Inspection of local authority arrangements for the protection of children

Waltham Forest

Inspection dates: **7 January to 16 January 2013**
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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 Waltham Forest is judged to be adequate.

Areas for improvement

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

Immediately:

- ensure that child protection concerns identified within the children with disabilities team and the hospital social work team are robustly assessed and managed
- ensure that all staff receive regular, challenging, critically reflective supervision and that this is effectively recorded by managers
- ensure that management oversight within the referral and advice team and the children with disabilities team is robust and that decision making and rationale for decision making is recorded within contact and referral records
- ensure that all contacts and referrals are assessed by qualified social workers.

Within three months:

- review, revise and monitor the impact of the current recruitment strategy within children's social care to ensure that progress towards recruiting permanent high quality staff at all levels is accelerated

- ensure that management oversight and direction of case work is robust and is appropriately recorded

- ensure that the views of children and young people are routinely collected and that where appropriate these are used to inform case planning and that all case recording and assessment reflects the views and experiences of the child.

Within six months:

- in partnership with the Waltham Forest Safeguarding Children Board develop a comprehensive strategy to protect children and young people at risk of, or being, sexually exploited and ensure that it is fully implemented

- review the council's children and young people's scrutiny arrangements to ensure that they effectively incorporate the scrutiny of early help and child protection provision

- develop, implement and monitor the impact of an outcome focused quality assurance strategy that incorporates scrutiny of performance information, case auditing and other quality assurance activities

- the Waltham Forest Safeguarding Children Board to develop and implement comprehensive systems to assess, evidence and monitor the effectiveness of safeguarding and child protection practice across the partnership; ensures that multi-agency case audit of child protection work is rigorous and results in improvement in the quality of practice

- develop effective systems across early help and children's social care services to obtain, record and collate the wishes and views of children and young people about the service they are receiving and use these to influence the development of services

- ensure that children and young people are, where appropriate, actively supported to attend their case conferences and have access to an independent advocacy service

- ensure that all children's plans are specific and measurable, and regularly reviewed in order that timely interventions are based on an understanding of current risk and need

- ensure that children's identity and cultural need are fully incorporated within assessments and reflected in their 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 five of Her Majesty's Inspectors (HMI) and an additional inspector seconded from a local authority

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

Service information

9. Waltham Forest is an outer London borough with many inner London characteristics. Situated in the north east of the city, Waltham Forest was one of the five host boroughs for the 2012 Olympic Games. The borough has a population of 258,200 with 67,000 children and young people under the age of 19. This is around 26% of the total population. It is estimated that this age group will increase by 12,500 by 2021. Waltham Forest is one of the most ethnically diverse boroughs in London, 48% of residents are from minority ethnic groups. The three biggest ethnic minority groups are Pakistani (10.2% of total population), Black Caribbean (7.3%) and Black African (7.3%). The borough has the second highest percentage in London of residents from EU accession countries (9%) with arrivals to the borough coming from Poland (12,250 in the last 10 years), Lithuania (7,410), Romania (6,940) and Bulgaria (4,170).

10. Waltham Forest is ranked as the 15th most deprived authority amongst the local authorities in England. Around 11,000 children live in workless households and the proportion of children considered to live in poverty is

32.7%. There are higher than national average levels of child obesity with 21.1% of children in Year 6 measured as obese.

11. Of the 67,000 children and young people under the age of 19 years living in Waltham Forest, the proportion entitled to free school meals is 26.4% for primary schools and 27.1% for secondary schools and both are above the national average. Children and young people from minority ethnic groups account for 63% of the 0-19 population. The largest minority ethnic groups are Pakistani (15.1%) Black African (10.3%) and Black Caribbean (9.5%). The proportion of pupils with English as an additional language is significantly above the national figure. At the time of this inspection 196 children and young people were the subject of child protection plans and 285 children were looked after by the authority.

12. Early help to children, young people and families is delivered primarily through a newly configured early intervention and prevention service and 17 children's centres located throughout the borough in six clusters. The borough also hosts a number of commissioned services ranging from the family nurse practitioners and primary mental health advisors (PMHA) through to a number of community and school-based activity and support services.

