupils with English as an additional language is below the national figure.

11. At the time of the inspection, some 438 children were subject to child protection plans, from a total of 4109 children formally identified as formally in need of specialist services. This was a reduction from an average of 505 children over the year 2011-12.

Overall effectiveness

Inadequate

12. Children and young people in Northamptonshire are not effectively protected from harm. There are systemic weaknesses and inconsistent and ineffective practices that contribute to children and young people at risk of harm not consistently being recognised or helped. Key partner agencies do not focus sufficiently on the potential risks faced by children and young people to ensure that further harm is prevented. Many services are process driven rather than focused on the needs of the child or young person. While a considerable number of children and young people are subject to child protection enquiries, too few have the risks they are subject to fully identified, or benefit from sufficiently robust or coordinated response. As a consequence there is now a legacy of children and young people who have been exposed to chronic, and periodically acute, harmful experiences of which some are unlikely to have been either assessed or addressed.

13. Children and young people at the highest degree of risk are mostly effectively identified by public agencies. Prompt joint action between social care and the police is taken in responding to referral information. However, all risks to children and young people are not consistently or well enough identified, assessments are not sufficiently thorough, and plans do not routinely identify the changes necessary to safeguard and protect. Too many children and young people are subsequently 'stepped down' to child in need status, or even closed, without a robust joint assessment and the necessary protective activity being undertaken.

14. The high numbers of unallocated cases, at the time of the inspection, in children's social care had not been risk assessed or prioritised. The council acknowledge this and there is a plan to ensure these cases are all allocated by the end of the inspection period. While partner agencies mostly communicate concerns to children's social care in a timely way, some are delayed, some are unclear, and with too many there is evidence of insufficient shared, joint or coordinated focused activity that achieves improved protection for children.

15. The most vulnerable children, young people and their families experience delays and discontinuities in service at all stages of work. The pathways for assessing and addressing the needs of children are often unclear to families and key universal agencies. As vulnerability and risks increase for children, it is not sufficiently clear that help is available in a graduated and responsive way. Effective signposting is too often missing. Many parents seen expressed the view that they had not been helped at an early enough stage in the development of their difficulties. When agencies do engage with children and families, constructive and helpful work is done. However, too many experience services that lack the focus, determination

and drive to deliver early, assured change. As a result, many families do receive help but often this is late, frequently slow in the pace of delivery, and too often characterised by numerous changes of lead professional. The latter results in families describing themselves as experiencing differing standards, expectations and advice.

16. Children and young people's voices from the earliest point of need throughout many public service interventions are infrequently heard. The child or young person's experience is rarely heard to a sufficient extent. Even services designed specifically to support and advocate the expression of their wishes and feelings of children and young people do not have the capacity to do so, leaving children and young people voiceless in decisions about their lives. Too few assessments reflect children's own wishes, feelings or view of their world with many being adult focused and over-optimistic about the changes or improvements that can be achieved in parenting.

17. Early help professionals seen by inspectors are committed to improving the life chances of children and young people and are keen to provide support to those vulnerable to harm. Some then develop effective plans with the parent and sometimes the child. Outcomes for some are positive, reducing the need for targeted services but for too many this is not so. In these cases there is no clear, targeted and well-implemented early help offer that flows from a joint strategy by the key agencies or supported by commissioning arrangements. While there are plans for greater attention to supporting the needs of children and young people, there have been limited achievements in building capacity or providing a coordinated strategy for universal services to deliver this support.

18. Many professionals express a lack of confidence in their individual understanding of the thresholds of need currently applied and show limited preparedness to undertake the role of lead professional in plans. Many express a lack of clarity about the threshold at which a referral for specialist social care help should be made, although almost all are clear about those for child protection. While thresholds are appropriate, having been recently reviewed, it is unclear how well-engaged partner agencies were in this. Too few children and young people benefit from coordinated prevention and early help with consequently significantly more children and young people identified as children in need than in similar authorities. Timely, sustained information sharing between agencies is also inconsistent, and while some do communicate well, this is not always the case.

