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Inspection of local authority arrangements for the protection of children

Cumbria County Council

Inspection dates: **13-22 May 2013**
Lead inspector **Mary Candlin HMI**

Age group: **All**

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Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Cumbria County Council 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 Cumbria, the local authority and its partners should take the following action.

Immediately:

- ensure that where known child protection concerns are identified, prompt strategy discussions are held and result in effective intervention
- ensure that child protection enquiries are child centred and where children are suspected to have suffered injury, appropriate and timely medical intervention is sought
- ensure that all social workers and managers who undertake child protection work are competent and experienced in child protection and act on potential signs of child abuse and neglect
- ensure that children and young people who are subject to child protection plans are seen and seen alone where appropriate and their views are recorded and considered in response to their needs ensure that the out of hours services appropriately respond to child protection concerns and that young people are not kept in police custody overnight
- review the caseloads of all child and family workers and ensure work allocated is appropriate

- ensure the quality of work signed off by managers meets acceptable social work standards and that the rationale for decisions are clear and recorded, and progress of actions monitored and reviewed
- ensure that children and young peoples views, experiences and needs are clearly recorded in assessments and are taken into account in decisions affecting their lives
- ensure that core groups are regular and effectively develop and implement the child protection plan

Within three months:

- review the arrangements for the transfer and allocation of work within family support and child protection teams and ensure that children and young peoples needs are appropriately responded to
- ensure that social worker supervision is regular and demonstrates reflective practice
- improve the quality of child protection plans to ensure objectives are clear and achievable, have specific timescales and set out what action is required to reduce risk and the consequences of non-compliance
- ensure reports to child protection conferences are made available for parents to read in sufficient time before meetings to support their contribution and participation in meetings
- ensure case recording is up to date and that the quality of chronologies is improved and supports effective practice, management oversight and decision making
- ensure that assessments sufficiently identify risks, taking into account historical factors, and that childrens and young peoples views inform the assessment process and planning
- ensure child in need plans are outcome based, child focused, regularly reviewed and demonstrate progress against objectives set
- ensure reports for child protection and child in need meetings facilitate the understanding and contribution of families
- review safeguarding agreements between the council and parents to establish whether they are an effective tool for use in work with families

Within six months:

- the Cumbria Safeguarding Children Board (CSCB) should ensure the effective use of the common assessment framework (CAF) to identify the needs of individual children who may benefit from early intervention services and ensure they receive effective help

- the CSCB should ensure that the quality of CAF's improve and that there is a robust audit programme in place to oversee findings and promote improvements

- develop plans to extend advocacy support to include children and young people in need of protection so they are supported in contributing and influencing decision and 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 focussed 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. Cumbria has a total population of over 499,000 (ONS: Mid-2011 Estimates). Over 20% (107,100) are aged between 0 and 19 years. Of these children and young people 2.7% are from minority ethnic groups. There are 1,243 children and young people who have English as a second language with more than 50 languages spoken by pupils in Cumbria's schools. The largest minority ethnic communities are Asian/Asian British.

10. A total of 28 wards, out of 168 in the county, have levels of child poverty above the national average with 14,630 (14.9%) of children in Cumbria living in poverty. Eight lower super output areas in Cumbria fall in the most deprived 3% in England, six of these are in Barrow in Furness.

11. Early help for children and families in Cumbria is provided through a range of directly provided and commissioned services. Responsibility for the nature and range of the services commissioned is located within the partnership & prevention service. Services are arranged so that the majority of early help services are delivered through or by children's centres, a variety of targeted youth support services and the LA child and family support teams and family centres.

12. Contacts and referrals for targeted children's social care support are managed by the council's triage service. Child protection referrals then receive an immediate response from the district child protection teams. Child in need referrals are passed to the appropriate district child protection or child and family support for assessment planning and service delivery.

Overall effectiveness

Inadequate

13. The overall effectiveness of the arrangements to protect children and young people in Cumbria County Council is judged to be **inadequate**. This inspection found that a significant number of children required immediate action to secure their protection. The failure to act swiftly following known child protection concerns left children at risk. In a significant number of cases, inspectors found unsafe practice that required urgent attention, including the need to initiate legal proceedings for some children, child protection enquiries, strategy meetings, risk assessments and home visits, in order that that the council could satisfy itself that children known to the council are adequately protected. Management oversight of social work practice is not consistently robust and as a result of the findings of the inspection, immediate action was taken with a number of staff.

