Inspection of local authority arrangements for the protection of children

Norfolk County Council

Inspection dates: **14 – 24 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 Norfolk 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 Norfolk, the local authority and its partners should take the following action.

Immediately:

- ensure that strategy discussions held under section 47 provide a timely and swift response to the need for a joint investigative strategy to protect children
- ensure that all child protection enquiries are carried out by a qualified social worker
- improve the consistency, timeliness and quality of all assessments undertaken, and ensure they include an effective analysis of risk and protective factors
- improve the timeliness and quality of all multi-agency meetings to ensure that they result in plans for the protection of children that are specific, measurable and focus on individualised needs. Plans need to include robust contingency arrangements that are well understood by both parents and professionals
- improve the quality and consistency of management decision making to ensure that it always leads to appropriate and timely action.

Within three months:

- ensure the common assessment framework is delivered to a consistent quality
- ensure children's views are always explicitly included in their case records, their diversity is considered and they are seen alone unless it is not appropriate to do so.
- ensure that Norfolk Safeguarding Children Board (NSCB) has sufficient high quality information so that it can effectively monitor and challenge deficiencies in front line child protection practice
- accelerate plans to analyse disparities in workload between social work teams and achieve a more equitable split, to enable a more consistent response from front line managers to monitoring for quality
- improve the functioning of performance management so that it results in consistent and identifiable improvements to front line service delivery.

Within six months:

- ensure the receipt of timely early intervention services for vulnerable children and their families by accelerating the development and dissemination of a coherent and shared early help offer
- ensure that plans to extend existing advocacy support to children and young people in need of protection are fully implemented and effectively promoted.

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 scrutinised case files, observed practice and discussed the help and protection given to 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. Norfolk is geographically the fifth largest county in England. It has approximately 175,300 children and young people under the age of 19 years. This is 20.4% of the overall population. The 2011 Census showed a lower proportion of children and young people under the age of 19 years than all but three of its statistical neighbours, which is also lower than the England average, where the figure was 22.7%. However, the population is continuing to increase and the 0-19 population is expected to increase by over 13,200 (7.2%) between 2011 and 2021, although not evenly across the county. Average earnings in Norfolk are well below the national and regional average. Many of the more deprived areas in Norfolk are characterised by high levels of income deprivation affecting children. Children living in these areas are exposed to multiple social deprivations.

10. The multi-agency information sharing hub (MASH) receives and responds to all contacts and referrals to children's social care where children are considered to be at risk. Professionals from key partner agencies (children's services, health, police and, more recently, adult social care) are co-located and work closely with the emergency out of hours service. The MASH service is linked to a number of early intervention teams. Early help for children and families is provided by a wide range of services in

cooperation with other agencies. Services available include 54 designated children's centres, child and adolescent mental health services (CAMHS), children with disabilities service, schools, colleges, primary healthcare services, parenting support, and the family nurse partnership.

11. Community based social work services are provided by three duty teams, six safeguarding teams, and seven children in need teams, in addition to early years and school support teams. These are supported by county-wide teams such as the diverse community team which deals with private fostering arrangements, the children with disabilities service, adult mental health and substance misuse services.

Overall effectiveness

12. The overall effectiveness of arrangements for the protection of Norfolk's children is **inadequate**.

13. The delivery of arrangements for the protection of children in Norfolk is inconsistent and patchy. While some examples were seen by inspectors of effective intervention, there are too many cases where practice is very poor. As a result, the council and its partners cannot be confident that all eligible children have been identified, their needs appropriately assessed and plans put in place for their protection.

14. The establishment of an early help offer for children and their families is underdeveloped. Some aspects of early help provision have been strengthened by the recommissioning of children's centres, which now focus more clearly on vulnerable families. However, the provision of early help to families to prevent risks escalating remains uneven across the county. Use of the common assessment framework (CAF) to coordinate the range of services available to improve vulnerable children's lives is also uneven, and when it is used, the quality of CAFs is too variable.