19. The trend of those subject to referrals, child protection enquiries, children in need plans and those with child protection plans has been persistently upward in recent years. This had not, however, ensured that risks have been effectively managed as too many child protection enquiries are terminated prematurely, with too few being undertaken as joint

investigations. However, specifically, the numbers with a child protection plan have fallen sharply since their high point in 2011-12 without an appropriate explanation. Assessments and plans are too often not clear, thorough or focused on the risks and needs of the child, resulting in plans that do not specify the changes required to protect them. Consequently, too few children and young people are considered for inter-agency child protection plans. The high proportion of child protection enquiries that do not lead to services and the very high rate of re-referrals to social care are testament to the lack of effectiveness in addressing risk and vulnerability.

20. The child protection plans for some children cease prematurely, before full consideration of identifiable risks, or without evidence of sustained improvement. In a significant number of cases, undue confidence has been placed on the views of parents. Improvements are also required in the assessment and service coordination of other known risk factors, such as domestic abuse, child sexual exploitation and children missing from home or care.

21. The legacy of children and young people not receiving sufficiently focused help at various stages in the emergence of risk has left too many with chronic, and periodically acute, levels of vulnerability. Some are beginning to get help, although the pace of improvement in their lives remain slow. The needs of some children and young people are not well understood and their plans are insufficiently clear, leading to continued drift and, at times, in understanding and meeting their need for protection. Too few benefit from robust plans overseen effectively by managers. Out of hours services too often apply thresholds that are too high, leaving some children and young people in a vulnerable position, for example those in overnight police custody, and others in hospital or community settings.

22. Local leaders express commitments to sustaining and improving the quality of protection and services to children and young people. However, there is limited evidence of this being clearly articulated, effectively communicated, implemented well or evaluated for impact. Recent changes in key personnel in some agencies have contributed to the lack of clarity about thresholds, pathways of help or in achieving delivery of coordinated services to children. Leadership has not been effective in supporting and driving improvements in service quality.

23. Senior officers and those with statutory roles have begun to respond to the emerging findings of this inspection, although it remains too early to identify impact. The extensive turnover in staffing at all levels in social care, has contributed to a reduced management focus. Operationally, families experience working with many social workers, many of whom are less experienced, as a consequence contributing to some drift in developing and implementing individual plans.

24. Performance management in the Northamptonshire Local Safeguarding Children Board (LSCBN) is focused on data relating to compliance without a qualitative evaluation of service delivery. While draft proposals for a more robust approach are welcome, managers and leaders currently have a limited understanding of how well services help children. The LSCBN has focused on monitoring compliance with statutory duties and less on constructive challenge, drive and leadership to bring about improvement.

25. While pressures on budgets and resources are well recognised, a lack of resources has an adverse impact on some services, for example advocacy for children and in fully implementing the multi-agency safeguarding hub (MASH). For others, for example the social care out of hours service, missing children and those vulnerable to sexual exploitation, fully effective service provisions are not in place. Some service developments are taking place but are not fully coordinated, as with the contact centre, MASH and joint child protection team. The external and internal commissioning of services, including early help, is also at a rudimentary stage, with limited evidence of a clear strategy for a comprehensive early offer and services beyond.

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

Inadequate

26. There are a large number of insufficiently risk assessed, unallocated child in need cases within children's social care. Other cases seen, including child protection cases, are allocated to workers without sufficient skills to manage their complexity and significant drift was identified in implementing child protection plans. There is a consequent legacy of children who have been exposed to chronic and periodically acute episodes of harm. The immediate response to children and young people who require protection is highly variable. Inspectors saw a number of cases where children had experienced significant harm, and remained at risk of further harm as they did not receive services that ensured they are protected and risk is reduced. This resulted in children being left at risk and, in some cases, continuing to experience harm.

27. Children and young people at risk of harm or potential harm, but who do not reach the threshold for statutory services, are not consistently identified or well served in Northamptonshire. In the best early help cases seen by inspectors, children and families were listened to, engaged and received effective support in the early stages when problems and potential risks are first identified. In these cases help was well planned, responsive and coordinated, often by skilled practitioners. However, this is not the experience of all children and young people who have similar levels of need. In too many cases, children receive help that is fragmented, too late to prevent problems escalating or insufficient to meet the range of need.

