Inspection of local authority arrangements for the protection of children

Calderdale Metropolitan Borough Council

Inspection dates: **3-12 December 2012**
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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.

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

Immediately:

- ensure the local authority's action plan for the first response team is implemented as a matter of priority, to ensure the effective functioning of arrangements for contact, referral and assessment
- ensure that all section 47 enquiries are compliant with child protection procedures and no enquiry results in drift and delay
- review practice and procedures for pre-birth assessments to ensure that when required timely and effective plans are in place for the unborn child
- ensure that social workers undertaking child protection work are suitably experienced and caseloads are commensurate with their experience
- ensure all cases closed at the point of contact/referrals, including those that require a step down to further support, are not signed off by managers until all actions have been completed
- ensure that chronologies are up to date and are utilised effectively in the assessment process

- ensure that all plans in place are specific, measurable, attainable, relevant and time limited (SMART)

- ensure that information about children missing from home is collated, analysed and shared appropriately to establish current trends and provide focus to the management of risk

- ensure children subject to child protection plans have access to the advocacy service and their views and wishes are fully considered in decisions affecting their lives.

Within three months:

- improve the understanding and focus of front line managers on the role of performance monitoring in improving the quality of service

- reduce the caseload sizes of social workers within the first response team and ensure that practice supervisors are able to fulfil their role as non case holding supervisors of social work practice

- ensure that the co-working arrangements between experienced workers and newly qualified social workers provide for clear accountabilities and responsibilities in work undertaken

- improve communication within the sexual exploitation operation group and ensure clarity around the respective roles and responsibilities of partners, so that children known or assessed to be at risk receive appropriate levels of intervention

- ensure that the arrangements for delivering the council's offer to newly qualified social workers (NQSWs), in particular reflective supervision and developmental opportunities, are routinely monitored and rigorously adhered to

- ensure that the practice improvements contained in strategic plans are well understood and consistently delivered across the partnership.

Within six months:

- further develop the understanding by elected members of the child's journey from early help to child protection to enable a greater comprehension of and aspirations for the holistic needs of children and families.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

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

7. The inspection team consisted of six of Her Majesty's Inspectors (HMI).

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

Service information

9. Calderdale has approximately 45,400 children and young people under the age of 18 years. This represents 22.7% of the population, of which 10% is comprised of minority ethnic communities. Calderdale's minority ethnic population is mainly Pakistani, Indian and Bangladeshi. The Pakistani (9,800) and Indian (2,000) communities are the largest in the borough, other communities include those of Chinese, Black British and Eastern European ethnic origin; indicative figures show the latter is a growing population.

10. Calderdale is ranked as the 80th of all local authorities on the 2010 Index of Multiple Deprivation, compared with 71st in 2007; it is estimated that 10,050 children and young people are growing up in poverty.

11. Referrals to children's social care are managed through the first response team, which includes a multi-agency safeguarding, screening and tasking team (MASSTT), the common assessment framework (CAF) coordinator and social workers undertaking initial assessments, section 47 investigations and core assessments. Following assessment, cases requiring child protection or child in need support are transferred to one of

four locality teams or the disabled children's team (DCT). The teams are linked to commissioned specialist services, support services for young people at risk of sexual exploitation and missing children. Oversight and coordination is provided by sub-committees of the Calderdale Safeguarding Children Board (CSCB). Referrals which require a multi-agency response, but do not meet the threshold for children's social care, are considered by one of the four early intervention panels in localities. These panels have developed a collaborative model of providing services, which includes health partners and schools, to access and coordinate a range of early intervention services. Services provide a continuum of family support; through 16 children's centres on 21 sites, the families matters team, the Family Intervention Team, the targeted youth support team and targeted youth offending workers.

Overall effectiveness

Inadequate

12. The overall effectiveness of the arrangements to protect children in Calderdale is judged to be inadequate. This is an authority under notice to improve following an Ofsted inspection of safeguarding arrangements in 2010. The Director of Children's Services (DCS) appointed in April 2012 has appropriately established the foundations for improving the service, albeit from a previous low base where children and young people were not consistently protected. Whilst this has overall improved safety for children and young people in Calderdale, there is more to do in relation to improving the quality of child protection practice, particularly in the first response team to ensure that social workers consistently deliver robust risk assessed interventions.

