Inspection of local authority arrangements for the protection of children

Cheshire East

Inspection dates: **11 March to 20 March 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 Cheshire East 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 Cheshire East, the local authority and its partners should take the following action.

Immediately:

- ensure that all contacts and referrals which indicate potential child protection concerns, including those arising in relation to child sexual exploitation, are appropriately progressed in a timely way
- ensure that the reasons for all management decisions are clear and recorded
- ensure that appropriate and timely action is taken to investigate child protection concerns which emerge whilst children and young people are subject to child in need plans
- ensure that managers at all levels effectively challenge and monitor the quality of practice in order to reduce delay.

Within three months:

- ensure that the local authority's new assessment service is implemented as a matter of priority and functions effectively, and incorporates robust data analysis and performance management of contact and referral arrangements and workloads

- improve the effectiveness of information sharing between multi-agency risk assessment conference (MARAC) arrangements and children's social care to ensure that referrals from MARAC are clearly made and that decisions in respect of these are evidenced and recorded
- ensure that children and young people experience a more consistent service by reducing the number of changes of social worker that they experience
- ensure that children and young people's experiences, views and wishes are incorporated into assessment and planning and that these are effectively recorded
- accelerate plans to ensure that the electronic social care record efficiently and effectively supports assessment and planning for children and young people
- develop, implement and evaluate a systematic training programme to ensure that all elected members are aware of their safeguarding and child protection responsibilities.

Within six months:

- ensure that the Joint Strategic Needs Assessment incorporates an analysis of children and young people's safeguarding and child protection needs and that these are accurately reflected and prioritised in the local area's joint Health and Well Being Strategy
- demonstrate that all partner agencies are able to evidence that they are fully and effectively engaged in common assessment framework (CAF) processes to identify, assess and support vulnerable children and young people
- significantly improve the quality and consistency of child in need planning. Specifically to ensure that all children and young people have a robust outcome based plan that is regularly reviewed and reassessed in the light of changing family circumstances. Ensure that children and young people receive regular visits from social workers and other professionals in line with the plan and are aware of their right to access the services of an independent advocate
- demonstrate that feedback from children, young people and parents is effectively incorporated into service planning and delivery
- develop, implement and evaluate the impact of an outcome focused quality assurance strategy that includes early help, referral arrangements and child in need and child protection planning; to ensure that this results in consistent and improved standards of practice across services

- the Cheshire East Safeguarding Children Board to further develop, implement and evaluate systems to comprehensively monitor and challenge the quality of child protection practice and performance of all statutory partners, including robust multi-agency case audit; to ensure that this results in measurable improvements to the quality of practice.

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).

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

Service information

9. Cheshire East Council covers a geographical area of 1,116 square kilometres. There are approximately 83,400 children and young people aged 0-19 years, which is about 23% of the total population. There is one nursery school, 124 primary, 21 secondary, four special schools and one pupil referral unit. The proportion entitled to free school meals is well below the national average, with 11% of primary school children and 9% of secondary school children entitled, compared to the national average of 19% and 16% respectively.

10. Of the 50,119 children in Cheshire East mainstream schools and academies, 91% of primary school and 93% of secondary school children

are of White British origin. The largest ethnic minority group is White Other which accounts for 2.5% of the population. Over 100 different first languages are recorded for primary and secondary pupils, although the proportion of pupils who have a first language other than English is only 4% of primary pupils and 3% of secondary pupils compared to 17% of primary pupils and 13% of secondary pupils nationally.

11. At the time of the inspection there were 176 children who were the subject of a child protection plan and 1558 open child in need cases.

12. Early help in Cheshire East is led by the local authority's early intervention and prevention department. This includes the Cheshire East family service, the youth engagement service, which provides targeted youth support, 13 children's centres and four family centres, with an additional three outreach sites offering a range of locality based support services. Early help is also delivered through a range of partners, including schools and health.

13. At the time of the inspection referrals to children's social care and initial assessments of children's needs were undertaken by the children's assessment team. However, from the end of March 2013 a new integrated service door, the Cheshire East consultation service (ChECS), will be in place.

14. Following assessment, children requiring child in need or child protection support are supported through one of two child in need and child protection teams based in two local offices. Safeguarding and child protection services for children with disabilities are provided by a specialist disability team.

