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Inspection of local authority arrangements for the protection of children

Cambridgeshire County Council

Inspection dates: **10 – 20 September 2012**
Lead inspector **Chris Sands HMI**

Age group: All

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

Immediately:

- undertake a review of all the open cases within the temporary access team established to provide additional capacity for the three Area Access Teams in the north of the County which have been subject to the original audit to establish that all identified actions have been taken or are planned within appropriate timescales to ensure children and young people are being adequately protected

- commence a review of all section 47 enquiries undertaken over the past six months to ensure that actions from strategy discussions are clearly recorded, enquiries are undertaken appropriately and the outcomes of enquiries are clearly recorded and signed off by a member of staff with the appropriate level of expertise. This review to be completed within three months

- review practice so that in future strategy meetings are held with all relevant professionals

- review all cases where children are subject to child protection plans to ensure children are being visited in accordance with current statutory guidance
- review the performance management framework supported by themed audits to ensure robust monitoring of social work practice which is compliant with current guidance and which drives improved and consistent practice
- ensure that the workforce steering group task and finish group gives appropriate priority and focus to improving the quality of recording

Within three months:

- review the format for child protection plans to ensure that the key issues and risks are clearly identified with measurable outcomes
- improve the recording of parents' and children and young people's views within initial and core assessments, child protection and children in need plans.

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) and one local authority secondee.

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

Service information

9. Cambridgeshire County Council has approximately 127,744 children and young people under the age of 18 years. This is approximately 21% of the total population. The proportion entitled to free school meals (10.8%) is below the national average of 18.2%. The proportion taking free school meals as at January 2012 was 11.6% (nursery and state funded primary schools) 9.2% (state funded secondary schools) and 30.0% (special schools). Children and young people of school age from minority ethnic groups account for 10.8% of the total population, compared with 16.3% in the country as a whole. The largest minority ethnic group is Asian (3.5%), but there is a notable group of Travellers, of both Gypsy Roma and Irish heritage, 0.7% compared with a national average of 0.3%.

10. Cambridgeshire is a relatively prosperous county. Cambridgeshire children generally have above average health, educational attainment and life chances. However there are pockets within the county where deprivation levels exceed or equal the national average, most particularly in parts of Wisbech, Huntingdon North and the north east of Cambridge City. A particular feature of Cambridgeshire is that deprivation is spread widely across the county with 70% of children living in deprivation not living in the 30% most deprived wards. Areas of deprivation in Cambridgeshire are characterised by high levels of income deprivation (around one in three children live in families in receipt of benefits); by a high proportion of parents/carers with no formal educational qualifications; and by a high proportion of families living in rented social housing some of which is overcrowded. Children living in these areas are exposed to multiple social deprivations which adversely affect their health, educational attainment and life chances.

11. Cambridgeshire is a rapidly growing county. The 0-19 population of Cambridgeshire is expected to increase by 16.8% between now and 2031, but not evenly across the county. Some districts will see a decrease. Huntingdonshire, which currently has the joint highest child population, is facing the greatest decrease of 2,200. In contrast, child population is expected to rise by almost 10,300 in Cambridge City (from 25,900 in 2010 to 36,200 in 2031) and by 8,500 in south Cambridgeshire in the same period. East Cambridgeshire and Fenland face increases of 3,100 and 4,300 respectively. Births are expected to increase by 6.8% between now and 2031.

12. Early help services are delivered through the Enhanced and Preventative Services Directorate; 14 multi-disciplinary locality teams and 40 children’s centres provide a wide range of services and advice; 32 of the children’s centres are managed as part of the 14 locality teams.

13. At the time of the inspection, Cambridgeshire County Council was in the middle of a significant change programme in their delivery of children's social care services. Traditional social work teams are being replaced with social work units. These units, of which there were 24 in place at the time of the inspection, work to a model of shared case work by professionals within each unit which includes a part time clinician. The work of the unit is underpinned by a strong focus on systemic thinking and social learning theory.

14. The number of children subject to a child protection plan at the time of the inspection was 201 and there were 2594 children in need receiving support from the children's social care service.