13. Clear strategic vision and leadership are in place, and these are underpinned by an informed assessment of local need. Strategic partnerships are developing, along with a shared understanding of the journey ahead, supported by the Single Integrated Improvement Plan (SIIP) which assures sustainability. However, the pace of change in relation to the improvement agenda has been hindered by instability across the staffing structure, leading to interim appointments and an over reliance on agency staff. The permanency of the senior leadership team has only been very recently secured. Recent recruitment activity has yielded positive results but gaps in structure remain, as key appointees have not yet taken up post. Elected members have not yet developed a sufficient understanding of the child's journey to champion the vision for children and families. Strategic planning and performance management is not yet sufficiently understood at all levels so that it can be embedded to improve the quality of practice and shape service delivery.

14. The launch of the early intervention agenda in September 2012, the concept of the continuum of need, and more recently a MASSTT, is facilitating an increased understanding of thresholds across agencies, and resulting in some effective multi-agency working at a universal and targeted level through children's centres and family support teams. The use of the CAF is increasing, alongside the implementation of locality based teams. Coordination via early intervention panels is facilitating access to a range of support services either at an early stage or for those children who are no longer subject to social care intervention. The locality based teams are appropriately supported, resourced and overall are providing an adequate social work service. However, significant pressures remain within the first response team and this is impacting significantly upon the quality of social work practice. The team is not sufficiently experienced, with high numbers of newly qualified and inexperienced social workers and this means less experienced staff are managing high numbers of complex cases. Management oversight of some cases is

insufficiently robust. This leads to both the premature closure of contacts and referrals before actions are complete, and drift and delay for children and families in receiving appropriately assessed support to reduce risk. The arrangements for assessing unborn children do not ensure the timely delivery of plans for their protection. Although the council's own data shows that previous high numbers of re-referrals have recently reduced to below statistical neighbours and national average, there is not yet sufficient understanding by the council and its partners as to why this is the case. The inspection did not identify any individual children who had suffered harm as a result of the practice deficits seen. However the quality of practice was at times insufficiently robust to ensure their safety. Senior leaders are aware of the immediate action and additional staff required to ensure a robust response to child protection concerns and provided an action plan to manage this during the inspection.

15. Whilst some good examples of assessments were seen that contributed to a full understanding of children and young people's needs and associated risks, the quality of assessments overall is too variable. Risk and protective factors are not consistently well identified and analysis is not always sufficiently evident. The use of chronologies to inform assessments is hindered because they are not kept up to date and there are gaps in recording on the Children's Assessment and Safeguarding System (CASS) in some cases seen. Children and young people's views are not always well reflected in the assessment and planning process. Written plans are not sufficiently outcome focused or specific to monitor progress and to ensure that parents are clear about what needs to change. However, when interviewed parents were very clear about what was required to reduce risk for their children due to the clarity and consistency of messages they had received from the agencies involved. Advocacy arrangements are available for children and families to assist their understanding of the child protection process; however social workers were not aware of these arrangements.

16. When children and young people become subject to child protection plans, agencies work together effectively. These families are well supported by Family Intervention Teams (FIT) and a range of agencies ensuring that risk is managed appropriately by core groups and children and young people are safe. Appropriate arrangements are in place to monitor children who are missing from school and the launch of the West Yorkshire protocol for managing missing children ensures that where children are missing from home appropriate action is outlined to agencies to secure their safety. However, this is currently monitored on an individual case basis rather than ensuring that the need of and risks to these young people as a group are understood and evaluated. Joint work to reduce risk to children from sexual exploitation is not yet fully cohesive and this reduces the likelihood of children receiving appropriate levels of intervention.