14. In response to the concerns raised by inspectors, the Corporate Director of Children's Services implemented a number of immediate changes to address the serious failings identified in the majority of the seventeen cases referred back to the council during the inspection. The quality assurance and practice development team were directed to undertake an audit of all case files held within an identified team, report daily to senior managers and submit a final report to the senior leadership team as a matter of urgency. Changes were also made to management arrangements within the triage team to ensure social workers receive effective supervision. After inspectors identified the practice of contacts being closed without appropriate management oversight, instructions were issued by the local authority to ensure that all future decisions within the triage team are signed off by a manager.

15. The Corporate Director of Children's Services has demonstrated commitment and leadership in promoting the improvement agenda. For instance, driving improvement in training and in developing the multi-agency triage team, established in November 2012, which is showing promise in facilitating effective joint working across the partnership. However, the pace of change is too slow, particularly in ensuring that basic social work practice is consistently applied, such as statutory visits and in ensuring that effective management oversight at middle and team manager level is in place in front line services. The reconfiguration of services in November 2012, with new roles and responsibilities has had the unintended effect of placing additional pressure on many front line staff. Senior managers' response to the repeated concerns by some operational managers in supervision regarding the impact of the changes has been ineffective. The council acknowledges that achieving consistency in social work practice across the council is a significant challenge and remains a key priority.

16. The inspection of safeguarding and looked after children services in April 2012, found the overall effectiveness of safeguarding services in Cumbria inadequate. The council is aware of shortfalls in practice and is working to an improvement plan to address these. However, at the time of this inspection, insufficient progress has been made to ensure that all children known to Cumbria County Council are adequately protected. Since the last inspection, considerable activity has taken place to carry out the ambitious safeguarding improvement programme which takes account of the notice to improve issued by the Department for Education in July 2012. The Safeguarding Improvement Board acknowledges that the first phase of the Improvement Plan (IP) has focused on putting effective systems and processes in place and also recognises that the impact of progress at operational level now needs to be fully demonstrated.

17. Cumbria Safeguarding Children's Board (CSCB) has made progress in developing representation and in promoting collaborative working arrangements across the partnership. However, the effectiveness of the work of the CSCB has been limited in driving improvements at an operational level, particularly around integrated working, including early help, the common assessment and team around the child process. The work of the board has also been hampered due to the absence of a shared performance information data set and robust joint quality assurance and management information.

18. Child protection is given a high priority across the partnership and children's services receive good support from the council and partners. Front line services for vulnerable children continue to be protected in a climate of financial austerity. During 2012/13 additional resources were provided to create 14 extra posts in children's services to support practice improvement, and significant new investment into provision for homeless young people and support to victims of domestic violence.

19. The views of children and young people and their families regarding their circumstances are insufficiently gathered and used to inform early intervention, child protection and child in need work. This remains a key weakness in the planning for children and young people in ensuring their voice is heard and responded to.

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

Inadequate

20. The effectiveness of the help and protection provided to children, young people, families and carers is **inadequate**. Children and young people at risk of harm are not consistently identified and provided with effective protection. The risks to children and young people in the majority of the cases referred back to the local authority were not adequately identified,

managed or appropriately assessed. Consequently, the local authority cannot be confident that all children known to Cumbria County Council are safe.

21. While inspectors saw some practice, which ranged from inadequate to good, the overall effectiveness of intervention was inadequate in too many cases. This often left children where there were known child protection concerns without adequate protection. For instance, the need for consultant paediatric health assessments to determine risk and protective factors was not always identified and progressed as part of child protection joint enquiries. The concerns of some children and young people went unheard and were not robustly or appropriately acted upon. Consequently, there were missed opportunities to effectively act on child protection concerns and for the local authority to appropriately intervene. These cases which involved a significant number of children were brought to the council's attention by inspectors and appropriate and immediate action was taken to address the failures.