Overall effectiveness

Inadequate

15. Overall effectiveness is inadequate. A comprehensive early help offer and services delivered by partner agencies combined with an extensive redesign of children's social care services into social work units which include clinicians is showing increased responses to need and improved outcomes for some children and families. However, not all children are effectively protected from harm. Prior to this inspection, child protection practice weaknesses in the temporary access team established to provide additional capacity for the three area access teams in the north of the County had been identified by senior managers. While actions were taken which included a change in local management arrangements, these lacked rigour and urgency. The council undertook an audit of 81 cases involving 164 children. This revealed significant failures to take appropriate action to ensure the safety of 29 children and young people. For these children, the council had concluded that the initial response had been inadequate leading to a concern that the council could not be reasonably assured that some children were safe. Additionally, nine cases which had been closed were referred to the integrated access team for further assessment. The council is now taking remedial action to address these failures and at the close of the inspection, had sought to ensure those children at greatest risk had been seen.

16. During the inspection, inspectors saw evidence of some good casework especially within the new social work model where, through a systemic approach, there was a strong focus on the child and the family. However, from cases tracked, case observations and sampling, case recording of significant activities was variable. For example, strategy meeting notes were not routinely evidenced on the file, the outcome of section 47 enquiries were not clearly recorded, child protection plans were excessively lengthy, core groups were not routinely recorded or did not clearly evidence a focus on progress and actions agreed at the social work unit meetings were not clearly identified or tracked consistently. Social work units were using

different risk management tools and there was an absence of a consistent risk management system for cases discussed at the unit meetings. Consistency of management oversight was an area for development in the Safeguarding and Looked after Children inspection in September 2009. The quality of recording was an area for development identified in the unannounced inspection of contact and referral arrangements in February 2011. The Council has recognised that its current social work case recording system is not an intuitive tool and sometimes hampers effective social work practice and recording. The council is taking steps to address this, including the retendering of the contract for the system.

17. Services delivered through the Enhanced and Preventative Services Directorate are well coordinated, comprehensive and are delivering improved outcomes. A wide range of early help is available, delivered through 14 multi-disciplinary locality teams, children's centres and school resources. The common assessment framework (CAF) is being used effectively and extensively to assess need and target resources with outcomes for children and families in receipt of early support often being good. Children with disabilities in receipt of the higher level of disability allowance who are not already receiving short break support have been automatically entitled to 100 hours of support services without the need for an additional assessment. This offer has now been converted to an indicative personal budget of up to £2000 to reflect the implementation of self directed support for disabled children.

18. Targeted approaches such as the multi-systemic therapy programme, the family intervention project, the high demand families programme and alternative curriculum provision are effective in improving outcomes: for example, in reducing the need for a child to become looked after, improving school attendance, reducing permanent exclusions and first time entrants to the youth justice system. Five senior social workers based within locality teams support appropriate professional oversight of cases and provide advice at locality allocation and referral meetings to seek to ensure the appropriate level of support is provided in accordance with the council's model of staged intervention (MOSI).

19. Arrangements within the multi-agency referral unit (MARU) promote effective partnership sharing of information. Plans are in place and to be realised in the very near future to increase the partnership arrangements with the introduction of community health services, child and adolescent mental health, Adults service (vulnerable adults) and the emergency duty team. The response to initial contacts by the central contact service and the integrated assessment team (IAT) located within the MARU is prompt and timely supported by a clear protocol.

20. Ambitious leadership is exercised across the council including elected members, the chief executive and through the engagement of key stakeholders. This is very clearly demonstrated through the determination to change traditional social work practice through the implementation of social work units. The investment in all staff to be trained at different levels in systemic practice is impressive. The political will to preserve child protection services and to improve them through a number of spend to save initiatives provides a strong foundation on which to complete these ambitious plans.

21. The council places a strong emphasis upon learning and evaluation with the most recent example being the cabinet decision to fund a three year dynamic evaluation of the new social work model. The use of the CAF has also been evaluated recently by the Centre for Excellence in Outcomes (C4EO) and confirms the positive impact of the use of CAF in Cambridgeshire. A very comprehensive member led review into domestic abuse has resulted in increasing the numbers of independent domestic violence advisers.

22. Through detailed profiling, the council understands the local demography well and uses this intelligence to focus services where most needed. Some good focused approaches have been taken to reduce disadvantage and vulnerability. For example, the drive to increase take up of free school meals in the East Cambridgeshire and Fenland areas which has resulted in a significant increase in children benefitting from free school meals and an increase in government funding for schools in the county. The council has also identified the over representation of children on child protection plans within the same areas and has commissioned an independent provider to establish a volunteers in child protection service with the express aim to reduce the number of children on plans.