15. Children in need who require provision of services in accordance with section 17 of the Children Act 1989 are not always allocated to a social worker and are placed on a list of unallocated work. Although some initial assessments indicate the need for a more comprehensive assessment, core assessments are not always completed as required. Children in need (CiN) plans are also not always completed and this means that the identification and management of risk, and prevention of risks escalating, cannot be assured.

16. The development of the MASH, which included the allocation of additional resources against a backdrop of budget reductions, has added considerable value to the council and its partners' initial response to risk of harm. Understanding of the thresholds for referral to social care is generally sound and the MASH team effectively gathers information, signposts to alternative services where necessary, and refers appropriately to duty social work teams when more detailed assessment of children's needs is considered necessary. It links well with the emergency duty service to ensure a consistent response out of hours.

17. The social work service which provides an initial response to, and assessment of, children's need for protection is weak. While some examples were seen of children being appropriately protected, particularly in those cases identified by the council as examples of good practice, in too many others the response to risk of harm to children was not sufficiently timely and did not result in effective action to protect them. Contrary to the requirements of Working Together to Safeguard Children, enquiries into children's need for protection were not always undertaken by a qualified social worker. Strategy discussions to develop an inter-

agency response to an immediate risk of harm are not always timely, potentially leaving children at risk.

18. Too many examples were seen of the completion of initial assessment formats which had an undue emphasis on timeliness, and therefore used only referral information, without the child or their parents being seen or their diverse needs being considered. Recommendations for core assessments of need and risk were not always responded to in a timely manner or at all, leaving lengthy periods where potential risk to children was not assessed and arrangements for their protection were therefore not firmly in place.

19. Where a formal plan for the protection of children is required, the system of multi-agency meetings to support this is too variable. Some examples were seen by inspectors of satisfactory meetings, but in others poor information sharing was evident and strategies to protect children were therefore weak and potentially left children at risk. Initial child protection conferences are not always timely, and multi-agency child protection plans seen by inspectors were too often formulaic, and did not result in clear actions for partners and parents to follow to keep children safe.

20. Management of child protection arrangements by senior leaders at a strategic level, including the Norfolk Safeguarding Children Board (NSCB), demonstrates considerable management activity, such as delivery of the performance framework and attempts to recruit a permanent, suitably qualified and experienced workforce. However, this activity does not result in sustained improvements to social work services, where significant variations in workload are affecting front line managers' capacity to respond consistently and effectively to children's needs. Management decision making is not always well recorded and lacks consistency, with some examples seen of very poor decision making which left vulnerable children at risk.

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

21. The effectiveness of the help and protection provided to children, young people and their families is **inadequate**.

22. An early help offer and strategy for children and their families is currently under development, and in its absence the delivery of early help is inconsistent. The CAF is not used consistently and when it is used, the quality of assessment and planning is too variable. At a strategic level, the council has strengthened aspects of its early help provision by refining the specification of children's centres to ensure a focus on the needs of vulnerable members of the community. However, use of the CAF has declined and the partnership is not fully clear as to why this is the case.

Although an audit of CAFs has been undertaken and work is underway to improve its effectiveness, progress to address this has been slow.

23. Participation in CAF meetings by professionals is too variable. Some schools do not participate effectively in providing holistic support to children and their families. Agencies are not always fully prepared when attending meetings and information is therefore not effectively shared. This subsequently hinders planning and the delivery of good outcomes for children and young people. Some agencies, such as schools remain resistant to taking on the role of lead professional. However, where the lead professional role works well, it ensures good accountability and coordination of services. Inspectors saw some good practice in relation to parents choosing the lead professional, which helped to ensure their continued engagement.

24. Parents spoken to by inspectors had mostly positive experiences of early intervention and they could identify improvements in their lives and for their children. However, a common frustration was the lack of recognition of problems when they first emerged, particularly by schools. This led to unnecessary delays in gaining the support and help they needed and left parents feeling isolated and struggling to cope with issues such as their children's behaviour or level of attainment.