Overall effectiveness

Inadequate

15. The overall effectiveness of the arrangements to protect children in Cheshire East is inadequate. Although some examples of good quality practice were seen by inspectors across services, the quality of practice varied greatly and is judged overall as inadequate. Children, young people and their families experience poor recognition of risk, delays and inconsistent management decision-making. This increases children and young people's potential risk of harm. Planning for children and young people in need is also inadequate. Once risk is recognised, multi-agency child protection services work together adequately to protect children and young people. Children and young people in receipt of targeted early support receive a prompt and effective service. As a result of the deficits above the local authority cannot be confident that front line management oversight and decision-making is effective at all points in a child's journey through services.

16. Examples of inadequate decision-making in respect of contacts and referrals were seen during the inspection. In a significant proportion of cases not all risks to children and young people were explored and referrals were prematurely closed. In other instances there was delay in commencing assessments leaving children and young people potentially at risk of harm. In the vast majority of these cases a second referral or a change of worker had resulted in appropriate action being taken. This ensured that risks were assessed and children were protected. At the time of the inspection these children and young people were safe. However, in a small number of instances information indicating possible child protection concerns remained unassessed at the time of the inspection and the local authority acted promptly to ensure that assessments were undertaken.

17. Child in need planning is inadequate. Not all children have a plan, many plans do not contain clear and achievable aims and they are not robustly reviewed. Some children are not regularly visited by the social worker overseeing their plan. Inspectors also identified a number of situations where although children continued to receive support, child protection concerns were not responded to promptly and appropriately and this left those children at potential risk of significant harm.

18. Where children are clearly identified as at risk of immediate harm prompt and appropriate action is taken to ensure that risks are thoroughly investigated. Multi-agency planning for children subject to child protection plans is effective in appropriately reducing risks and parents are well engaged in this process. Planning for young people who are identified as at risk of child sexual exploitation is robust.

19. Outcomes for children receiving early help are adequate. Early help is accessible, increasingly effective and the common assessment framework (CAF) is established. Many children and young people, in particular those supported through the council's targeted services, make good progress due to well-coordinated and effective support. Concerns are effectively escalated to children's social care and children are well supported when child in need or child protection plans end. Multi-agency arrangements to monitor the welfare of children and young people missing from home or school are robust.

20. When children are subject to a child protection plan, agencies work well together to ensure that they make progress and that risks are appropriately reducing. The quality of plans is satisfactory overall and there is positive practice in ensuring that children, young people and parents' views are well addressed. This is recognised by parents who are clear about what is required of them. Timely reviews are effectively chaired by experienced practitioners and offer an appropriate level of challenge.

21. Senior leaders in the council have strong corporate and political support and demonstrate clear determination to fully engage all statutory partners in strategic planning and to secure significant improvements in the quality of provision. Systems are in place to monitor performance against national indicators and to audit practice but they are not fully effective. Weaknesses in contact, referral and assessment arrangements and in respect of child in need planning have been recognised and action taken to strengthen and replace the provision. However, the extent of the deficits identified by this inspection were not fully known and understood by senior managers or by the Cheshire East Safeguarding Children Board (CESCB).

22. The senior leadership team has the confidence of elected members, partners and front line staff. A culture of challenge and support is developing and staff benefit from sound training. Efforts to recruit experienced staff are beginning to have a positive impact. Effective strategic planning in relation to the early help offer is resulting in a suitable range of well-targeted early intervention services. Child protection planning is satisfactory and there is a track record of improvement. However, the rate of change has been insufficient to ensure that practice is of a consistently acceptable standard across all stages of the child's journey, or to improve the effectiveness of the electronic social care record. Some recommendations from the Safeguarding and Looked After Children (SLAC) inspection in June 2011 such as improving the timeliness of assessments and ensuring that children's wishes and views consistently underpin individual planning and service development have not been effectively addressed.

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

Adequate

23. The effectiveness of help and protection provided to children, young people, and their families in Cheshire East is adequate.

24. Outcomes for children and families in receipt of early help are overall adequate and there are many examples where children and young peoples' lives benefit from the services that they receive. Children and young people in receipt of targeted early support receive a responsive service. This includes timely referral to social care when concerns about their welfare and emerging risk are first identified. Sensitive and focused strategic planning has ensured that children and families living in areas of highest deprivation have full access to the range of targeted provision. This is supported by performance data showing improvement in identifying and supporting children and families. Recent re-organisation has created an integrated early intervention service and this has enhanced

communication and learning between the council's own provision and that commissioned from other providers.