13. The safeguarding and family support service is situated alongside the looked after children service and the fostering and adoption service. Contacts and referrals for children's social care are screened by a dedicated referral and advice team. Assessments are undertaken by three assessment teams, and longer term work with children in need and those on child protection plans is undertaken by a further four teams. The service also has a dedicated Hospital Team, currently based at Whipps Cross Hospital, and a children with disabilities team. All teams (with the exception of the hospital team) are based together within one central building in the heart of Walthamstow.

Overall effectiveness

Adequate

14. The overall effectiveness of local authority arrangements to protect children in Waltham Forest is adequate. Significant improvements have been made since the last inspection of safeguarding services took place in 2011. The council and its partners have a sound understanding of their services' strengths and areas that require further development and these are progressively being tackled. As a result of improvements made no systematic failures leading to children failing to be protected were identified within this inspection.

15. The Waltham Forest Safeguarding Children Board (WFSCB) now functions satisfactorily and scrutiny arrangements have been improved, however, further work is required to strengthen the challenge and oversight

provided by the Board and council members. Child protection services are appropriately prioritised by all partner agencies.

16. A wide range of family support and early intervention services are in place. These work well across the partnership and are supported by increased use of the common assessment framework (CAF), although the overall effectiveness of early intervention services has yet to be evaluated. Social work assessments and direct work with children are undertaken to an adequate standard, although the quality of practice was judged to be too variable with some inadequate and some good examples seen by inspectors. Children and young people subject to child protection plans are visited and seen regularly. Children and young people are appropriately protected through multi-agency plans and support which is well coordinated in multi-agency child protection conferences; however the quality of written plans, particularly for children in need which were on occasions too long and imprecise, requires improvement.

17. The views of children and their parents are captured within some individual cases, although it is not always evident how these are used to influence case planning. There is little evidence of the views of service users being collated and used to shape service development, although some young people have been involved in the recruitment of key appointments. The workforce reflects the wide ethnic and cultural mix of the local community and the diverse backgrounds of children and their families are routinely captured. However, it is not always evident how diversity issues are considered within case planning.

18. Performance management is underdeveloped and has focused primarily on national performance indicators, compliance and some case auditing within children's services and by WFSCB. Management information for the council and the WFSCB is not comprehensive. Local and qualitative performance measures have only recently been developed and are yet to be implemented. Management oversight and supervision has improved since the last inspection, but insufficient attention and action has been given to assessing and improving the quality of social work practice.

19. Workforce planning is based on a sound analysis of the local market. However recruitment strategies have not had sufficient impact and a significant number of social work and management posts are filled by interim or agency staff. Appropriate action has been taken by the council to ensure that only suitably experienced staff are appointed and that poor performance is robustly tackled. Staff are readily able to access appropriate training and development to enhance their practice.

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

Adequate

20. The effectiveness of the help and protection provided to children, young people and their families is adequate. Effective prevention and early help is provided by the early intervention and prevention (EIP) service established in July 2011. Individual case studies demonstrate that the EIP service has improved outcomes for those children and young people. Families spoken to by inspectors report that they feel that they have been well supported.

21. Children's centres and schools work closely with the three area-based multi-agency early intervention teams. Children's centres provide well integrated early help to children under five and their parents. Centres that have been inspected by Ofsted have, in the main, been judged to be good for safeguarding. Robust sharing of information between all partner agencies, particularly with health visitors, enables effective identification of the most vulnerable families. Children's centres are located where they are most needed and their key priorities are targeted appropriately to reach the most vulnerable children and families.

22. The CAF has been increasingly promoted amongst partner agencies over the last year and has resulted in a significant increase in the number of professionals trained to undertake CAFs in 2012. However, the effectiveness of the assessment process and its impact on improved outcomes for children, particularly older young people, has yet to be consistently evaluated. CAF assessments are well embedded in the early years services. Within children's centres the CAF is used well to support children and families most in need. Case sampling by inspectors demonstrates that outcomes for children and young people subject to a CAF have improved. However not all CAF assessments contain clear action plans and some plans did not precisely state the expected outcomes to enable families to know what they need to do to improve their situation. CAF champions have recently been identified in schools to increase the use of the CAF, particularly within secondary schools.

23. Young people are well supported through the targeted youth support service and through the adolescent support team who are involved in agreeing action plans to address concerns before issues escalate. Parents and carers are actively engaged and their views are taken into account to ensure that they understand and utilise the help that is offered, for example within 'Team Around the Child' (TAC) meetings. This has helped to improve parenting skills and school attendance and has contributed to improving the effectiveness with which young people's emotional and health needs are met.