23. The forward thinking approach by the council through their work on high demand families places them in a strong position to deliver to the government's Troubled Families agenda. Additionally, the appointment of an independent domestic abuse adviser within the MARU with a specific focus on young people aged 16 plus reflects well the very recent government announcement to lower the age definition for domestic abuse to 16 years.

24. Performance management structures are firmly in place. Quality of practice is a clear priority. However, the impact of the performance monitoring on the overall quality of practice was not clearly evident from the cases seen. There has been a strong focus on the implementation of the new social work units. However, there has been a less strong focus on compliance with their own child protection procedures and in some basic social work practice when working with the most vulnerable children.

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

Inadequate

25. The effectiveness of help and protection provided for children, young people and their families and carers is inadequate. Agencies know and understand the threshold for access to services and children are referred to children's social care for an assessment of risk appropriately. The percentage of referrals progressing to initial assessment has increased and more children's situations are benefitting from an assessment by a qualified social worker.

26. There are many examples of good social work interventions to protect children and reduce risk of harm and significant harm. In these situations children are seen and seen alone and good use is made of genograms and risk matrices to explore extended family circumstances to determine risks. However, within the temporary access team in particular, there have been significant failures in the clarity and effectiveness of social work practice at the critical point of a section 47 child protection investigation. The Cambridgeshire Safeguarding Children Board child protection procedures are not always complied with. As a result some vulnerable children are receiving ineffective help and some children known to the council are not being effectively protected.

27. Although the new arrangements for the co-location of the integrated access team in the MARU unit has already led to significant improvements in joint working, there are particular concerns about the service operation at the temporary access team. Within this one access team based in the north of the county, social work responses to ensure children are safe have been insufficiently robust. There were many examples of cases where children were not seen promptly. Procedures for recording child protection investigation decisions were not always followed by social workers and managers. Strategy discussions, section 47 child protection investigations, records of outcomes and management decisions lacked rigour and effectiveness making it unclear what factors were considered and what action was taken to confirm these children were being effectively protected.

28. In the majority of cases sampled by inspectors, children who are the subject of child protection concerns are seen regularly and social workers and clinicians have developed good working relationships with children and families to reduce risk. In a very small number of cases children are not always seen alone or young children visited more than once to explore significant harm concerns. In a small number of cases seen, children subject to a child protection plan had not been visited and seen by their social worker within the minimum expectation of one month or not seen alone when they should have been.

29. New arrangements for the management of contacts and referrals through the integrated access team aims to ensure swift action is taken to prioritise cases. However, social work decisions in the assessment of some re-referrals is hindered by a legacy of poor quality recording which does not always demonstrate how actions have reduced risks including the reasons why managers' decisions were made and cases closed.

30. Progress on most of the children in need and child protection plans sampled by inspectors is good with risks posed to children being reduced. However, practice is not consistent. In some cases risks posed to children have not been reduced and plans not used effectively to monitor progress. Child protection plans have too many actions which can reduce the focus on the identified risks and make the plans difficult to monitor effectively. Core groups do not effectively focus on the key issues or progress. The length of child protection plans have resulted in some social workers translating some of the key issues from the plan into a word document to make them easier to read by parents.

31. An analysis by the Cambridgeshire Safeguarding Children Board of children subject to a child protection plan for two years or more showed that in some cases there remains professional reluctance to de-list children combined with a lack of progress in some cases. However, effective targeting of services supported by the new social work model has helped to reduce significantly the number of children with a child protection plan. For example since January 2012 children in need teams have safely de-listed a number of children with child protection plans without a rise in number of children being subject to a second or subsequent child protection plan.

32. Social work assessments and reports to support child protection work are generally good. There are many examples of good social work interventions to ensure the most vulnerable children who need safeguarding are protected such as work to safeguard unborn children. Pre-birth assessments seen by inspectors were of good quality. Strategies to improve the quality of children's social care child protection responses are having an impact. New systemic approaches to social work and improved models of assessment such as the Barnardo's risk matrix are helping children and families receive the services they need early. Step down arrangements from children's social care services to locality teams is generally good ensuring continuity of service and progress. There are many examples of effective multi-agency work in the locality teams which is leading to improved outcomes for children and young people. Where there are sharply focused plans agreed with parents and children, these are making a difference, reducing risks and helping children remain in their own families safely.