25. The MASH provides appropriate advice to families who experience lower level problems and where necessary, cases are escalated appropriately. Processes to transfer CAF cases to children's social care when the risk to children increases, and to step cases down when risks have been reduced, are established, although not consistently developed across the county.

26. Children in need of provision under section 17 do not receive a consistent and timely service. Large numbers of children in need do not have an allocated social worker and therefore do not have an assessment of need or have incomplete assessments on their file. Children in need plans have not customarily been in place and in some teams visited by inspectors social workers have only recently received training to complete them electronically. This means that it is impossible for the council to know whether children are receiving the right levels of support, or intervention that is proportionate to identified risks. Inspectors identified a number of cases where children who were subject to children in need intervention had not been seen for extended periods of time. Consequently, children and young people are experiencing unacceptable delays in the provision of services with the risk of cases escalating unnecessarily because their needs are not being met. However, action taken to protect children who are missing from education and with those families who choose to educate their children at home is appropriate.

27. The opportunity for pre-birth planning, assessment of risk factors and engagement with parents is hindered by current NSCB policy. The protocol

for pre-birth assessments recommends that a referral is made to MASH at 20 weeks gestation. While some examples were seen of good assessment, partner agencies who spoke to inspectors raised concerns about some subsequent delay in undertaking pre-birth risk assessment. In cases reviewed by inspectors, this was particularly evident where parents did not cooperate and other child protection processes needed to be activated, for example legal planning meetings. Inspectors saw examples where assessment did not commence promptly and this meant that there was insufficient time to consider a full and informed assessment of the risks to the unborn child. Inspectors saw further examples of children being born before the pre-birth assessment had been either commenced or completed.

28. Some parents are not always sufficiently engaged in child protection and children in need processes and the lack of specific and measurable plans for intervention further reduces their understanding about how to keep their children safe. Parents spoken to by inspectors reported that they had understood the reasons for intervention and found the support and help offered to be effective. However, the quality of both children in need and child protection plans is too variable, which leads to a lack of clarity for those delivering the plan, and does not provide parents with a clear understanding of what they need to do to keep their children safe, or of the consequences of their failure to sustain change. In some cases seen, children were assessed as being at risk, and lack of effective monitoring and review has led to risk factors going unrecognised.

29. Children and young people's views and their diverse needs are not consistently taken into account or used well to inform individual assessments and planning. The local authority's own audit of 20 cases identified that 14 children were not sufficiently engaged in child protection processes, assessments and interventions. Advocacy arrangements are not routinely in place to support children and young people to make a positive contribution to the process. However, these can be spot purchased through a voluntary organisation and plans are in place to facilitate children's involvement via the children's participation service, but these have not yet been fully implemented. The basic requirement for recording the ethnicity, religion and language of children, young people and their families is undertaken in the majority of cases at the referral stage by the MASH team. Access to interpreters is readily available for children, young people and their families for whom English is not their first language. However, insufficient consideration is given in assessment and planning to the way in which diversity impacts on the ability of parents to protect their children from harm. This means that for some children, individualised needs are not being appropriately identified or met.

30. Whilst some positive examples were seen of well-formed relationships between social workers and children; for example in relation to supporting private fostering arrangements, other children experience too many

changes of social worker. This is in part systemic, as different teams are allocated different parts of the child protection process and implementation of the transfer protocol is variable. However, it has also been a consequence of a turnover in social work staff. Frequent changes of social worker hinder continuity and engagement, and prevent the formation of positive relationships with children, their families and carers.

31. Children and young people are not consistently in receipt of timely specialist services to meet their assessed needs. In some cases seen there were lengthy delays in accessing services such as CAMHS and the child and adolescent welfare service, which provides direct work with children. Health representatives spoken to by inspectors expressed concern that they did not always know what services the partnership provided to support children and families. Direct work by family support workers located within social work teams effectively supports children in some cases. This includes one to one work to raise self-esteem and promoting awareness around keeping themselves safe, and this work is compensating to some degree for the inconsistent availability of service provision for some children.