24. The targeted youth support service also provides effective early help for vulnerable older young people and has well established links with social care services, health agencies and schools. It uses a range of local providers to support those young people identified as in need. Groups are run for disabled children aged 10 to 25, for young carers and for young people on the edge of involvement with gangs. Health programmes raise awareness of issues such as sexual health and more recently sexual exploitation through the Heart programme. However, these programmes are not systematically monitored and evaluated to ensure that they are effective in securing positive outcomes. Some good outcomes were seen by inspectors for children and young people working with the adolescent support team, and cases reviewed demonstrated that staff were highly skilled in engaging, challenging and developing constructive relationships with young people, and in supporting their families.

25. The council and its partners support many initiatives and programmes to help children and their families before issues escalate to become serious concerns. However, success criteria to evidence and evaluate the difference the early help offer is making to the life and well-being of children and families are underdeveloped. There is no coherent and robust assessment tool established to enable the EIP service to measure the overall impact of its interventions. Partner agencies report that the EIP service provides a good level of support and achieves positive outcomes for children with additional needs. Partners also report that whilst there have been improvements over the past year, the service can still sometimes be slow to respond to referrals.

26. The numbers of children who have been referred for specialist support from children's social care for a second time in 12 months has significantly reduced over the past year to 8%, which is below the national average and statistical neighbours. However, due to the lack of systematic analysis it is not clear whether this reduction is linked to the effectiveness of early help provision.

27. Where children and young people are referred to specialist services as a result of child protection concerns, strategy discussions in most cases are conducted within appropriate timescales and effective action is taken to ensure the children's safety. However in a very small minority of cases seen by inspectors, following a response to the immediate risks, a delay in holding strategy discussions and instigating child protection inquiries resulted in not all factors being considered in a timely manner. In all cases identified by inspectors the council acknowledged this and responded appropriately. Effective action is taken to ensure the safety of children during child protection inquires, for example by placing children in alternative care, with extended family members, or through high levels of multi-agency monitoring.

28. Most child protection inquiries are undertaken within the three assessment teams and almost all are undertaken to at least a satisfactory standard. However, child protection concerns for children with a disability or those attending hospital are assessed by the children with disabilities team and the hospital social work team respectively. Child protection cases reviewed by inspectors within these specialist teams were not as robustly managed as in other teams and in a few cases seen by inspectors, although not resulting in harm to the child, did result in undue delay in undertaking inquiries within child protection procedures. This was recognised by the council.

29. Where children do not meet the threshold for a child protection investigation, initial and core assessments are undertaken primarily within the assessment teams. The timeliness of assessments overall has improved over the past year and is now above the national and statistical neighbours averages, with 84% being completed within timescales.

30. Most assessments seen by inspectors identified the key issues in the case, although not all as the quality varies widely. A few examples were seen which demonstrated a thorough understanding of the child's needs and used research material appropriately to evidence impact. Some, however, were less effective and did not consistently identify the impact on the child of significant risks, for example the potential implications for parenting of neglect due to drug or alcohol misuse. In some instances this leads to child protection plans which do not clearly identify desired outcomes, timely objectives or measures of success. A few parents seen by inspectors stated that they were unclear about what they need to do to demonstrate that they are able to keep their child safe.

31. Inspectors saw a few examples of high quality direct work by social workers that engaged children in assessments and effectively sought their views, which were used to influence case planning. However, this was not consistently evident, and in some cases seen records do not evidence how children's wishes and feelings are taken into account in assessing their needs or developing a plan. Many records do not show clearly that assessments and reports have been shared with families and whether they understand the reasons for the work undertaken.

32. Most children in need plans managed by the long term family support teams are effective, following the child being removed from a child protection plan or to prevent welfare concerns escalating into child protection issues. 'Step up and step down' processes from children in need to child protection are effective in most cases. However, this is less secure within the disabled children's team, where poor planning and limited management oversight in such cases too often results in a lack of purposeful intervention, with ineffective work to improve outcomes for children.