25. The CAF process is established and is used effectively in most cases to respond swiftly to those children and families who need early help. Family service workers based in children's centres and family centres provide consistently good support. Children's centres based in the most disadvantaged areas are improving the well-being of families through the provision of strong multi-professional help to children under five. Lead professionals working with the CAF generally have a good understanding of the 'step-up' and 'step-down' procedures to ensure children receive the most appropriate level of support and intervention. Some partner agencies, such as health services and secondary schools, have been slower to engage with CAF processes, and a number of weaknesses have been recognised in the completion of assessments. Better management oversight and training have been implemented to address these inconsistencies.

26. Primary and secondary schools receive good guidance, training and support from the local authority to address safeguarding and child protection concerns. The Safeguarding Children in Education unit (SCiE) has been particularly effective in providing targeted work with children experiencing family breakdown or trauma. Joint working by partner agencies has improved outcomes in, for example, attendance, achievement and behaviour of more vulnerable children. 'Team around the family' meetings held in locality areas are working well to ensure a whole family approach. The youth offending service and youth engagement team effectively provide well planned and timely interventions for young people at risk of offending. This is reducing the numbers of young people who offend for the first time and who engage in anti-social and risky behaviours.

27. Professionals across all agencies collaborate well to ensure that early help and services to protect children recognised as at risk of harm are proportionate and appropriate. This includes good partnership working with the police through face-to-face multi-agency strategy meetings to plan child protection investigations. Child protection conferences and core groups are routinely attended by a range of professionals from across the partnership and plans consistently identify actions for all members. In the majority of cases robust communication and liaison is evident and parents spoken with during the inspection confirmed that coordinated planning is effective. One parent in receipt of early help services stated that she 'felt more in control' than she had felt for a long time.

28. In the majority of the cases reviewed during the inspection risks were appropriately identified and protective measures had been put in place. Once children are recognised as being at risk of potential or actual harm, risks are promptly assessed and managed, and where necessary action is

taken to protect children. No children or young people were identified where immediate action was needed to protect them from significant harm. However, in some cases not all children and young people had their need for support or protection immediately recognised. Some referrals were prematurely closed and this led to delays in children accessing the right level of help.

29. Some children in receipt of child in need plans had not previously received a timely assessment of their needs for protection where emerging information indicated that they were at potential risk of harm. These delays meant that some children and young people remained without the appropriate level of support for a period of time and may not have received sufficient opportunity to voice their needs and concerns.

30. Once young people are recognised as being at risk of sexual exploitation multi-agency support to ensure they remain safe is effectively coordinated and reviewed. Positive action has also been taken to raise the awareness of secondary school pupils of the consequences of risky behaviours and the importance of keeping safe. The missing from home and child sexual exploitation sub-group works effectively with key partner agencies, including the police and commissioned services, to ensure that when young people are missing action is promptly taken, including tracking their whereabouts and the provisions of support following their return home. The services of an advocate are available if this is requested. Inspectors also saw some effective joint working in response to situations in which children were living with domestic violence.

31. The number of known privately fostered children is very low and the CESCB are aware of the need to accelerate action to ensure that all agencies are aware of and exercise their responsibilities for privately fostered children.

32. Child protection processes are applied in a timely way and child protection enquiries lead to plans that both reduce risk and meet children's needs. Child protection planning demonstrates that agencies collaborate effectively, risks reduce appropriately and consequently children's development and welfare is enhanced. Action to improve children and parents' experience of child protection processes has been effective. The collective multi-agency report shared with parents prior to review conferences has strengthened information sharing. Parents spoken with value the support offered by social workers and all agencies. They understood why a child protection plan was in place, what they needed to do to make improvements and the consequences of non-compliance.

33. Reviews of child protection plans are timely and challenging which ensures that drift is minimised and plans are effectively monitored and progressed. There is no evidence that children and young people are unnecessarily subject to child protection processes. Decisions taken to end plans are

appropriate as risks to children have lessened and cases are 'stepped down' to child in need where, for the majority of children and young people, their services are then effectively coordinated by a child in need plan.

34. All parents spoken with during this inspection felt that they are being effectively helped. They understood the nature of the support provided and are supported to participate fully within all meetings and plans. This was identified as an area of strength across the local authority, both within social care and within the targeted services providing early help. However, some parents receiving a social care service are unhappy with frequent changes of social worker. They are also frustrated when last minute changes are made to care plans and by some delays in responding to their children's needs.

35. There are some good examples of workers seeking to fully understand the child's experience and perspective through creative direct work. However, many case records do not include comments about the child's wishes and feelings and this lack of recording undermines the level of child-focused practice that staff described as taking place.