33. Practice in the recording of children and parents' views in initial and core assessments and children in need and child protection plans is too variable. Action to implement the new systemic model of social work practice has already had an impact. Nearly all of the most recent children in need meeting minutes, assessments and plans include the views of parents and children leading to improved outcomes for children. Child protection meetings observed by inspectors confirmed that practitioners are harnessing parents' views effectively to tackle child concerns reducing risk for children. For example, initial child protection conference chairs take a rigorous approach to effectively engage and challenge perpetrators of domestic violence.

34. The capacity of independent domestic violence advisors has been increased recently as a result of a comprehensive review undertaken by the Safer and Stronger Overview and Scrutiny Committee on domestic abuse. Although many victims of domestic abuse are accessing programmes of support to build resilience, for example through the Freedom Programme, these programmes are only delivered using English speaking workers. This excludes some victims such as those living in the Wisbech area for example, from the Eastern European community. Access to therapeutic programmes for perpetrators of persistent low level domestic violence is limited and those who attend programmes have to travel long distances to access them.

35. Some parents accessing social care services report that they have received good support. Others who are reluctant to engage also recognise that they need help and support as a result of good social work intervention. These parents are being appropriately signposted and engaging targeted programmes which are making a difference such as AddAction to tackle drug and alcohol misuse. Parents accessing children's centre programmes generally do very well, including those with children with special educational needs. Parents report positively on the impact of parenting programmes which are helping them to keep their children safe supported by positive relationships with workers which helps them feel safe whilst dealing with problems. Nearly all parents who spoke with inspectors are happy with the support they were receiving and the progress their children had made. Parents who spoke with inspectors confirmed that their wishes and feelings are considered in assessments and plans and these are acted on by professionals. Most parents who met with inspectors understood what the risks and concerns were. Social workers in most of the cases seen were actively challenging parents who were hard to engage and reviewing slow progress.

36. Many parents from vulnerable groups are accessing services delivered from children's centres such as targeted services for migrant families in the Wisbech area. An increasing number of families with children in need are being encouraged to engage with local services, and efforts are made by children centres to provide both universal and targeted

services to meet the identified needs of groups living in the community, including those in rural areas and the Traveller community. Through the services of the Cambridgeshire Race Equality and Diversity Service (CREDS), good arrangements are in place to support children and parents whose first language is not English to contribute to assessments and plans.

37. Robust procedures and practice are in place to raise awareness and monitor children placed in private fostering arrangements. These arrangements are effectively monitored by the Cambridgeshire Safeguarding Children Board. Although the number of privately fostered children cases is relatively low, good publicity to promote awareness has resulted in a high number of referrals. Private fostering cases are closed promptly and others are visited regularly by an allocated social worker to ensure the children are safe.

38. Outcomes for children and families in receipt of early support are often good. Responsive services in local communities are effective in identifying and helping children and families with a wide range of needs. There are many examples of good practical work and timely support for families delivered by locality teams, schools and children's centres addressing the diverse range of needs of children and families. For example, young mums groups, parenting skills programmes, substance and alcohol awareness and home safety advice, all of which are helping to reduce risk for children so they can remain at home safely. Innovative actions have been taken to streamline access to services for children with disability resulting in better take-up of support services by families to reduce risks for children. For example, automatic entitlement to self-directed support if children are in receipt of a higher level disability living allowance and better advice on the range of services families can choose to purchase.

39. Children's centres and schools make an active contribution to supporting families they have identified as needing additional help and work closely with locality teams to provide the right support. Family workers, young people's workers and in-school support teachers work purposefully with families and outcomes are usually good. The team around the child and team around the school processes provide good arrangements for agencies to agree actions and monitor the progress made by children to ensure the help offered is closely matched to meet needs.

40. Locality teams, working in close partnership with health professionals, children's centres and schools, provide effective help to individual children and families at risk of harm. The good arrangements for coordinating the work of a wide range of agencies has a positive impact on the identification and allocation of appropriate resources to meet assessed needs of children and families within local communities.

41. The CAF is being used extensively across partner agencies to assess the needs of children to ensure they receive a service at an early stage. Partner agencies demonstrate a strong commitment to work together. This is making a positive difference by building resilience in families to meet their children's needs and reducing risks for children so that they do not enter the children social care system unnecessarily. As a result the rate of referrals to children's social care has remained stable and below that of comparators.