33. Cases seen by inspectors consistently evidence that the ethnicity, culture, language and any disabilities of children involved with children's services are known and recorded. Religion is recorded less consistently. Interpreters are routinely well used to enable a clear communication between professionals, children and their families. Referrals are made where appropriate to culturally specific provision, and staff report that these are readily accessible. Individual case recording within children's social care services does not provide a picture of how well children, young people and their families feel they have been helped or their views of the effectiveness of the services that they receive.

The quality of practice

Adequate

34. The quality of practice is adequate. Thresholds for accessing services and for referring concerns are generally understood by partners and this has been strengthened through multi-agency training. The EIP team and TAC provide appropriate early intervention support to children and families to prevent concerns for the welfare of children escalating. Where such concerns increase they are appropriately referred to social work assessment teams.

35. The majority of contacts and referrals received by the central referral and advice (RA) team are progressed in a timely manner. In most cases appropriate decisions are made in relation to the level of concerns being presented, with child protection concerns appropriately progressing for assessment. Assistant social workers are tasked with gathering key information and giving advice to partner agencies. On occasions, when there has been a shortage of qualified social workers available, social work assistants have, in cases judged to be low risk by the manager, assessed needs and risks presented by members of the public attending the office. This is not acceptable as it does not consider the importance of an analysis of need being undertaken beyond the presenting problem by a suitably qualified and skilled social worker.

36. Partner agencies make appropriate referrals to social care services, with good information sharing from the police, schools and health services in most cases. However, a high number of police referrals under the category of domestic violence are made, many of which do not meet the threshold for social care. This creates additional pressures for the RA team to screen out those that require further action. Referrers are not routinely informed of the outcomes of referrals.

37. Where child protection concerns are identified, strategy discussions are routinely held between the police and social care services. However, in some cases not all partner agencies relevant to the case are involved and this inhibits full consideration of all the background information. The overall quality of child protection investigations is adequate. The majority

are conducted thoroughly, with effective information gathering. Children are routinely seen and are seen alone, and medical interventions are progressed where appropriate. However, in a small minority of cases child protection concerns were not rigorously assessed, the full range of agency checks were not undertaken and all historical risks were not evaluated. In a small number of cases, although risks were appropriately managed, there was undue drift and delay resulted from a lack of direction and oversight from managers.

38. The quality of social work assessments is adequate, although variable. Good assessments included robust summaries of risk and good analysis leading to clear recommendations. Some assessments demonstrated good examples of direct work being undertaken and did reflect the cultural needs of the child. However, weaker assessments were seen which did not sufficiently consider the child's individual needs, and contained poor risk assessment and analysis. In the majority of cases, the child's ethnicity and cultural needs were appropriately recorded. However, this was rarely reflected and fully considered within the assessment to influence case planning. Too many assessments within the children with disabilities team, seen by inspectors, are poor and unfocused.

39. Planning and practice within the long term teams for children in need are robust and timely with clear actions and interventions being supported by partner agencies. Social workers make appropriate use of the available resources and refer families to services where needs have been identified. However planning for children in need cases within the assessment teams is not sufficiently robust. Core assessments are rarely supported by a specific and measurable child in need plan and this negatively impacts on the ability to implement early multi-agency intervention. In many children in need cases seen work was not sufficiently focused, had little analysis, and measures of success to achieve good outcomes for children were not clear.

40. Most children who are the subject of concern are seen regularly and alone, where appropriate. In most cases practice is focused on the experiences of the child and their wishes and feelings are routinely sought and used to inform assessment and planning. However, in some cases recording was too focused on the needs of the parents instead of the child. Social workers were able to describe positive relationships and engagement with children and their families. However, some cases reviewed by inspectors did not consistently evidence that social workers developed good relationships with children or that they used a range of tools and child focused communication skills to better engage children.

41. Child protection conferences are well structured and are attended by the appropriate partner agencies. Conferences are effectively facilitated by experienced conference chairs. Risks to children are thoroughly explored and there is a strong focus on the child's on-going needs. Most agencies

participate regularly but the quality of the contributions by partner agencies at conferences, both written and orally are variable. Written reports are not routinely available until shortly prior to the conference and verbal contributions can lack clarity and analysis of risk. Parents are largely well prepared for the conference and those seen by inspectors understood the purpose, implications and seriousness of the meeting as well as the recommendations and decisions being made. Whilst appropriate processes are in place to enable conference chairs to raise alerts to managers to challenge poor practice and planning, there is limited evidence that managers consistently utilise this information effectively to improve practice. Children, young people and parents involved in child protection processes do not benefit from access to an independent advocacy service. Young people are not routinely invited to their own child protection conference, without sufficient assessment whether this would be appropriate, and this limits their ability to fully engage in the process and to have their voice heard.