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

Adequate

17. The effectiveness of help and protection provided to children and young people and families is adequate.

18. There is a suitable early help offer available to children, young people and their families. A variety of help and support is available for families at a universal level through the children's centres and family support workers are offering a range of help at an early stage. In the Early Years Foundation Stage, the gap between the performance of children of low income families and that of others of their age has reduced by three percentage points. This shows the positive impact that children's centres and nursery provision are having on raising achievement. Families can access parenting support provision such as Triple P, Stepping Stones and Strengthening Families, Strengthening Communities and help through family group conferencing. During assessments more intensive support, such as regular visits by a key worker to help the family address identified problems, is available from the Family Intervention Teams. Information gained by these workers contributes to assessments and to early planning. The Early Intervention Family Support Strategy was produced in consultation with relevant agencies and launched in September 2012. Central to its implementation are the very recently established locality-based early intervention panels. Evidence of their work to date shows that they are establishing coherent systems for providing a coordinated, multi-agency response to cases. The implementation of a common referral form and the requirement that all cases have to be brought to the panel before they can be escalated or de-escalated is helping to foster greater coherence and continuity in early intervention work. However, it is too early to determine the full effectiveness and impact.

19. The use of the CAF has had a chequered history within the borough. Some partners, notably schools, have used a multi-agency approach but have not formalised it through a CAF document. Agencies do not always inform the local authority when a CAF is completed. As a result it has been difficult for the authority to identify precisely what support some families are receiving and to evaluate the effectiveness of the interventions made. Considerable work has been undertaken recently to tackle these problems and to improve the quality of the documentation relating to CAF and the team around the child (TAC). The impact of this is seen in the improved quality of the most recently produced CAFs. However, there continues to be a lack of precise timescales and outcomes in the action plans. This makes it difficult to evaluate their effectiveness. The number of CAFs produced and of health visitors, schools and other agencies undertaking

the role of lead professional has increased and this is positive. In the past children have not received early enough help to prevent situations escalating to children's social care and there are early indications to show that following an initial increase the numbers of referrals are reducing. However, the local authority has not yet conducted a systematic analysis of the reasons for this.

20. When children and young people are clearly at immediate risk of harm this is identified promptly and appropriate action is taken in the majority of cases to investigate and reduce risk. No cases reviewed by inspectors required further immediate action to protect children at risk of harm. However, the local authority cannot be sure that risks are consistently well assessed and responded to in all cases because there is not yet a consistently robust multi-agency response within the first response team. However, there are very recent signs that this is improving through the MASSTT. In spite of some poor quality social work practice within this team, overall, children did receive a range of help appropriate to their needs at all stages of their journey. Information sharing between agencies is satisfactory with good working relationships demonstrated between practitioners at TAC meetings, early intervention panels, core groups and children in need (CIN) reviews. This ensures a proportionate response as needs and risks change.

21. Appropriate systems are in place to identify and track children who are missing from education and to monitor the safety for children educated other than at school. The secondary schools behaviour and attendance collaborative ensures coherence in processing applications for school places and managing moves to keep children in education and to promote their safety. It is less clear how this is dealt with in primary schools. Whilst no child was seen at risk, children's centre staff report long delays in placing children in primary schools. A collaborative of primary schools has recently been established. However, this only operates in one area of the authority. Adequate arrangements are in place for responding to children missing from home. The recently launched West Yorkshire protocol incorporates guidance for children missing from home, children looked after and children who are also at risk of sexual exploitation. However, the local authority and the Local Safeguarding Children Board do not currently have an overview of or collate data about children missing from home. No analysis has been undertaken of any themes or patterns as to why children are going missing which could be used to reduce risks.

22. The sexual exploitation operational group is well established and has appropriate systems in place. However, inspectors found that information sharing and monitoring of individual cases is insufficiently robust. As a result the local authority cannot be confident that risks to these vulnerable children are consistently well identified and responded to. The Children's Society has very recently been commissioned to work directly with this group of children but it is too early to evidence any impact of this work.

23. When children reach the threshold for referral to children's social care there is a wide range of targeted help and intervention provided by the Family Intervention Teams. Families receive intensive support, including individual direct work with children and for some this has been effective in promoting their welfare and reducing the likelihood of them entering care. However children, young people and their families do not consistently receive timely and focused support because plans are not specific. This hinders the planning process and has led to drift and a loss of focus in some cases. There is evidence in a small number of cases of children remaining on child protection plans for too long. In some instances managers are taking cases prematurely to the Gateway panel for consideration of care when further work to prevent this can be done.