Quality of Practice

32. The quality of practice is **inadequate.**

33. There is too much variation in the quality and effectiveness of the early support offered to children, young people and their families where problems emerge. In some cases seen, multi-agency work is effectively underpinned by use of the CAF and delivers positive outcomes for children and their families. However, in too many other cases the quality of early help offered is poor.

34. Partner agencies make suitable use of the MASH team to discuss possible referrals. The local authority has also successfully encouraged the widespread use of a standardised referral form that has led to a generally sound understanding amongst agencies of the threshold for referrals to social care, and has helped make referral information generally comprehensive. However, information from the police regarding domestic violence incidents is not provided in accordance with the standard format and is more variable. As a result, the impact on children of domestic abuse incidents is not always clearly stated to social care and the risks to children are not clear from the referral form. Agencies' understanding of when a referral should be made regarding a private fostering arrangement is limited.

35. The MASH team offers a prompt screening system for referrals which usually includes a swift gathering of agency information, sound decision making and appropriate recording. An appropriate transmission takes place of the decision to the duty teams, and referrers receive suitable

feedback regarding the decision made. Signposting of families to other sources of help is appropriate. Information from the emergency duty team to the MASH team on issues arising out of hours is promptly provided and suitably detailed.

36. Strategy discussions are not always promptly held where children and young people are considered to have suffered or be at risk of significant harm. Examples were seen by inspectors where this delayed appropriate action, such as police interviews, and as a consequence children were left at potential risk for too long. When they take place, strategy discussions appropriately involve police and social care staff, but the involvement of other agencies is limited. Decisions are almost always sound but re-referrals are happening on occasions as a result of cases being closed too soon. Where child protection concerns become section 47 enquiries, these were not always carried out by qualified social workers in accordance with *Working Together to Safeguard Children* in all cases seen by inspectors.

37. Practice in completing initial assessments is often influenced by a perceived priority for front line staff and managers to ensure their timely completion. However, this focus on timeliness has not been effective and in some teams existing poor performance is deteriorating. Further, this overall lack of timeliness hides a significant variation in service provision between teams, so that while some children in parts of the county receive a very timely service, in other parts service timeliness is very poor. There are also delays in service delivery for some children with a moderate disability, where responsibility for these children's assessments between the children with disabilities team and other social work teams is unclear.

38. In too many cases reviewed by inspectors, an emphasis on timeliness has resulted in completed initial assessments that lack important information such as historical background, the views of other agencies, and the role of male figures and extended family members. In a number of cases seen, parents were not seen at all during the initial assessment. Children are also not being routinely seen by social workers during initial assessments and where they are, it is not always clear if they are being seen alone, and their views are inconsistently captured. However, in the children with disabilities team, children's contribution to assessments is enhanced through these children having an established relationship with the team's social workers. Decision making regarding next steps are consistently recorded and is usually appropriate. However, in some instances cases were inappropriately closed before further actions had been completed.

39. Referrals are appropriately made by the police regarding missing children. However, in cases seen by inspectors, social workers and managers did not sufficiently recognise and assess the risk of child sexual exploitation and abuse, and related patterns such as grooming of children, and this led to premature closure of cases, placing some children at very high levels of risk, and potentially poor outcomes. In those cases where families are

assessed as needing a more detailed core assessment of need, the assessments are not sufficiently timely. According to the council's own figures 49% of core assessments have not been completed within 35 days in the year to date. However, this is in the context of a significant increase in volume and substantial variation between different areas. In some parts of the county both the initial and core assessment phases of intervention are not timely whilst in other areas, timely assessments result in children receiving a prompt service.

40. The quality of core assessments is too variable, ranging from inadequate to good with most being in the lower range. The absence of completed core assessments on too many of the files seen by inspectors does not ensure that risks are satisfactorily identified and reduced. Inspectors saw some examples of good work where risk and protective factors were clearly identified and children's views were reflected well; for example, consideration of the stress caused by parents' addiction. In some private fostering cases, there was good consideration of young people's development and diverse needs. Generally, children, parents' and carers' views were well considered. However, this was not consistent overall. Analysis, next steps and the focus of future intervention are not always clearly stated.