22. The establishment of the countywide multi-agency triage team has led to an improvement in the response to contacts and referrals when children require statutory intervention, however, it is too early to fully demonstrate impact. When children and their families require additional help to address emerging needs, a range of effective support is available through children's centres, schools and other services commissioned by the council. These services, which include family intervention, domestic abuse and parenting programmes, are valued by families who access them and parents report that they are making a positive difference to themselves and their children. The Children's Centres inspected by Ofsted in Cumbria range from outstanding to good.

23. However, not all vulnerable children and young people receive the help they require at the right time. When children and young people need targeted, integrated support through the use of the Common Assessment Framework (CAF), they do not get the right level of help, as the use of the CAF is significantly underdeveloped. Common assessments were identified as a priority for improvement for the council in the last inspection and in recent serious case review recommendations. The council recognises the need to accelerate progress, but oversight of this area of work is not robust and the number of common assessments being undertaken has declined sharply in the last year. As a result, some children are not accessing the type and quality of help they need. In a sample of common assessments seen by inspectors, a significant number were found to be of inadequate quality. In these cases, assessments were superficial and unclear, did not involve the child, lacked an action plan and did not lead on to an effective offer of help.

24. Some recent practice is more effective in engaging families to address long standing difficulties. There are examples of effective joint

intervention and improved outcomes for children, where agencies offer high levels of support. For example, the Barnardos Family Intervention Programme helps to improve parenting or reduce substance misuse, and creative work results in some children resuming education. In some instances, flexible arrangements ensure that the agency with the best relationship with the child undertakes the key tasks, resulting in better engagement with the plan by the child or family members.

25. Management oversight of social work practice is inconsistent and often inadequate. In some cases, there are significant gaps in social work visits and in the frequency of core group meetings. This means that some children and young people are not seen in line with their plans and their plans are not reviewed as regularly as they should be. In some cases, children and young people benefited from regular social work visits and individual practice observed by inspectors including core groups, demonstrated effective joint working leading to good outcomes.

26. The views of young people and their families regarding their circumstances, proposed plans and the effectiveness of the help they have received are insufficiently gathered and used to inform early intervention, child protection and child in need work. This remains a key weakness in the planning for children and ensuring their voice is heard and responded to. For instance, few young people participate in child protection conferences and reviews, either in person or through an advocate. The length and overly formal language used during these meetings makes plans difficult to understand and creates confusion about what is expected of families to achieve progress.

27. However, inspectors also saw some good examples of direct age-appropriate and creative work with children which reflected their wishes and feelings and informed intervention and planning. Some families also reported to inspectors that they valued the support they received from their social worker. They acknowledged the range of help available, understood what needed to change, and were aware of support available to make the necessary changes and the consequences of non-compliance with actions they needed to take to minimise risks to their children.

28. Overall, assessments adequately identify children's ethnicity, culture, religion and disability but do not consistently inform on-going work. In some instances, inspectors saw examples where child rearing practices were taken into account and informed an individualised approach to planning.

29. There are protocols in place for children who go missing and child sexual exploitation (CSE) services are increasingly being developed. The numbers of children known to be at risk in these circumstances are low. However, multi-agency arrangements, for instance, to examine trends and particular areas of concern are underdeveloped. Consequently, the local authority

cannot be confident that all children at potential risk of going missing or CSE are identified, but agencies have plans in place to improve these arrangements. Where children go missing and then return, appropriate arrangements are in place to ensure children are seen by an independent adult who can explore with them the reasons for going missing and take appropriate action to support them.

The quality of practice

Inadequate

30. The quality of practice is **inadequate**. Inspectors found too many cases where children and young people, who were subject to known risk, were not adequately protected. In a number of cases, urgent interventions was required by the council in order to ensure children and young people were safe, including the immediate instigation of legal proceedings, the convening of child protection enquiries or legal threshold meetings.

31. Universal services make appropriate referrals to childrens services for children and young people. They are assisted in this through the implementation of the revised guidance in January 2013, of a comprehensive thresholds document, developed following extensive consultation across the partnership. The recently established county triage team has social care, police and health colleagues co-located. This provides an efficient vehicle for sharing information in order to progress contacts and enquiries arising from child welfare concerns. A consequence of joint working has seen the number of contacts concerning domestic abuse reducing, due to effective screening by the police in the co-located multi-agency county triage team. Representatives from education and learning, and adult services plan to join the team to further strengthen joint working arrangements.