24. The culture, language and religion of children and families is appropriately considered. Several family support workers are trilingual and these skills are used well to enable families to identify the services they need and to comment on their quality. Families of Polish and Czech/Roma heritage also receive advice and support from speakers of their languages at drop-in sessions at some children's centres. Translated information is available and there is good access to interpreters which helps parents to contribute to their assessments and planning. Inspectors saw some good examples of work with children and families which showed an awareness of and good attention to identity and diversity issues. However, this was not consistent in all cases examined.

25. Most parents seen and those who responded to evaluations carried out by the local authority say that they understand why services are involved with their families and what is expected of them. Parents say that this is because social workers and staff from other agencies spend time helping them to understand how their behaviours impact on the well-being and safety of their children and challenge them when necessary. Inspectors saw several examples of effective work and persistence by workers to engage parents and to sustain improvements made. However, parents and families also gave critical feedback about the negative impact of frequent changes in social worker, feeling that involvement of children's services had gone on longer than was necessary and that they felt powerless during child protection investigations.

26. Inspectors saw examples which showed that some children feel that the help they have received has made a difference to their lives. Intervention by social workers and other agencies has made them feel less socially isolated; prevented their offending behaviour escalating and helped them understand and change risky behaviours. The authority is developing a coherent and consistent system for gathering the view of service users from the youngest children to adults, which rates effectiveness using numerical scoring and smiley faces for younger children. Responses are generally positive. However, although the authority notes criticisms made, there is no indication of how it intends to tackle them. The system for

gathering the opinions of young people has recently been revised within Children's Services. A strategy has been agreed for gathering young people's views and this is in the process of implementation.

The quality of practice

Inadequate

27. The quality of practice is inadequate. Although early help is developing well and the locality teams are responding appropriately to children on child protection plans, currently the first response team is not functioning effectively and so the local authority cannot be confident that all children known to Calderdale Council are safe, although no individual children were identified by inspectors as having suffered harm. A number of cases were seen during this inspection where child protection procedures were not complied with and as a result risks were not fully assessed. In a number of cases referred, intervention to safeguard children on a multi-agency basis was not in place. This included occasions where strategy discussions had taken place but recommendations made by managers to convene further strategy meetings had not been followed up. Inspectors found some evidence of good practice, such as timeliness of assessment, social work visits, including direct work with children and joint working at operational level across services and partners. However, in a number of cases, plans to safeguard children on a multi-agency basis were not in place and the overall quality of practice is too inconsistent. The local authority acknowledges these weaknesses and has firm plans to strengthen management and social work capacity by urgently restructuring the first response team.

28. At the time of inspection, the MASSTT had been established that week within Halifax Police Station in response to the need to strengthen multi-agency working from first contact point but, whilst co-located, it is not yet delivering an integrated service. The MASSTT also has health representation and aims to build on established joint working relationships across the partnership. Prior to the establishment of the MASSTT, there was no joint screening of domestic violence incidents, leading to a high number of inappropriate referrals to children's social care. Early indications are that the new co-location arrangements are supporting effective processing of these incidents and understanding of the threshold for referral to children's social care. However, it is too early to evidence impact and caseloads remain high in the first response team.

29. Management oversight of social work practice within the first response team is poor overall and does not support the effective management of cases and functioning of the service. Inspectors found that practice supervisors within the first response team held a significant number of cases alongside their supervisory role. This weakened their availability to effectively manage staff. The majority of social workers within the first

response team have very high caseloads and newly qualified social workers (NQSWs) caseloads are not commensurate with their level of experience. The number of NQSWs within the team is high and equal to the number of experienced workers. This is leading to additional allocation pressure. The management arrangements across the locality and disability teams who undertake longer term work were robust overall. The locality teams have very recently restructured to support the delivery of services to families and in most cases there is effective management oversight, clear assessment of need, robust planning and quality interaction with children and young people and parents.