41. Where children need further intervention, they are not being effectively protected through a timely and effective system of multi-agency meetings. In the year to date, 24% of Initial Child Protection Conferences (ICPCs) were not timely, although reviews and core groups were. The quality of child protection conferences and other multi-agency forums such as strategy meetings, core groups and common assessment framework meetings is variable with some good examples seen. However, some meetings observed by inspectors demonstrated poor information sharing, insufficient challenge, and an inadequate response to identified risk and protective factors amongst partners. Inspectors observing formal meetings for the protection of children saw evidence of variable attendance by partner agencies, and a lack of confidence in their role in these meetings. It is not typical for children to attend initial and review conferences.

42. Too many of the child protection plans seen by inspectors when reviewing cases were inadequate. Too many plans have generic actions which do not clearly relate to the specific children in the case, and fail to translate the areas of concern into clearly written actions or measures for progress. These concerns are often further diluted as records of core groups become over focused on current events. Written agreements between the council and parents are often clear and specific regarding what needs to change, but are worked on independently to the child protection plans delivered through the core group, which do not refer to these documents. Even where children are on child protection plans, inspectors saw poor practice in protecting them by not responding appropriately to disclosures

of abuse. Contingency arrangements in child protection plans are usually included, but are formulaic.

43. Case recording is generally up to date. Some examples were seen of detailed recording that included observations of children's presentation and clear evidence of the child's progress. Social workers can often verbally describe well the child's circumstances and journey but do not translate this knowledge into useful case records; often case records of visits, including of some child protection visits, are overly descriptive of what was said, but show little evidence of an identified purpose for the visit, who was present or analysis of what was seen and discussed. Inspectors saw some examples of chronologies which captured the child's journey well but this was not consistent.

Leadership and governance

44. Leadership and governance arrangements are **inadequate.**

45. Despite evidence of scrutiny and challenge from senior leaders, there has been an insufficiently consistent impact on the quality of services to protect children at the front line. Front line managers and social work teams with responsibility for delivering strategic priorities do not reflect the level of understanding of them at a senior leadership level. Management oversight of the quality of social work is ineffective as demonstrated in the poor quality of many initial and core assessments signed off by managers. The recording of management decisions in social work teams is not consistent and is at times too brief. Some examples were seen of reflective supervision and it is usually regular, but is too often overly focused on tasks to be done and insufficiently addresses the professional development of workers. Some records do not demonstrate that child protection plans are subject to rigorous scrutiny by managers and their failure to hold social workers to account has, in some instances, led to delay in actions being completed. On occasion, managers are carrying out and then signing off their own assessments, so that there is insufficient independent oversight of their quality.

46. Inspectors have seen substantial variations in workloads within social work teams, and this significantly affects their effectiveness and functioning, which in turn has a consequential negative impact on outcomes for children. Whilst the action plan following the last Ofsted inspection resulted in a review of workloads and secured additional resources in the areas of highest demand, the current situation is one of great differentials in social work caseloads. In some other areas, unallocated work is a concern, as is casework being undertaken on occasion by unqualified workers or by managers, and the varying means of coping with variable workloads are contributing to the failure of the service to protect children at the front line. The disparity in workloads and the variable capacity of managers to cope is well known to the council, and a caseload weighting

exercise is currently underway, as it is acknowledged that significant disparities in workload negatively impacts on the ability of the service to provide a consistent overall response to child protection concerns.