42. Child protection plans ensure that children are appropriately protected. However, the majority of written plans were not sufficiently specific, or measurable. Often plans contain too long and exhaustive lists of actions or requirements that some parents found confusing or simply unachievable, rather than being focused on the key actions required. Core groups are routinely held and are well attended by partner agencies. The groups routinely consider the child protection plan, but this is not always fully reviewed to ensure that agreed tasks are completed and timely. Parents are generally supported to engage in these meetings although there are delays in recording and distributing the records of the core group.

43. Case recording by social workers is mostly timely but varies in quality and detail. In many cases the recording does not always reflect the depth of work undertaken. Social workers who spoke with inspectors were frequently able to demonstrate a higher level of engagement and analysis of the case than was evident in case records. Some work was appropriately recorded and was evaluative; however in many cases the recording was too descriptive, with too much focus on the parents' needs and very little reference to the child. Chronologies seen by inspectors were not consistently of a sufficient standard or routinely used to inform case planning. The council has recognised this and has taken action to introduce mandatory training for relevant staff.

44. Management oversight of cases is evident in most cases and social workers and managers report that case discussions are frequently undertaken. However case records do not consistently demonstrate the depth and detail of management oversight and direction. Evidence of management oversight within the RA team is not sufficiently robust. In a high proportion of closed contacts seen by inspectors no clear explanation and rationale for decisions made was recorded, although staff reported that managers had overseen the cases and had authorised closure. Within

the assessment and long-term teams decisions and management oversight are generally better recorded although they do not consistently record in all cases the specific actions required, timescales, or the rationale for the decisions reached. In most cases the level of management oversight is sufficient to ensure that work is progressed. The council recognises that this is an area that requires improvement and has taken action to improve training and support to managers.

45. Most staff receive regular supervision. Social workers comment positively about their experiences of supervision. They report that managers are readily available to discuss cases and that their caseloads are manageable and fairly apportioned. Staff report that managers routinely discuss on-going development issues, offer time for critical reflection and that managers at all levels are easily accessible and visible. However, supervision files sampled by inspectors did not support this. The quality of supervision files is weak overall. They are poorly organised and many omit reference to recent training or its impact. Few files evidenced that supervision had offered systematic feedback to staff on their development and performance.

Leadership and governance

Adequate

46. Leadership and governance are adequate. Early help and child protection are suitably prioritised and front line social care resources have been preserved during a period of financial challenge. As a consequence, statutory requirements are largely met. Strategic managers have a clear understanding of the strengths and weaknesses of provision. A robust action plan is in place following an inadequate judgement for services for looked after children in the inspection of safeguarding and looked after children services in September 2011 and this effectively incorporates child protection issues. Improvements have been made in a number of areas: in particular, the co-location of services, a developing culture of support and improved risk management within children's social care teams supported by visible and active senior and middle managers. Social work caseloads are manageable and there is no unallocated work at the time of this inspection. Partner agencies and staff seen during the inspection confirm that they are aware of and largely support key changes that have taken place and are well motivated to improve further.

47. Council priorities appropriately incorporate safeguarding. The respective responsibilities and accountabilities of the Health and Well-Being Board (HWBB) and the Waltham Forest Safeguarding Children Board (WFSCB) are clearly understood by partners and systems to ensure mutual challenge have been recently agreed. The WFSCB provides a satisfactory level of oversight and has appropriately defined broad child protection

priorities: for example, the development of a multi-agency safeguarding hub (MASH) and the relatively recent early help strategies which are becoming more embedded through the early intervention multi-agency panel and area practitioners' network meetings. However, there is scope to ensure that early help and children's social care provision are more effectively integrated.

48. Multi-agency planning is tackling risks to young people arising from gangs and youth violence and there are examples of positive practice to address the needs of young people from ethnic minority communities such as Asiana, a support and housing project for young Asian women. However, a strategic response to understanding and tackling sexual exploitation in all its forms is underdeveloped. The council recognises that joint commissioning activity requires a more focused consideration of children subject to child in need and child protection processes and that it is not currently able to demonstrate the impact of commissioning on outcomes for children.