32. Advice and guidance for professionals and agencies is available from qualified staff within the triage team. Agencies informed inspectors that this was helpful and the quality of the advice and guidance given was good. The out of hours emergency duty team is co-located within the triage team; provides a responsive service and has increased the staffing complement to meet demand. However, Inspectors observed a failure to identify the accommodation needs of some young people, who have been detained in police custody overnight. The council accept that this action is not appropriate and are putting plans in place to ensure alternative arrangements are available.

33. Case transfer arrangements between the triage and other teams, including the child protection and child and family support teams is not robust. Some cases are inappropriately transferred to family support teams rather than child protection teams. These errors mean there is a delay in an appropriate assessment of risk for some children and young people and,

too often, such cases are initially allocated to unqualified workers, which is unacceptable. A number of cases seen resulted in them becoming escalated as child protection concerns at a later point, which meant that some children and young people were not being appropriately safeguarded at the right level at the right time. In a number of cases pertaining to unborn children, such practice led to re-active rather than pro-active planning, with no post birth plan in place when the child was born.

34. When some children and young people are considered to have suffered or be at risk of significant harm, strategy discussions are not always held promptly. Examples were seen where this delayed actions being undertaken and children and young people were left with risk un-assessed. When strategy discussions do occur, they involve relevant agencies and decision making is generally appropriate. Child protection enquiries are undertaken by suitably qualified social workers. However, enquiries are often not well coordinated, with poor joint working and planning. Consequently, some children and young people's needs for protection are not adequately identified, assessed or effectively managed.

35. Some improvements in performance have been made since the last inspection such as the timeliness of initial child protection conferences, reviews and the distribution of minutes. The sharing of reports prior to child protection conferences remains problematic and parents are frequently given limited time to read the report. Conference chairs are suitably qualified, but due to capacity issues, cannot always be allocated to individual children. This potentially undermines the consistent oversight of child protection plans and the robust management of risk, particularly for those children and young people who have also experienced several changes of social worker. The recently introduced dispute resolution process has strengthened the work of conference chairs in escalating concerns regarding practice.

36. The quality of assessments is too variable. Some good work was seen where children's needs and risks are comprehensively assessed and this provides a sound basis for plans. In others, assessments do not sufficiently identify risks or include historical factors and lack effective analysis. The voice of the child is often absent in assessments which too frequently focuses on the needs of adults. In a number of assessments seen by inspectors, overly optimistic conclusions were drawn and insufficient weight was given to history. Few assessments refer to research or current council training initiatives to support effective analysis.

37. Too many child protection plans do not focus on key risks and needs and they often lead to actions that do not relate to the concerns of the case. Plans do not routinely set out the consequences for parents for non compliance if they do not meet the objectives in the plans, within specified timescales. Some children are on plans for unacceptably long periods and

there is limited evidence that the risks identified in the plans are always effectively addressed. This means that some cases drift, without the right intervention or actions. Some child protection plans were prematurely ended and children and young people were quickly re-referred back to the service, sometimes requiring urgent intervention to secure their welfare and protection. While some child in need plans were outcome focused, others were inadequate, too focused on the needs of adults, and lacked measurable outcomes, timescales and evidence of progress. Consequently, children and young people do not always get the right support.

38. Core group meetings are not always held regularly, or used to develop the outline child protection plan into an effective working tool. This means that, in some instances, the development of well-coordinated services to children and young people and their families is weakened and the right support is not secured. Safeguarding agreements between the council and parents are frequently used in casework, although they are not routinely specific about what parents need to do to change. The use of agreements when child protection plans exist, appear to have no rationale and potentially confuses parents.

39. Some visits, including unannounced visits are appropriately undertaken by social workers. However, there are often significant gaps in visiting patterns to children subject to child protection plans. Therefore, potential changes to children and young peoples' circumstances may not be known and risk may go unnoticed. While some examples were seen of recording that captured the views of children and young people, it was often unclear how childrens views contribute to case planning. In a number of cases, good working relationships were evident between the social worker and the young person and clearly supported improved outcomes. However, in too many cases the ability to build close and effective relationships is undermined by frequent changes of social worker and led to delay in the progress of meaningful interventions.