36. The degree to which children and young people receive a service that is responsive to their ethnicity, culture, religion, language or disability is variable. Within targeted services families newly arrived in the United Kingdom receive effective support from children's centres to help them settle and improve their wellbeing. Children's ethnicity is mostly identified within social care assessments and its potential impact is explored in some instances. However, case records do not demonstrate that subsequent planning is ethnically and culturally responsive. Translation and interpreting services are used to good effect to enable children and their families to be fully engaged in planning. The disabled children's team makes extensive efforts to ensure that the range of children's needs, including those associated with their disability, informs decision-making.

The quality of practice

Inadequate

37. The quality of practice is inadequate. Decision-making on first contact with children's social care services at the point at which the inspection commenced was insufficiently robust to identify all potential risk. The quality of child in need planning is inadequate. Inspectors found that in a significant number of cases risks were unassessed at the point of referral, leaving children and young people at potential risk of harm. Children receiving early help are supported well and child protection planning is adequate. Although the quality of practice is too variable overall, inspectors saw individual examples of good child-centred planning.

38. Thresholds for access to services are clear but are not fully understood by all partners. The quality of referrals from partner agencies is variable. Some effectively demonstrate sound understanding of thresholds and clearly identify concerns and needs but others omit key information, including, for example, details of the children being referred, which creates additional pressure of work for contact and referral services.

39. Referrals do not receive a consistent response from children's social care. This inspection found a significant number of cases that were prematurely closed before information indicating possible risk of harm was explored, including examples of young people who may have been at risk of sexual exploitation. In some cases information that identified potential child protection concerns was not made subject to further enquiries in accordance with child protection procedures. In other instances, it was only following a subsequent referral that the child protection concerns previously identified were swiftly acted upon. At the point of the inspection a small number of cases were identified where children's needs and potential risks had not been assessed and the council acted promptly to ensure that these were followed up and identified.

40. Historical information is not routinely taken into account in reaching initial decisions concerning referrals and records do not consistently show that the necessary checks have been made. Information sharing and referral arrangements between MARAC and children's social care are not clear, particularly in distinguishing between information that requires action and information that does not. The MARAC information held within children's services is not subject to robust management oversight.

41. Inspectors found that in the majority of cases the response to children and young people identified as at immediate risk of harm is prompt and effective. However, a small number of child protection enquiries were not progressed in a sufficiently timely way. In other cases referred to senior managers by inspectors, the council was unable to demonstrate the rationale for decisions made. Strategy discussions are routinely held and are well attended. Child protection enquiries are all undertaken by qualified social workers. Assessments completed as part of child protection enquiries are satisfactory; they effectively identify risks and strengths and in some instances also include the children's views about their situation. Most records clearly identify findings in relation to significant harm. In the cases reviewed during the inspection enquiries appropriately progressed to child protection conferences.

42. The quality of assessments is adequate overall. CAF assessments completed by family service workers are of a consistently good standard. They demonstrate parents and children's involvement and lead to clear objectives and realistic goals. Others are more variable in the extent to which they clearly identify needs. There is a similar mixed picture within assessments completed in children's social care. A proportion of these

clearly analyse needs and risks while others contain limited information and the standard of analysis is weak.

43. The timeliness of the completion of assessments is below the local authority's own target for improvement. Inspectors saw some that resulted in a timely offer of help or protection to children and their families. However in other cases, unacceptable delays occurred in completing assessments, including those undertaken as part of child protection enquiries, private fostering arrangements and assessments of young people at potential risk of sexual exploitation.

44. In those cases reviewed targeted intervention across the council's early help services was of a consistently high standard. Plans are comprehensive, outcome focused and are regularly reviewed. Children receive sensitive direct work and risks, including those from domestic abuse, are appropriately addressed. The quality of multi-agency engagement and support, including from youth offending, health and adult services, is good. In particular the support from SCiE is of a consistently high standard. Arrangements for de-escalating child in need plans to a lower level of need are appropriate.

45. Planning for children in need is inadequate. In some complex child in need cases, where allegations of harm were made or child protection concerns emerged, these were not effectively investigated. In others there was delay before the severity of the issues was recognised and the appropriate action was taken. In the cases seen several children did not have plans in place. Too few plans set clear and achievable objectives and outcomes. However, there are some examples of good practice and more recent plans are comprehensive and reflect positive multi-agency working. The arrangements for reviewing plans are not sufficiently robust or supported by effective joint working. The local authority is aware of this and has plans in place to review plans more rigorously.