30. Most contacts are responded to in a timely manner and within statutory timescales. However, the management practice within the first response team of closing contacts prior to the completion of information gathering does not facilitate informed decision making or a clear audit trail of action taken. Inspectors found that some requests for assessments under the CAF were not completed even though the reason for sign-off was that a step-down to CAF was appropriate. Therefore, this meant that families were not receiving the service that had been anticipated by the manager.

31. Weekly transfer meetings held between the first response team and locality team managers are facilitating a smoother transfer between the teams. Audit of cases by the first response team manager ensures that cases are fit for transfer and no transfer is completed until a joint visit takes place which promotes case continuity for families. However, in some cases the transfer process was slow and although cases remain allocated there is potential for the previous worker to become detached from the case. In one case seen the first response team FIT worker was the only allocated worker of a complex case during the transition from first response team to the locality team and this resulted in a complex child in need (CIN) case being managed by an unqualified worker.

32. Section 47 enquiries are not always compliant with child protection procedures. In some cases this has resulted in drift, lack of robust assessments and absence of clear plans. Inspectors found that roles, accountabilities and responsibilities were not clearly defined between NQSW's co-working cases with more experienced workers. In some cases it was unclear which worker had overall case management responsibility. Management oversight of section 47 enquiries is inconsistent. In some cases, children's needs were not fully risk assessed and this resulted in delay and drift in planning timely and appropriate interventions for children and families. Other section 47 enquiries are thorough, timely and outcomes are clear, particularly those undertaken by the disability team.

33. There are suitable arrangements in place for ensuring continuity of service for children and families beyond the working day. The emergency duty team operates an appropriate service out of hours. An effective working arrangement with key agencies such as the police means that risk to

children is effectively managed. Where necessary the team undertakes child protection enquires and information about children at risk and the actions taken is shared promptly, securely and effectively with day time services. However, the local authority lacks specific provision for children and families who present as in crisis or in need of family support overnight and at the weekend. Also the gaps in recording mean that the out of hours team do not always have access to updated electronic case records.

34. Overall social workers receive frequent formal supervision and the content and quality of supervision files audited is satisfactory. Whilst some files demonstrated effective case monitoring by managers and reflective discussion this was not consistently provided, particularly in the case of some newly qualified social workers. Social workers report they receive regular informal supervision and value the 'open door' policy of managers.

35. Overall, the timeliness of assessments seen is good and the local authority's performance demonstrates sustained improvement. However, the quality of assessments is too variable and in some instances there was serious drift and delay, particularly in the formulation of pre-birth assessments. This resulted in a lack of clear and well informed planning for the safety of the unborn child in some instances. The local authority's protocol in respect of the timeframe for commencing pre-birth assessments hindered timely planning in some instances. While inspectors saw some good assessments which identified both risk and protective factors and reflected the views of parents, in some cases analysis was poor and the voice of children not sufficiently reflected or child focused. Overall the views of partner agencies were evident in the assessment process and informed analysis and decision making.

36. Children and young people are seen regularly and seen alone but not always within statutory timescales. The absence of records of some social work visits means that the local authority cannot be confident that some children are seen when they should be. Children and young people's views and comments are recorded and social workers are able to verbally demonstrate their knowledge of the children's lives. However, a frequent change of social worker for some children and young people prevents them from forming effective relationships. Children and young people are not routinely invited to meetings and inspectors found limited evidence of children and young people's views directly impacting on planning.

37. Children in need plans are of variable quality and actions and objectives set are often too vague. While inspectors saw some good practice the views and feelings of children and young people were not always evident. Child protection conferences observed were effectively chaired and attended by relevant agencies. Social work reports to conference seen were comprehensive overall but in some instances insufficiently analytical and details were sometimes incorrect. Child protection plans agreed at

conference were appropriate and parents spoken to said they understood what needed to be achieved for risk to be reduced.

38. The timeliness of reviews of child protection plans is good overall but the quality of planning is variable. While inspectors saw evidence of satisfactory plans, the objectives set in the majority of plans were descriptive rather than being specific about outcomes to be achieved and the timescale for completion. Core group meetings are held regularly and attended by appropriate partners and parents. Core groups observed by inspectors gave appropriate attention to risk, protective factors and progress made. Parents were engaged by social workers and were encouraged to participate and this helps contextualise some of the poor social work practice seen.