40. There is no unallocated work within teams, although the capacity of some social work teams is stretched and workloads vary across the county. The reconfiguration in November 2012 resulted in some staff taking on new roles and, although work is in progress to help them to understand and adapt, some lack confidence in the work they are expected to do. For instance, since the reconfiguration, some family support teams do not have sufficient capacity to undertake the volume of initial assessment and child protection work. Managers and social workers who spoke to inspectors attribute deficits in practice, such as the recording of managerial decisions to lack of capacity. Too often, managers accept work that is of poor quality.

41. Generally cases are allocated promptly. The council's own information highlights that a number of cases within child and family support and child

protection teams going back to January 2013, are allocated to team managers awaiting transfer. In many cases, there is little evidence that the allocated social worker receives clear instructions as to what they are expected to do, although some teams' managers have securely established practice and, in those cases seen, clear directions were provided to social workers.

42. Social workers report that they receive informal supervision from managers who are approachable and supportive. In some records, supervision was poor and characterised by lengthy gaps. Other records demonstrated supervision was held more regularly and contained appropriate management directions. There is an absence of reflective supervision or actions to address deficits in practice, such as failed statutory visits or evidence of audit activity on cases. Workers at all levels spoke highly of the strengthening practice programme, but the impact is not yet reflected in supervision records. Support to newly qualified social workers (NQSW) varies across the council. Some managers use group supervision for NQSWs and the workers value this level of support. However, due to capacity in some teams, not all managers are able to protect NQSW caseloads.

43. The quality of case recording is variable and often poor. In some cases seen, records support well the quality of interventions. However, too frequently the impact and significance of events are not sufficiently recorded, including from the child's perspective. Inspectors identified gaps around the recording of key actions and decisions. Managers acknowledge that high caseloads prevent some workers keeping records up to date and chronologies are not always completed. Inspectors found that lack of chronologies means that workers cannot refer to the history of the case to inform assessments. Consequently, planning and decision making is potentially weakened. This was a particular shortfall identified in longer term cases.

Leadership and governance

Inadequate

44. Leadership and governance arrangements are **inadequate**. There is senior strategic management, commitment and vision across the partnership to drive improvement. However, this is not consistently and effectively translated across management groups, in particular at middle and team manager level. This inspection identified a significant number of children and young people who required immediate intervention to ensure their welfare and protection. Leaders in the council, elected members and members of partnership boards cannot be confident that all children known to Cumbria County Council are adequately protected.

45. The Corporate Director of Children's Services has demonstrated leadership and commitment in driving improvement across the partnership. The recently achieved stability at senior manager level in the directorate has underpinned the progress made in establishing systems and processes since the last inspection.The Lead Member demonstrates knowledge, commitment and understanding of the council's priorities and pressures on front line services.

46. The Safeguarding Improvement Board oversees the notice to improve issued by the Department for Education in July 2012. During the past year, many systems and procedures have been implemented and particular attention has rightly been given to improving quality assurance. However, leaders in the council and across the partnership acknowledge that they now need to demonstrate the impact of these changes, particularly around improving consistency of front line social work practice.

47. The CSCB has made progress on its strategic objectives during 2012/13.The effectiveness of the CSCB has increased over the past 12 months but it is not yet sufficiently challenging the performance of front line services in child protection and early help. There has been insufficient scrutiny and challenge regarding the development of the CAF, where the take up by partners remains poor. Early help and CAF are priorities in the improvement notice and this is a key area that should ultimately help to resolve many of the problems faced, such as capacity in social care teams. The lack of progress across the partnership in implementing consistent use of the CAF as a tool to identify the needs of individual children who may benefit from early intervention services is impeding efforts to improve practice in social care. The quality of performance information supplied to the board by children's services has improved but insufficient information is available from other partners for the CSCB to assess robustly the performance and effectiveness of local services. For example, there is no strategy or data set for child sexual exploitation to measure effectiveness of the work that is taking place.