Due to insufficiently strong inter-agency links, information sharing can be weak which leads to ineffective or incomplete responses to children who require help and protection.

28. The number of common assessments (CAF) completed is low and falling, particularly in schools with few health professionals or commissioned services initiating assessments. The skills, knowledge and expertise in universal services to identify and support children and young people at risk of harm remains patchy across the range of practitioners in the area. Where children and their families live can affect the support they receive as the quality of children's centres inspected by Ofsted is variable, with the majority judged as no better than satisfactory. While some schools are highly active and confident in working with vulnerable children and young people, other agencies are insufficiently engaged in the key role of lead professional. Those parents seen by inspectors were well engaged in CAF processes. Children, young people and other stakeholders have recently been consulted about revisions to the CAF and the development of tools to increase participation. These developments, while welcome, are not yet implemented.

29. Across the agency partnership, there are insufficiently effective systems supporting robust joint working to ensure that risks are properly recognised so children and young people are protected. The contribution of social care to joint working is also poor and the service has been resistant to change despite having an awareness of the shortfalls in its delivery to vulnerable children. The current service improvement plan does not make clear how improvements to referrals into social care will be secured.

30. Those experiencing persistent and/or high risks from domestic violence receive a fragmented service by agencies across the partnership. The Sunflower Centre has approved staff to work with victims of domestic violence and they provide knowledgeable and effective services in identifying and communicating risks to children in the course of their work. However, the work of the multi-agency risk assessment conference (MARAC) is not always supported by clear and effective information sharing by all agencies and this can result in delays in assessing risk for vulnerable children and their families.

31. Children and young people already recognised as vulnerable, through going missing from home or care, are not supported by a coordinated or effective inter-agency strategy. As a result, the understanding of risk to children and young people through sexual exploitation and trafficking is not properly understood and systems to protect them are, as a result, not robust. While policies and procedures for children who go missing from education have recently been revised to reflect roles and responsibilities within the local authority, these are not yet embedded. Multi-agency processes and procedures underpinning work to protect children and

young people are not sufficiently understood to ensure that all agencies work effectively together. There are limited referrals to MARAC and, as a result, victims and their families who have not come to the attention of the police do not have the benefit of multi-agency support to reduce risks to them.

The quality of practice

Inadequate

32. Children are not sufficiently or consistently well protected within the area. Professionals in a range of agencies are not confident in their understanding of the current thresholds of need. Consequently children and young people are left in unsafe circumstances if practitioners are unclear about indicators of significant harm. In the cases seen by inspectors for those receiving statutory services, the provision of early help within and across agencies was variable. Professionals making referrals are not routinely kept informed of the action proposed by children's social care. In some cases, opportunities to escalate cases to children's social care are also either not taken, or not done in a timely way, again leaving children and young people potentially at risk of harm.

33. New concerns in relation to the welfare of children are screened by the initial contact team (ICT), passing child protection concerns on this brief process. Screening is undertaken promptly and by suitably qualified staff. However, the quality of information from referring professionals is highly variable and is frequently lacking in essential information. Consultation is available through the ICT and there is evidence that this is used by some professionals.

34. Some partner agencies aim to move to a single point of contact for all daytime referrals, managed through the MASH, but the current arrangements do not serve children and their families consistently well. The service structure is not child focused, resulting in fractured pathways into social care. This can mean a child or young person having several changes of social worker and managers overseeing their case in a very short space of time. Variable decision making by social care can also lead to vulnerable children and young people being exposed to unnecessary harm and, in the worst cases, significant harm. In many cases, decision making by managers and staff does not reflect guidance or local procedures. Inconsistency in making decisions and the failure to identify and understand some risks to children and young people results in work that is not robust at times and, in too many cases, does not provide adequate protection to the children involved.