46. The regularity of social work visits to children subject to child in need plans is variable, with significant gaps in their frequency in a number of cases. Recording does not consistently identify whether the child or young person was seen or spoken to alone. A number of children and young people experience frequent changes of social worker over a relatively short period of time. Not all indications of escalating stress in a family result in a timely visit to explore the issues. Despite these significant weaknesses there are examples of positive practice where children are seen alone and observations of their presentation and views. Inspectors identified some effective multi-agency working to support young children's development and to enhance the social involvement of disabled children with their peers. Although children in need have access to independent advocates not all children are made aware of this service.

47. Child protection planning is adequate and plans are of variable quality. Some identify clear objectives but others lack detail and do not always set out the consequences if change is not forthcoming. Core group meetings are regular and well attended. In most cases children subject to child protection plans are seen and seen alone where appropriate, but in a very small number of cases children are not seen within established timescales and attempts to make contact with them are insufficiently robust. There are some examples of good practice in considering children's needs and seeking to include their voice within the child protection planning process.

48. Sustained improvements have been made in the timeliness of child protection reviews. Social workers' reports for child protection conferences seen by inspectors were detailed and underpinned by robust analysis. Recommendations were appropriate and had been shared with the parent in advance. Conference reports are written in a way that makes them accessible to parents and this is good practice. Conferences observed during the inspection were well managed and provided effective challenge. The progress of plans was effectively reviewed and parents were supported to fully participate and contribute. The arrangements for agreeing the venue of conferences appropriately takes into account parents' needs.

49. Front line management oversight and decision-making across children's child protection and child in need services is variable. It is poor overall in identifying and managing risk in the children's assessment service and in the oversight of some child in need work. However, oversight of children subject to child protection plans is satisfactory. Most front line social workers receive regular supervision. They report that supervision generally helps them direct their work and that managers understand their strengths and weaknesses. The quality of supervision files is satisfactory overall. The majority are in good order and auditing was seen to have been undertaken on most files. However, recording is action focused and does not consistently demonstrate that critical reflection has taken place.

50. Although most records are up-to-date, the quality and timeliness of case recording is variable. The current electronic system does not support the effective management or retrieval of information and managers had considerable difficulty in locating key documents. Some case records lack detail of the child's voice and experiences. However, there are also good examples where the child's voice is clearly recorded. While some files contained a chronology which provided sufficient detail to ensure an overview of key historical factors, it was not always clear how these are used to inform assessments and planning for children and young people.

Leadership and governance

Adequate

51. Leadership and governance are adequate. Early help and child protection priorities are clearly defined and shared by strategic leaders across the partnership. However, whilst agencies are committed to partnership working, its impact on strategic and front line working is variable. Strategic planning across the partnership effectively targets identified gaps in provision. For example, domestic abuse perpetrators not subject to statutory programmes now have access to a service that challenges them to change and partners are well engaged in the development of the new Cheshire East consultation service (ChECS).

52. Recent accelerated action to improve strategic partnership working with local health bodies is resulting in some positive outcomes. For instance, health commissioners have incorporated performance in relation to early help and CAF outcomes into all provider contracts. Good progress has been made in commissioning early help services from a range of voluntary and community sector providers and this includes some examples of collaborative commissioning. However, senior managers recognise that joint commissioning is under developed and that the Joint Strategic Needs Assessment and the Health and Well-Being Strategy do not effectively incorporate analysis of children's needs for safeguarding and protection.

53. Senior leaders are ambitious; they are committed to delivering high quality services to ensure children are helped and protected and are developing a culture of supportive challenge. Accelerating the rate of change is now a key priority. There is evidence that this has gathered momentum in recent months. The senior leadership team has a clear understanding of many of the strengths and weaknesses of provision and have taken action to make improvements. For example, the new Cheshire East consultation service (ChECS) is due to be imminently introduced and will offer one entry point for all concerns about children's welfare or safety. However, senior managers had not accelerated plans sufficiently at the time of the inspection to ensure that contact and referral practice was effective. This was recognised and action was commenced during the inspection to address this. Leadership is active and visible but it is not yet fully effective. The council acknowledges that in some aspects the rate of improvement across the partnership has been slow. For example, ensuring that referrals to children's social care are of a consistent quality, progress in replacing the electronic social care record and in improving the timeliness of assessments, which was a recommendation from the SLAC inspection in June 2011.