42. Agencies work well together to provide early help. For example, health centres, health visitors and midwives identify young parents and families who need additional help. Good communication between universal and social care teams ensures families who need support receive continuity of service when their needs change. Information sharing and the quality of reports provided by partner agencies to support decision making as children's situations escalate is also generally good. For example, reports submitted to initial child protection conferences and child protection reviews.

43. There are many examples where the use of support from the young carers service is making a demonstrable difference to improve life chances for children who have experienced corrosive relationships with adults and this is reducing risk for these children.

The quality of practice

Inadequate

44. The quality of practice is inadequate. Practice is variable across the county and there are significant concerns arising from poor practice over recent months in the temporary access team which provided a service to the East Cambridgeshire and Fenland area. In this area, a number of children have been left at risk of significant harm and, at the time of the inspection, the risks had still not been adequately assessed. In addition, a small number of cases in other areas of the county were referred to senior managers due to a lack of clarity, poor recording or concerns about decision making. In three cases the local authority accepted further work was required. For example, to improve protection arrangements for the children of one family, to address the loss of direction and drift in another and to reopen one case for further assessment.

45. At the time of the inspection the council had already established that in a large number of both open and closed cases to the temporary access team it was unclear whether children were safe because the concerns and risks originally reported had not been adequately assessed. The council's audit of all open and closed cases presents a picture of poor decision making, management oversight and practice. These included a number of significant issues which had not been carried out which would have determined risk factors and put in place

appropriate protection. For example, section 47 enquiries not being undertaken or not recorded, decisions to hold initial child protection case conferences not being taken forward, assessments to identify risks which had not subsequently been carried out and children not being seen. Some remedial action was in progress but this was not moving at sufficient pace or with sufficient rigour. The local authority's own audit of these cases had established the concerns and actions needed. Nine cases which had been closed had been referred back to the IAT to be re-opened for further assessment. For 29 children in 22 families whose cases were open to the team, the audit identified that the response to the referral and subsequent actions led the auditor to conclude that the council could not be reasonably assured that the child was safe. At the point this came to the attention of the inspectors, the cases had been evaluated and risk rated but senior managers were unable to confirm whether or not all the children identified in the audit were safe. In other areas of the county children who are the subject of concern are seen regularly in most cases. Social workers and clinicians have developed good working relationships with children and families and 'the voice of the child' is now coming through more strongly as a result of increased contact with workers through the new social work practice model. However, in a few cases children on child protection plans have not been visited and seen by social workers within the minimum expectation of one month or not seen alone when they should be.

46. Revised early intervention and prevention approaches for early help make clear the level of support available from local agencies and thresholds to access social care. Universal services, including those providing early help, make appropriate and timely referrals. Suitable advice is available to professionals in partner agencies to support them in determining whether a referral should be made to children's social care services. This includes the education child protection service, designated child protection leads in health and senior social workers in locality teams who can offer advice. The IAT also provides a 'What if' service for professionals. All enquiries of this nature are responded to within 24 hours.

47. The central contact team, the first point of contact for the public and professionals, provides a prompt and effective service. The staff are well trained for their role and are supervised by experienced staff. Working to a clear written protocol, the team takes information and signposts to other services if appropriate. All contacts which may require the involvement of the social care service are passed to the IAT for action.

48. The IAT, staffed by qualified social workers, screens referrals and makes additional enquiries, including a visit to families where appropriate, to establish whether further assessment is needed. The work of the team is generally prompt and effective. The team completes initial assessments on some cases and this work is reducing

pressure on the access units. However, this can lead to families meeting a series of different workers in a short space of time as cases may progress from the IAT to an access team and then to a children in need team in less than three months. To mitigate this, the team adopts a 'look and see' approach which results in a social worker making a specific visit toassist in early identification of support needs which can then be referred to the relevant service.

49. The overall quality of decision making in the IAT regarding contacts is good with prompt and thorough screening. In cases seen directly within the IAT, management oversight was clear at the point the case came into the team and when transferring these on. However, in a small sample of contacts closed by the IAT, whilst there was evidence of prompt and thorough screening, this practice was not consistent.