39. Case recording is inconsistent. Whilst some cases seen were up to date and the system facilitates the recording of children's views well, in other cases seen there were significant gaps in recording which compromises informed decision making. The individual records of sibling children are not always clear as the record of one child is often populated across sibling groups and does not reflect individual needs. Chronologies provided for legal proceedings are of a high standard. However, others are out of date; record the activity not the concerns; and are not routinely used to inform assessments. This reduces the likelihood of a well-informed assessment and a full consideration of the risks.

Leadership and governance

Adequate

40. Leadership and governance of children's services in Calderdale are adequate. Following the identification of serious shortfalls during an inspection of Calderdale's arrangements for safeguarding children in 2010 the council and its partners have been subject to a notice to improve. The Single Integrated Improvement Plan (SIIP) appropriately brings together the action plans and responses to the improvement notice, previous critical Ofsted inspections, peer reviews and annual assessments, with the overarching target that children and young people are safe. The plan comprises a wide range of measures to improve the performance of the council and its partners and is reviewed regularly with the DfE. It is suitably outcome-focused and sets clear measurable targets that are regularly reviewed and updated in the light of further findings. However, continuity in delivering the plan has been hindered by the absence of a consistent senior management team for children's social care. The Improvement Board, under the leadership of an effective independent Chair, is providing rigour and oversight to the progress of the SIIP. Additional measures have been put in place to review completed and archived actions, to ensure a continued focus on improvement whilst moving forward. Delivery of the SIIP has resulted in a range of enhanced

management processes. However, it is yet to produce hard evidence of sustained and consistent improvements to child protection practice.

41. The senior leadership team is ambitious under the leadership of the DCS, with clear vision and an acknowledgement that they need to increase the pace of change and focus on improving the quality of practice. The appointment of a permanent team of senior managers has only very recently been secured, following a lengthy period of interim appointments. The lack of a consistent senior management team has impacted upon the ability to bring about sustainable change. New senior staff with experience and track records have now been recruited, which has given the council improved confidence in delivering the vision for children, young people and their families.

42. The Council's Recruitment and Retention Strategy has been appropriately prioritised by the DCS, and is based upon a comprehensive and honest appraisal of the failure to date to achieve a stable workforce in children's social care. The strategy is supported by a detailed action plan to address these deficits, and there is significant ongoing recruitment activity, although a permanent structure is not yet fully in place. A weekly overview from Human Resources shows strong progress in reducing the numbers of agency staff in line with the SIIP. However, pressure to allocate work means that, contrary to the council's 'offer', newly recruited NQSWs are being accelerated inappropriately and carrying high numbers of cases. Consideration by inspectors of some NQSWs supervision files produced no evidence that they had received reflective supervision and although sessions were regular they were only briefly recorded, and focused on casework. It was acknowledged that 'fast tracking' is an established part of the career pathway used to attract staff to Calderdale, and this can result in relatively inexperienced workers inappropriately holding complex cases.

43. The Children and Young People's Partnership Executive (CYPPE) meets regularly and its membership are drawn appropriately from key agencies. Strategic priorities for the partnership are defined well and a suitable structure is in place, which includes clearly stated accountabilities to the Health and Well-being Board and the CSCB. The strategic planning framework is informed by a range of high level assessment information, including the Joint Strategic Needs Analysis, and appropriately determines the priorities for action in both partnership and single agency plans. Key professionals such as head teachers are supportive of the vision that has been developed. However, further work is needed to ensure a shared understanding of the mechanisms for its realisation. For example, there is more to do in relation to ensure consistent joint working, an understanding of the early intervention agenda, and referral thresholds to children's social care.