47. The Director of Children's Services (DCS), Chief Executive and Children's Services Lead Member demonstrate a strong commitment to the protection of children, championing children's issues at a corporate level and ensuring that sufficient resources are available. However, these have not yet been efficiently deployed and significant weaknesses in child protection services for children remain. The DCS has actively engaged with the changing health economy, with the aim of securing representation of children's interests in the new governance structures and, along with the Lead Member, sits on the shadow Health and Wellbeing Board. However this Board's responsibilities are heavily weighted towards adult issues, requiring significant proactivity from the children's services representatives present to ensure they have some prominence. Progress has been achieved with children's issues, for example becoming a standing item for all Clinical Commissioning Groups, although these arrangements are relatively new, and it is too early to evaluate their impact on prioritising children's services. Adequate arrangements have been put in place to oversee future governance of children's services following the dissolution of the Children's Trust Board, such as the vulnerable children's group of the NSCB and the joint commissioning group, which reports to the Health and Wellbeing Board.

48. The DCS has appropriately championed the early intervention agenda within the partnership resulting, for example, in the ringfencing of children's centres against a backdrop of reducing resources. However, practitioners and managers interviewed by inspectors expressed confusion about the extent and reach of early intervention services, particularly targeted ones and the early intervention strategy approved by the Children's Trust in 2010 is not fully understood across the partnership. The recent creation of the Early Intervention Programme Board reporting to the Children's Trust Joint Commissioning Group provides strategic leadership to drive this forward. However, although plans are in place they are yet to be fully implemented. This limits agencies' ability to provide early intervention to families and safely reduce the numbers of children who are referred to children's social care services.

49. Appropriate reporting arrangements are in place at a strategic leadership level between senior officers, the NSCB, the council's cabinet and the overview and scrutiny panel. Political oversight is supported by the Lead Member's regular attendance at political and operational meetings, including performance reporting meetings, which ensures she is appraised of challenges faced by children's services. Partnership working is reported by senior partners interviewed by inspectors to be a longstanding difficulty, fuelled by low levels of trust and anxiety about the consequences of sharing sensitive information. Commitment to child

protection arrangements remains inconsistent at a strategic level. Whilst there are examples of good engagement with the police at the NSCB and other public protection strategic forums, and regular health and children's services safeguarding meetings, hospital trusts and some district councils do not engage with the main NSCB at all. The development and ratification of a joint resolution protocol, whereby professionals can escalate difference of opinions, has been slow to progress. This has resulted in lack of clear guidance to staff of all agencies about how to address differences in operational responses and places children at potential risk.

50. Partners are not consistently involved in devising and implementing shared strategies for providing support and managing risk to the most vulnerable children and young people. Whilst examples of effective joint working at a strategic level are seen in relation to the development of MASH, some senior partners report that the council too often forges ahead with new initiatives without fully involving partners at appropriately early stages. This results in a reactive strategy and delays the provision of responsive services.

51. The work of the NSCB is underdeveloped. The NSCB is formally constituted and has had consistent independent chairing since its inception and is now succession planning. However, progress in ensuring a cohesive multi-agency approach and response to safeguarding has been slow; governance arrangements have taken a long time to become embedded and some partners report poor accountability and inefficient working, which is leading to inactivity. For example, an acknowledgement by the council, that the numbers of private foster arrangements (PFA) placements are low and that ethnic minorities are over represented, is coupled with an awareness of a need to secure NSCB engagement and raise the awareness of partner agencies. However, whilst a multi-agency workshop is scheduled and training is taking place, ownership and challenge amongst agencies is not embedded.

52. An appropriate range of sub-groups undertake much of the development work for the Board, but they are not impacting consistently well on practice. The Monitoring and Evaluation Group oversees the safeguarding performance of partners by undertaking audit and quality assurance activity, but the impact of this is not clearly evident. The Board does not have an agreed shared performance dataset by which it can judge safeguarding performance across the agencies, although this is currently being developed. Multi-agency safeguarding training has recently been commissioned from a voluntary agency and is valued by participants, but not all agencies are fully engaged and it is too early to evaluate the impact of the training provided. The three local safeguarding groups (LSGs) are a strength of the Board and enable safeguarding issues to be addressed on a local basis. LSG meetings are well attended, discuss a range of relevant issues and appropriately include local partners such as SSAFFA in areas

with significant presence of armed forces. The NSCB responds to specific safeguarding issues such as child sexual abuse and domestic violence, which are being overseen by sub-groups of the Board. However, response to child sexual exploitation has been slow and the sub-group is early in its development and in the case of domestic violence, data is not being used effectively to drive improved performance or inform service delivery.