50. The quality of section 47 enquiries is variable across the county. The better section 47 enquiries include records of discussions that consider risk and protective factors well. Not all case records contained a record of the strategy discussion or a record of the outcome of the enquiry, and in several cases it was not clear whether any action had taken place. A Local Safeguarding Children Board audit identified poor compliance with the child protection enquiry procedures and all managers were advised of the outcome of this audit in January 2012. However, the examples seen during the inspection demonstrated that practice had not improved significantly as a result. Where there were child protection concerns and a strategy discussion was held, in most cases this involved only the police and children's social care services. In some cases, a strategy meeting would have been appropriate to share information from all relevant services and agencies.

51. The quality of initial and core assessments varies widely. Where good, assessments include a well-focused summary of risks and protective factors, good analysis and clear recommendations. Others had limited information and made little contribution to the understanding of the case. Some assessments seen incorrectly carried the same start date and end date. In some initial assessments that resulted in no further action further signposting of families to other help should have taken place.

52. The quality of both children in need and child protection plans is variable. Some good plans were seen during the inspection, but many lacked a clear focus on risk, and were unclear regarding outcomes. Plans are shared with families but it is not always clear to families what they need to do or what the consequences of failing to do so are and, in some cases, contingencies are too general. Plans are not always effectively reviewed within core groups or child in need reviews, and discussions concentrate on updating events rather than a rigorous reviewing progress of the specific actions resulting in a lack of focus to ensure the plan and core group members contribute

effectively to identified areas for progress. The introduction of the new meetings proforma in April is contributing to improvements.

53. Attendance by partner agencies at the regular children in need meetings, core groups and child protection reviews is good and information sharing is effective. Investment in dedicated minute takers has improved practice. Child protection conferences are effectively chaired with good engagement with parents in the meeting. Reports presented to the conference support effective decision making. In one review observed parents confirmed that all the reports were accurate. Children's views are not always reported at core groups and child protection reviews.

54. Most staff in the access and the children in need units describe the weekly unit meetings as challenging and beneficial. These meetings provide the opportunity for unit members to discuss cases within a systemic approach and case work practice. As such, these meetings take the place of the traditional model of case supervision between the case holder and manager. Regular individual supervision is undertaken by the consultant social workers. Supervision of locality team workers involved in early help, prevention and intervention is provided regularly by line managers in localities. Workers report feeling supported by the arrangements especially where cases are causing them concern.

55. Within the social work units, cases are routinely discussed at least once a fortnight and, in most instances, every week. Most of the unit meetings observed were of a good standard overall, well led by the consultant social workers with good participation by all unit members. The involvement in the meetings of clinicians brings a valuable additional perspective. The children's current circumstances are described well and in most cases unit members have a good understanding of children's wishes and feelings. However, in some meetings actions referred to at the previous meeting were not routinely reviewed and actions arising from the discussion were not summarised to make it clear who would do what. Many of the actions agreed did not have set timescales.

56. The quality of recording is too variable, for example regarding the purpose of the visit, what the worker observed, and how what was seen contributes to the progress of the work. In some cases seen significant events such as core groups and visits to children were missing. Case chronologies are not always consistent and comprehensive, which impedes capturing a coherent picture of significant events. Recording was an area for development in previous inspections and has more recently become a focus for attention through a task and finish group set up by the workforce and development board.

57. There are good communication links between daytime services and the appropriately resourced emergency duty team which provides an effective response out of hours. Information sharing between agencies is effective. Schools, for instance, value the increased understanding arising from having named social workers with whom to discuss issues. The role of the unit co-coordinator is pivotal to effective communication between service users, agencies and the units. The co-location of agencies in the MARU is leading to good information sharing and improved joint working.

58. CAF assessments are appropriately targeted and are usually informed by a good understanding of individual need or family situations, and the child's strengths and needs. These assessments result in a timely and appropriate offer of early help, using a wide range of accessible professionals and agencies. The CAF is increasingly used well to identify individual or family needs and agree the kind of additional help needed. Families are involved in discussions about the practical support they feel they need. The practical and focused support of family workers and young people workers are instrumental in the success of many plans leading to improved outcomes, including improved school attendance and behaviour, reducing the need for the involvement of more targeted or child protection services. There are good multi-agency arrangements in place for the access team to step down cases to locality teams and step-up cases through the team around the child (TAC).

59. The council has an established and suitable advocacy service which supports children who are engaged in child protection conferences. Young people have good opportunities to use this service.