44. The role of elected members is developing, and there is a political commitment to ensure that children and young people's welfare is being promoted and that children are safe. For example, considerable additional financial resources have been invested in front line services. The Lead Member is well informed by the senior leadership of shortfalls in services, and has produced a newsletter for councillors to keep them informed about their corporate responsibilities. The Lead Member sits on the CSCB and has been fully involved in the improvement agenda. However, the sound progress in developing an understanding of corporate parenting responsibilities, championed by the Scrutiny Panel across the council, is less well developed in relation to understanding child protection. The Chief Executive has recently joined the organisation, but has already identified the need to improve an understanding of cabinet member roles and responsibilities and is introducing a performance cycle to facilitate this and promote more robust scrutiny arrangements.

45. Following an independent review as a result of the Ofsted's inspection of safeguarding arrangements in 2010, the CSCB is now firmly constituted, with an appropriate structure and membership in place under the leadership of a proactive independent Chair. Effective multi-agency partnership activities are being delivered by most of the Board's sub-groups, each of which operates to appropriate terms of reference, has a work plan in place that suitably links to the Board's appropriately focused Business Plan and is chaired by a member of the wider partnership. Firm arrangements are in place for the serious case review (SCR) sub-group of the CSCB to ensure that it is meeting statutory requirements, and given the legacy of poor safeguarding practice, the group is operating to a full business agenda. However, the impact of this improved Board structure on improvement to multi-agency working is yet to be fully realised. For example, the Board's Prevention of Harm sub-group is not linked effectively and at an appropriately senior level to children's social care and this results in a gap in oversight and challenge to shortfalls in front line social work safeguarding practice.

46. The council and its partners are committed to the intelligent use of performance information to embed a culture of continuous improvement, and a comprehensive and detailed performance framework has therefore been developed and introduced. However, performance management activity is not yet having its full, desired outcome on practice improvement and lacks rigour. For example, work to ensure child protection plans are SMART has been ongoing for some time without delivering significant improvement, and several examples have been seen during this inspection of inadequate social work practice that do not appear to have been picked up and addressed through routine performance monitoring activity, such as practice audits. Whilst there are some examples in evidence of improved performance as a result of monitoring, such as assessment timescales, these are quantitative, and an understanding by social care

managers of the impact of performance monitoring on the quality of the service is underdeveloped.

47. Robust performance monitoring processes at a senior level within the council and its partners, including both the 'herd' indicator data that goes to the Improvement Board and the CSCB scorecard, means that they are able to demonstrate a ready familiarity with the data underlying specific issues and to prioritise accordingly. Investment of resources by the council on an 'invest to save' basis, has resulted in all commissioned services being procured, contracted and monitored by a single staff team, underpinned by sound commissioning processes and delivered via suitably SMART plans, such as the procurement plan. The team work closely with partners, particularly health commissioners, to ensure a mixed market of commissioned services that knits together well. Several examples were seen by inspectors of commissioned services adding value to both in house services and to each other. However, contract monitoring remains underdeveloped; for example the contract for the advocacy service is ostensibly available to children and young people on child protection plans, but this aspect of the service has not been monitored, evaluated and promoted effectively, and as a result is under used. A clear commitment is demonstrated by the council and its partners to actively involving children and young people in decisions about services which affect their lives. Several examples were seen by inspectors of the pro-active involvement of children, young people and their parents in the design of services and of children and young people's views informing service delivery. This results in an effective and diverse set of services to local children and young people, with a shared vision which is in part maintained by the council's commissioning processes and practice.

48. A wide ranging workforce development programme offers substantial opportunities for professional development. However, it is acknowledged that previous shortcomings over retention have led to learning opportunities being repeated frequently but to a different audience, without practice improving and improvements becoming embedded. The programme is therefore particularly strong around induction, which has been appropriately identified as a key element, given the current level of recruitment and the need to build substantial numbers of present and forthcoming new starters into a stable and committed workforce. Social workers spoken to by inspectors said that training and development opportunities have helped them develop skills and improve practice. A change in culture to promote safe learning opportunities is developing although not yet fully established. A strong partnership is in place with the CSCB, whose multi-agency programme is delivered flexibly and provides significant contribution to the council's in house programme, with input such as lessons learnt from SCRs. Although not an annual report, the six monthly review of complaints demonstrates appropriate learning arising out of investigation of complaints; for example, the need to improve communication to parents.

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	Adequate
The quality of practice	Inadequate
Leadership and governance	Adequate