35. When identified as in need of immediate protection by the MASH, children and young people are transferred to a specialist multi-agency team. The co-location of the Police child protection staff and social workers and managers results in timely information sharing and timely strategy

decisions when undertaking child protection enquiries. Where appropriate, joint visits are made and children and young people seen, with evidence that many are seen alone. However, practitioners often have unrealistic expectations that children and young people will feel able to speak freely the first time they meet professionals. In too many cases decisions not to proceed to a child protection conference were made prematurely and without sufficient consideration of prior knowledge of parental responses. Such decisions are not subject to either routine audit or consideration by a senior manager. In those cases seen by inspectors, decisions had often been based on optimistic reliance on parental accounts and remorse, rather than robust assessment of risk and the likelihood of further harm. Enhanced quality assurance designed to improve the quality of decision-making at this point in service provision did not commence until late in the inspection period.

36. The out of hours service does not always provide an appropriate service to children and their families, with thresholds that are too high. In some cases seen, decision making does not reflect guidance or local procedures and the failure to secure detailed information and take steps to protect children and young people leaves some children open to the risk of further harm. Additionally, there is an over-reliance on police 'safe and well' checks to ascertain the well being of vulnerable children. As a result, children, young people and their families do not always receive a timely service that meets their need. Despite serious concerns, identified previously, of children and young people being inappropriately detained in police custody the position has not improved. They remain in custody as the local authority does not prioritise identifying suitable accommodation.

37. Too many assessments are of poor quality and characterised by a lack of robust analysis with a focus on actual or potential risk. The quality of CAF assessments seen varies from good to poor, with action planning a common weakness, a limited focus on measureable outcomes, and insufficient consideration of equality and diversity issues. The individual needs of children are not always considered sufficiently by social workers and, as a consequence, assessments can be too adult centred. Some examples seen describe sensitive and appropriate work by professionals in response to language and cultural risks and needs within families. However, these examples were too infrequent and in many cases the impact of religion, race, culture and language were not sufficiently considered. While translators are widely available and in most cases, ethnicity and culture are recorded, this does not consistently result in consideration of how individual characteristics are utilised within effective planning and service delivery.

38. Across and between key partner agencies, there are many examples seen of delayed or absent communication, impairing the timeliness or effectiveness of providing a joined up assessment and response to the needs of children. It was evident from cases seen that there is some

positive practice but this is not consistently recognised and then repeated in future work.

39. Across agencies, the child's perspective is not sufficiently evidenced in work with them and, as a result, does not reflect their wishes and feelings. In common assessments (CAF) seen by inspectors, it was rarely clear that children and young people have been consulted or involved as their views were not well documented. Advocacy services are insufficient to ensure all children who might need an advocate can receive one. Despite the best efforts of a highly committed staff team, there is insufficient capacity to offer a comprehensive service and it is not extended beyond the first review. There is no specialist service for younger children who have disabilities to ensure that their views are understood and their needs met. The extent to which cultural and diversity issues are considered or assessed is highly variable. The lack of awareness of cultural issues that impact on families across the partnership results in failure to address potential areas of risk in the changing demography of the area.

40. Parents seen by inspectors felt insufficiently involved in the assessment of their needs by children's social care. Some expressed frustration in changes in social worker and did not receive consistent and appropriate information from the department. Consistent efforts are not made to engage with fathers in assessments, even when they play a significant role in the child's life, whether for positive or adverse reasons.

41. The quality of child protection reports is variable, from good to poor, with many containing limited analysis or recommendations, despite being overseen by line managers. The collation and use of significant historical events is not well undertaken to inform the assessment of the current presenting risk. As a result, some children and young people have been left unprotected because assessments have failed to identify risk or, in other cases, the lack of analysis leads to poorly constructed plans that do not secure sustainable change. The poor quality of a high number of child protection reports and a lack of challenge by other professionals contributes to the poorer outcomes some children have, and they continue to experience continuing harm for longer. Where independent reviewing officers do identify shortfalls in practice this does not always lead to effective remedial action being taken. This important opportunity to evaluate the quality of work undertaken is not being used effectively.