54. The respective responsibilities and accountabilities of the Children's Trust Board, the Health and Well-Being Board and the CESCB are clearly understood by all partners. Senior managers have strong political and

corporate support from the Leader of the Council and the Chief Executive. The council accords a high priority to child protection and this is appropriately reflected in the Children and Young People's Plan. Resources for front line practice have been preserved in the light of financial stringency. A recently appointed Lead Member is well supported and is becoming informed through regular meetings with senior council officers. Front line staff appreciate the interest shown in their work through visits by the Leader and Lead Member to their teams. Appropriate scrutiny arrangements are in place. These are newly revised so it is too early to demonstrate their impact. Work is still required to ensure the wider group of elected members are well informed of and trained in relation to their safeguarding responsibilities.

55. CESCB membership and attendance reflect statutory requirements. Governance arrangements are satisfactory and kept under review. There is suitable evidence of the CESCB improving the quality of child protection across the system. An example is the positive multi-disciplinary approach taken to impact on child sexual exploitation, missing children and gangs. Similarly the recent appointment of a Chair to cover both Children and Adult Safeguarding Boards facilitates the strategic priority to develop a 'family approach'. Performance monitoring and internal challenge have had some positive results, such as an increase in the number of reports from GPs presented to initial child protection conferences. However, multi-agency case auditing and the range and use made of performance data are underdeveloped. As a result the CESCB has not impacted sufficiently to improve practice in key areas such as the children's assessment service and child in need planning. The CESCB does not have a high profile amongst front line staff although clear and useful executive summaries are made available following each board meeting.

56. Performance management is inconsistent due to a lack of timely impact in effectively tackling known areas of poor practice within contact and referral arrangements and child in need planning. In particular, arrangements to audit and monitor decision-making at the point of referral did not identify the scale of the inconsistencies in practice and management. In other aspects, senior leaders have improved the accuracy and robustness of performance information and have introduced a quality assurance framework. However, it is recognised that there is still some way to go to comprehensively embed this and ensure that it is consistently used by managers across the service. Performance management is effective in some areas, for example, child protection trends and performance are soundly monitored and reported and this has led to improvement in the timeliness of reviews.

57. Systematic auditing of the quality of CAF assessments is evaluative and challenging and has helped to drive up standards. Managers at all levels within children's social care undertake regular thematic audits and have a good understanding of their importance. A basic audit tool is in place and

further improvements are planned to enhance the rigour with which audits are undertaken. There is good evidence that weaknesses highlighted through audit are individually identified to staff although there is variability in how well these are used by front line managers to improve subsequent practice. Outcomes of audit are appropriately reported to senior managers and the CESCB and are incorporated in improvement activity.

58. The council has taken appropriate action to address workforce challenges within front line social care teams such as increasing staffing levels in the children's assessment team. A comprehensive recruitment and retention package, although at an early stage of implementation, is demonstrating impact in reducing the use of temporary staff and in increasing the number of experience social workers. Senior managers have suitable plans in place to sustain this improvement. Appropriate progress is being made to reduce sickness levels and to successfully tackle capability issues within children's social care. The workforce is reflective of local non-white minority groups and a sound plan is in place to enable white minority ethnic staff to obtain professional social work qualifications. A caseload management system has recently been introduced and there is evidence of caseloads decreasing. However some workers, including newly qualified social workers (NQSW), have demanding caseloads given the complexity of much of the work. Nevertheless the majority of staff, including NQSW, report that they are well supported.

59. Staff at all levels are motivated, have confidence in the senior leadership team and feel supported and challenged to improve their practice. They have access to an extensive range of single and multi-agency learning and development opportunities and can explain the benefits of these. Good advice is available to partner agencies to help them develop child protection training. However, the councils recent 'mock inspection' and thematic audits indicate that some basic practice issues have not been successfully addressed through training. The lessons learned as a result of serious case reviews and multi-agency case reviews are appropriately disseminated across the partner agencies. Learning from complaints is satisfactory and is being used to improve practice. For example, this led to the strengthening of systems to distribute minutes of child protection conferences to parents.

60. The council recognises that action to ensure that children and young people's feedback influences service delivery remains underdeveloped. This is receiving on-going attention, for example through work undertaken in conjunction with the Adult Safeguarding Board to identify good practice in this area and the inclusion of young people in recruitment. However, more remains to be done to collect and collate service users' views about the effectiveness of help across all stages of the child's journey.

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