49. A committed and well informed Lead Member meets regularly with the Chief Executive of the council, Director for Children's Services and Chair of the Safeguarding Board. The children and young people's overview and scrutiny committee is appropriately informed of key issues by the Lead Member and the Safeguarding Board. However, there is further scope to incorporate a focus on child protection within the council's scrutiny function.

50. Significant improvements have been made in respect of partnership working though the WFSCB which was inadequate at the last inspection. The Board is well led by a strong interim independent Chair who provides a high level of challenge and support and ensures that governance arrangements are solid to enable the Board to discharge its statutory duties. Recruitment of a permanent Chair has been successful. WFSCB membership and attendance reflect statutory requirements with a suitable ownership of individual and collective accountabilities by partner agencies. The inclusion of head teacher representatives has had a positive impact in raising the Board's profile with schools. Members have a good understanding of its strengths and weaknesses including the need to raise the profile of the Board with front line staff and local minority ethnic communities and to ensure that the views of children, young people and parents influence their priorities. The effectiveness of and challenge by the WFSCB is improving. For example, annual audits of member agencies' compliance with safeguarding requirements are thorough. The Board receives a range of information and reports to enable it to monitor provision. However, these are not sufficiently comprehensive and do not include early help and data about the operation of thresholds. Multi-agency case auditing by partners for the WFSCB lacks rigour and is not sufficiently embedded in the Board's work.

51. Performance management practice is developing. Regular reports on performance against a limited number of national and local indicators are received and understood by managers at all levels in children's social care and have resulted in improvements in the timeliness of assessments and the regularity of statutory visits by social workers. Case auditing, including of CAF assessments, is appropriately used to assess compliance against statutory and local requirements and to identify strengths and weaknesses. Inspectors observed this information being appropriately used to challenge practice. However, senior managers and child protection conference chairs are not formally engaged in routine auditing and the current arrangements are not sufficiently focused on the difference that practice is making to children's lives.

52. The council recognises that information available to managers to assist in quality assuring and monitoring performance is not comprehensive or reliably accurate and that the electronic social care record requires significant development. No central database for early help services has been established and this hampers the monitoring of impact of these services. Improvement plans within children's social care are not currently translated into service and team plans. A new management support unit has been created and a number of improvements to data quality are in the process of being implemented. Despite this, overall progress has been slow and the council does not have a comprehensive quality assurance strategy to underpin its ambition to become a 'good' service. Insufficient performance information relating to the child's journey through services, incorporating early help and children's social care, is collected and routinely analysed by senior managers and performance management is not sufficiently outcome focused.

53. Recruitment and retention of permanent staff at all levels remains a significant challenge within children's social care. A higher proportion of permanent senior management appointments have been made over the past year. However, a high number of social work posts are vacant although these are currently filled by temporary staff, many of whom have been with the authority for some time providing a level of consistency. The council's recruitment and retention strategy is based on sound analysis of the local market and recruitment is on-going. Despite this, implementation lacks momentum and has had insufficient impact. The council recognises there is a need to widen the range of strategies used to attract and retain high quality staff and this is acknowledged by senior managers. Appropriate progress has been made to reduce sickness levels and to successfully tackle capability issues within children's social care. The early help and child protection workforce is generally reflective of the diversity of local communities.

54. Staff have good access to a range of single and multi-agency learning and development opportunities and those seen during the inspection describe a positive impact of learning from training on their practice. Newly

qualified social workers receive sound support, however, there is scope to increase access to post qualifying training and to assess the impact of learning on subsequent practice. The lessons learned as a result of serious case reviews or multi-agency reviews are appropriately disseminated to a wide range of agencies, including schools. Learning emerging from the small number of complaints or compliments received in children's social care has been effectively used to strengthen practice. For example, this led to improved transfer processes between children and family support teams and looked after children's teams. However, there is limited systematic use of learning from compliments or complaints within the early help provision.

55. A promising start has been made to better understand young people's experiences of child protection processes. However, this inspection has found that the views of children and young people are not systematically obtained, recorded, collated and used to influence the development of early help child in need and child protection provision. The council recognises this as an area for improvement.

Record of main findings

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