Leadership and governance

Adequate

60. Leadership and governance is adequate. The council is in the middle of introducing an ambitious programme of redesign to its social work services through the new social work model. Comprehensive workforce planning, supported by a strong development programme, underpins firmly the implementation of this new social work model. The challenge to appoint to consultant social work and clinician posts within the new structure has affected the original timescale for full implementation. However, this has been risk assessed and plans put in place to mitigate these risks. Partners have been kept well informed of the changes and schools report increased proactive social care contact within school since the introduction of new social work model. It is too early to evaluate how well the approach is impacting upon improving outcomes for children in Cambridgeshire. However, a recent decision by the cabinet to fund a three year evaluation of the new social work model demonstrates a keen interest in evaluation and

learning and to ensure that the model is being effective and delivering improved outcomes.

61. Senior managers have a good understanding of strengths and areas for further development which has been informed more recently by the peer review. A revised performance framework in children's social care has been in place since April 2012. Performance boards are appropriately chaired by senior managers and the framework is clearly outcome focused with an emphasis on the quality of practice. Suitable arrangements are in place to ensure that the board considers information and analysis from a variety of sources. However, due to the introduction of the new performance framework, it was not evident from the cases seen during the inspection that the information provided to the performance board was having a discernible impact to improve practice. For example, audits undertaken by the authority identify many aspects of the significantly variable practice found by inspectors.

62. Whilst the programme for the transformation of social work practice is the primary vehicle to improve the quality of practice, there remain a number of practice deficits. As a result, a number of areas for development identified in the unannounced inspection of contact, referral and assessment services in February 2011 remain and social work practice is too variable. While senior managers recognised and took swift action to respond to capacity issues in the Access service, practice issues that have subsequently been identified within the temporary access team were not addressed with sufficient urgency and rigour to ensure that children's needs were assessed in a timely manner and swift action taken to reduce the risks presented.

63. A well-formed early help strategy is in place informed by good local knowledge and profiling and is understood and effectively delivered through local areas. Well established multi-agency partnerships are successful in providing a wide range of support services that are alert to identifying children and young people at risk of harm. The Education Child Protection Team provides highly responsive support, guidance and advice to schools developing their confidence and skills in managing risky situations and when to refer cases to social care.

64. The devolution of funds to local areas provides flexibility in the commissioning of services to meet established local need and make a difference to children and young people's lives. The role of locality managers in coordinating the work of agencies results in good communication and positive relationships in meeting the sometimes complex needs of families. Universal services work effectively in partnership with locality teams to assess need, identify appropriate early help and review the range of provision. Where issues arise, such as the bureaucracy of the CAF process, the council responds positively to service users' views to revise agreed protocols to better meet effective partnership working.

65. The MARU demonstrates clearly the effective shared local strategy. The MARU currently has partner representatives co-located from police, children's social care, independent domestic and sexual violence advisors and Women's Aid. Adult social care is soon to be represented as are housing and health. This service provides a coordinated point of access for professionals who have concern about children and vulnerable adults. The commitment by the council to promoting partnership working is well demonstrated by their funding of two community health workers within the MARU on a six month pilot basis.

66. The Cambridgeshire Safeguarding Children Board (CSCB) meets statutory requirements and is effectively chaired. The most recent annual report is comprehensive providing an overview of statutory duties undertaken and provides some analysis of effectiveness and identifies challenges going forward. The four point business plan is clearly focused on these identified challenges. Particularly good attention is given to the analysis of private fostering activity. Performance information is provided to the CSCB on a quarterly basis. This identifies trends and provides analysis and hypothesis for changes in trends as well as areas for follow up attention through the quality and effectiveness sub-group (QEG). The CSCB business plan identifies the need to strengthen the CSCB quality assurance framework. To assist with this a performance manager was appointed to the CSCB in April 2012. Immediate work is focused on developing a child sexual exploitation strategy which is not yet in place. A range of activity demonstrates that lessons learned from serious case reviews are disseminated and embedded well into practice.

67. A wide range of participation activity is undertaken across the children's directorate and service user feedback is central to commissioning contracts. The 'Talk and Change' group is a group for young people who are subject to child protection plans. This group is consulted on a variety of strategic issues by the CSCB. The council acknowledges that they are still to involve children, young people and their families in a systematic way in the development of services. Management of change and the implementation of the new social work model have been well led resulting in a very positive response to a recent staff wellbeing survey about the direction of the service, leadership and management, learning and development.

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	Adequate