53. A framework for managing performance is in place but it is having limited positive impact at front line management level, where its use in identifying and addressing poor performance in protecting children is not consistent. The various strands of performance management activity within the council are appropriately drawn together and overseen by a Performance Board. However, accurate performance reporting is undermined by data integrity issues with regards to information gathered from the electronic recording system. Children's social care services performance data is presented in the 'Performance Monitor', which is highly detailed but is not used systematically by all managers interviewed by inspectors. It lacks sufficient comparative analysis; performance is compared with the recent past and is neither longitudinal nor related to statistical neighbours or English averages. It therefore supports a false impression of continuous improvement, as performance overall is in reality both variable and considerably below that of comparators. Managers regularly receive further information at a team level and can interrogate the data further and some evidence was seen by inspectors of appropriate use of data, although not all managers spoken to by inspectors consistently do. A programme of audits is undertaken by children's social care services managers and the dedicated audit team within children's services. Audits seen are of good quality and include plans for improvement, although the actions recommended are not always sufficiently SMART and response to the findings can be insufficiently swift, even when they are marked 'urgent'.

54. Participation of children and young people is variable between service development activities, where examples were seen of effective involvement, and service delivery. Individually, children are not consistently enabled to understand the intention of the services they receive and where they are, this is not always well recorded. Findings from internal audits of teams typically report that 'The sense of the child, its wishes and feelings as well as those of its family was very hard to determine from the written record'. However, at a strategic level, children and young people's views are considered well and they contribute to the planning and delivery of children's services and the NSCB, such as the development of a 'junior NSCB'. Strong consultation with older young people has underpinned development of the Youth Advisory Boards (YABs) and consultation was effective when the CAMHS Tier 2 service was re-commissioned.

55. Good development opportunities are available for social care staff and these are becoming increasingly web-based, enabling staff to access a range of development opportunities based on their specific needs. The learning programme is responsive to an analysis of training needs and development opportunities are being supplemented with other creative ways of increasing skills, for example, an interactive case-based tool that can be utilised within teams. The creation of senior social worker posts is envisaged as driving improvements at an operational level, for example, in practice education and continuing professional education, by keeping up to date on and disseminating research findings. However, it is too early to see any impact of this initiative. The supervision policy has recently been refreshed and is supported by a training programme. Social work staff spoken to talked of feeling supported, and having access to appropriate training and supervision at both a formal and informal level, although this was not always well recorded and was not always sufficiently focused on individual performance improvement.

56. Good effort has been made to improve workforce planning and development within the council, although the activity is yet to show full impact. Representatives of the council with responsibility for recruitment report that it is working hard to secure a permanent workforce and reduce its reliance on agency social work staff. Their strategy includes improved approaches to advertising, use of modern technology and social media, a rolling programme of recruitment, and a plan to develop an internal 'bank' of social workers. The council offers a substantial number of student placements and there are strong links with local higher education establishments to support students and the staff development programme. Career progression arrangements are now suitably in place for newly qualified social workers, as well as more experienced social workers. The council is aware of the make-up of its workforce, which reflects the community it serves and there has been wide-ranging promotion of awareness of diversity issues within the workforce. The council reports that it is now able to be more selective in staff recruitment, and is promoting the message about the need to recruit only sufficiently competent staff, so that children young people and their families receive a satisfactory service.

57. Appropriate learning is drawn from complaints, serious case reviews, and research and agencies ensure that key messages are disseminated across the partnership. However, monitoring arrangements are not sufficiently robust to ensure that learning remains embedded. For example, the issue of neglect is acknowledged by partners interviewed to be a prevalent issue in the county, with partner agencies stressing the importance of appropriate shared responses, but there is as yet no overarching strategy in place to ensure that all agencies' front line services recognise and respond consistently to the issue.

Record of main findings

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