48. Performance management and quality assurance of safeguarding services were judged to be inadequate at the last inspection. Systems have been significantly strengthened and consolidated in the partnership performance management framework, but many have only been introduced since January this year. Performance management is not used systematically to improve practice. In particular, the monthly indicator on statutory visits to children on child protection plans has consistently shown that the minimum visiting frequency is not met in many cases. Less than 75% of children were seen within timescales in 8 of the past 12 months. Insufficient attention has been given to understanding and addressing this fundamental measure and the risks to those children and young people who do not receive visits to ensure their safety.

49. Quality assurance arrangements have been improved over the past year with the introduction of a strategic quality assurance panel. The panel has ensured coordinated action by the local quality assurance groups and has overseen three thematic audits since September 2012. The multi-agency audits were linked to the strategic priorities and findings have been reported to the CSCB and disseminated to front line staff. However, quality assurance processes do not yet offer an accurate picture of the quality of practice to protect and safeguard children in the county. The extent of the failings identified in this inspection of front line practice and management oversight were not identified through the council's own performance management and quality assurance systems and processes and this is a serious omission.

50. Since the last inspection, the pace of change has been too slow. The council's self-assessment, dated May 2013, is overly optimistic about progress made. The assessment makes reference to some achievements, such as the location of health partners and the appointment of a child and family worker to the triage team. There is an over optimistic view of such improvements, which have only very recently been put in place and are not yet able to demonstrate impact. The findings of the self-assessment do not accord with this inspection which reports that the quality of practice and effectiveness of help for children and young people are inadequate. Some achievements are noteworthy, in particular, the recent implementation of the escalation policy for independent reviewing officers (IRO) and the regular meetings held with the Corporate Director to review progress and address practice concerns.

51. Regular audits of practice now take place with all levels of management involved. Audit activity is leading to some improvements in the districts, although this is not consistent across the county. However, inspectors found that some managers audit their own work and this limits their effectiveness. A thematic audit has recently been completed to explore how well 'the child's voice' is represented in case records. This provides a baseline against which to measure progress.

52. The reconfiguration of services in November 2012 with new roles and responsibilities has had the unintended effect of placing additional pressure on some front line staff. This has caused significant problems in certain teams. Senior and middle managers have not been effective in tackling these problems. As a result of findings by inspectors, the council took action to make changes to management arrangements. The council issued new instructions to ensure decisions in the county triage team are authorised by managers. These issues should have been identified and tackled through normal management processes.

53. The quality of supervision of staff is generally poor, although some good practice was identified. The pressure of work was frequently cited by managers as reasons for not holding regular supervision with staff and

records indicated that there was limited opportunity for challenge and reflection, and brief recording. In some instances middle managers failed to appropriately respond to the repeated concerns raised by team managers in supervision of the impact of the recent configuration on teams. Some newly qualified social workers are not getting the support they should. This was also a finding in the last inspection.

54. The Children's Trust Board and the CSCB have improved the way they seek the views of service users in line with recommendations from the last inspection. In June 2012, almost 100 vulnerable young people were consulted and their views influenced the formulation of the improvement plan. Participation workers have consulted young people as part of the recent children in need case audits on 'risk taking or vulnerable behaviour in teenagers' and 'self-harm and suicide'. Systems are being developed to promote the 'voice of the child' in child protection conferences but, as yet, the advocacy service has not been used to support young people at conferences. Improvements in the management and response to complaints since the last inspection mean that lessons learned from complaints can be identified more clearly with action plans agreed with named leads and completion recorded.

55. Some social care teams are experiencing considerable workload pressure. This remains an area for development since the last inspection. The 'strengthening practice' bespoke training programme delivered to all staff is a key element of the improvement strategy designed to equip the workforce with the essential skills. This challenging programme has been well received by staff and managers. A 'strengthening leadership' programme will begin in June designed to help front line managers develop the essential skills for good social work practice. The council faces a major challenge in recruiting experienced staff and has devised an action plan to attract high quality applicants, which includes a recruitment pack develepod with partners including Health. The difficulty in recruitment has caused delay in establishing the audit and practice team. The recruitment of 18 agency social workers as permanent employees is a considerable achievement and has reduced the number of agency workers in social care teams to a small number.

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