42. Children and their families experience an inconsistent approach to child protection conferences. The 'strengthening families' approach, increasingly in use nationally is used by conference chairs but is inconsistently applied. While some social workers are able to provide information and contribute to discussions that support this model others do not. Parents report a general lack of assistance in preparation for case conferences, and having no time to read and consider professionals' reports. Children and young people are not well supported to contribute to their own case conferences

either directly or indirectly and it is a significant omission that there is no effective advocacy service to enable children to be listened to and heard.

43. Professionals usually attend case conferences but their impact in contributing to the conference is variable, as is their provision of a written report. Conferences observed identified limited evidence of professional challenge of poor practice. This, together with the lack of effective management oversight enables a culture that permits too much weak practice to co-exist alongside more robust child protection work.

44. The standard of case planning and individual case plans is poor overall. Child protection plans are not sufficiently specific, rarely containing clear timescales or articulating what needs to change for children and young people to be protected. The generic nature of plans indicates a lack of understanding of the importance of plans tailored to individual risk and need. Contingency plans are also generic and therefore ineffective. Inspectors saw a number of case files that showed a lack of response to change, with children and young people being exposed to avoidable harm, despite evidence of increasing risk.

45. Those at risk of, or experiencing, harm are not always overseen by rigorous or effective management in children's social care. Inspectors saw casework that lacked direction and sufficient focus on the needs of the child or a clear understanding of current and historical risk. For example, some children were placed with extended family in an emergency without assessing the safety of the child and likely child protection concerns within the placement. Potential kinship placements are not always sufficiently assessed for the contribution they can make for the child involved. Managers do not sufficiently focus on preventing drift in implementing plans. In some cases this has led to delays in undertaking legal planning meetings or taking other decisive action.

46. Support and help for children and young people where risks have reduced are not consistently well coordinated, timely or effective in sustaining improvement and in preventing them from re-entering the child protection system. The narrow referral criteria for the recent targeted prevention team do not include, for example, those with previous children in need plans. Despite families experiencing additional, unnecessary assessments, many have engaged positively with this team in its first few months of operation. Good examples were seen of transfer meetings from children's social care, enabling timely and confident contact to be made. It is too early to establish its impact in reducing the need for statutory services.

Leadership and governance

Inadequate

47. Leadership, governance and partnership arrangements have not been effective in driving continuous improvement across all agencies and helping and protecting children and young people. Senior leaders and elected members have not focused sufficiently on ensuring that the quality of services is effective, or that agencies are working together productively. Partner agencies have not established a shared focus on the needs of children and young people. Partner agencies express clarity about their responsibilities for the protection of children, and local leaders articulate commitment to maintaining and improving the quality of protection. However, this has not translated into services that are well coordinated, well understood by practitioners, or effective in improving outcomes for children and young people. While some improvements have been made to integrate practice, there is little evidence to suggest that agencies are sufficiently united and determined in driving improvement in providing both effective protection and early help for children and young people.

48. Some services have been significantly reshaped in the recent period to address budget economies and in response to some perceived deficits. These have had limited impact on improving outcomes for many children. An 18-month Children's Services Improvement Programme was introduced in April 2012, which has seen some positive impact such as the MASH which is now almost fully operational. There were avoidable delays in its implementation and it remains far from being effective in delivering the changes required. Through regular progress reporting, senior managers have been kept informed of risks of failure to deliver key plans and services. Very recent positive developments include a renewed vigour in the delivery of key commitments to the MASH, a projected reforming of the initial response arrangements for those most at risk and an emerging whole service improvement plan.

49. Senior managers have shown a willingness to scrutinise practice through initiating some improvements to data reporting and moving gradually towards a broader, more balanced performance reporting framework. An unintended impact of this greater focus and vigour in managing staff performance and improving poor performance has been in extensive turnover and discontinuities in operational and strategic leadership in the local authority. As a result, front line staff spoken to express feelings of insecurity. The local authority and its partners have also undertaken a major review and restructure of early help and preventive services in order to prioritise those in greatest need. However, many of the key structures, policies and procedures are at an early stage of development or have yet to be fully implemented.

50. The strategic vision for early help and preventative services including, for example, the role of new early help forums, is yet to be fully understood or shared by partners on the ground, particularly by those in universal services. The joint work between police and social care services to develop the MASH and the joint child protection team, and the development of the child sexual exploitation unit are positive indicators of a willingness to work in a more integrated way, although it is not fully functional and it is too early to identify impact.

51. The LSCBN has not exercised the leadership and challenge roles sufficiently. It has too wide a core membership as well as a limited focus on the development and delivery of sustained, high quality safeguarding services. Some agencies acknowledge that there has been a lack of leadership and strategic direction, with a failure to interrogate the quality of services. The quality assurance function has been lacking and the current value added by the board is unclear. A programme of multi-agency audits has not been established and the board relies almost exclusively on social care data rather than establishing its own multi-agency qualitative and quantitative performance framework. Some, but not all, agencies play full and active parts in the board and fulfil their statutory roles. Those that do not have not been subject to robust challenge about this. Many of the activities of the board have not been well promoted externally. For example, school staff spoken to by inspectors reported having little knowledge of the board.

52. Performance management and evaluation of safeguarding and child protection are insufficiently well developed or implemented in some agencies, including children's social care. Agencies rely on quantitative rather than qualitative information as proxy indicators of performance, and evidence of quality assurance is very limited. Similarly, there is no shared performance management framework in place to evaluate the impact of early help and preventive services. Managers across the range of early help provision cannot systematically and collectively identify strengths and weaknesses of current arrangements.

53. The development of a shared and joint learning culture across agencies is also at an early stage. Learning from serious case reviews varies across agencies. There are several completed serious case reviews awaiting publication and the learning has not been effectively aggregated or disseminated to practitioners across the agencies. To support learning, an appreciative inquiry approach is beginning to be used within the local authority, looking constructively at strengths and positives within practices, although this is at an early stage of implementation. In addition to serious case reviews, some single agency reviews are undertaken and these have led to some service improvements. However, learning is limited as feedback from children, young people, families and front line staff is not routinely collated by key agencies, or used to influence the quality of service.

54. There is currently no clear correlation between resources available, the range of interventions, and positive outcomes being achieved. Some elements of service are clearly insufficiently resourced to meet reasonable, sustainable expectations, for example the children's advocacy service, and services to work with male perpetrators of domestic violence. Concern about capacity within children's social care, at the point of the inspection, is more related to professional capacity and doing necessary things more efficiently. It was unclear what resource needs are likely to be once agencies begin to fully address the legacy of unmet need and risk. In the light of the nature and extent of the shortcomings in the area, it is likely that additional, specialised capacity will be required to ensure the range and pace of change is achieved in a sustainable way. Many professionals who spoke with inspectors felt stretched in terms of time, skill and expertise by the greater demands. Local authority commissioning arrangements, for example, with children centres and youth services, are under review and it remains challenging for providers to plan confidently for the long term when contracts with the local authority are uncertain.

55. Some local authority social work teams use insufficiently experienced staff to complement, support or mentor newly qualified workers, potentially reinforcing poor practice. The emerging use of senior practitioners is likely to assist in supporting more effective risk assessment, planning and delivery of services. Applying assured high quality managerial oversight in the critical early stages of social care intervention is only just beginning to be implemented. While current workloads for almost all practitioners are not obviously excessive, some teams continue to carry unallocated cases or allocate them to managers. The absence of an effective workforce strategy in the out of hours service has adversely impacted on developing existing staff or attracting new recruits, resulting in a small number of staff routinely working overtime.

56. Social care staff have good access to a range of internal safeguarding and child protection training. Practitioners in early help and preventative services have access to a range of training. However there has been an insufficient focus on the development of capacity and expertise and sharing learning across agencies in supporting families once they leave, or 'step down' from, statutory services. Additionally, there have been delays in disseminating the learning from several recent serious case reviews. There are currently three that are yet to be published and a further one very recently agreed to be undertaken.

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