raising standards improving lives

Inspection of local authority arrangements for the protection of children

Calderdale Metropolitan Borough Council

Inspection dates: **17 - 26 June 2013**
Lead inspector **Pietro Battista HMI**

Age group: All

© Crown copyright 2013

Website: www.ofsted.gov.uk
This document may be reproduced in whole or in part for non-commercial purposes, provided that the information quoted is reproduced without adaptation and the source and date of publication are stated.

Further copies of this report are obtainable from the local authority or at www.ofsted.gov.uk

Contents

Inspection of local authority arrangements for the protection of children 2

The inspection judgements and what they mean 2

Overall effectiveness 2

Areas for improvement 2

About this inspection 4

Service information 4

Overall effectiveness 6

The effectiveness of the help and protection provided to children, young people, families and carers 7

The quality of practice 11

Leadership and governance 15

Record of main findings 17

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 Calderdale is judged to be **inadequate**.

Areas for improvement

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

Immediately:

- Ensure that management application of thresholds for access to children's services, oversight and direction within the contact referral and assessment services is consistent, robust, recorded and effectively monitored
- ensure that the quality of work within the contact referral and assessment services is safe – specifically that; risks to children are robustly and identified managed; that response is timely; assessments are thorough and ensure risks are fully analysed; assessments fully consider historical information; and that recording is sufficiently up to date
- ensure that strategy discussions include all relevant partner agencies, fully consider relevant historical information, and make specific and measurable decisions and actions that are clearly recorded and followed
- ensure that section 47 inquiries are effectively undertaken, the outcome is promptly recorded and that managers monitor and direct the inquiries and record their involvement

- the Calderdale Safeguarding Children Board ensures that it robustly oversees the quality of the work of its partner agencies and that practice is safe
- review all the recommendations from the previous Ofsted inspection of child protection services and the peer review in 2012, in the context of the findings of this inspection, and prioritise these according to potential risks to children.

Within three months:

- Ensure that performance management and audits are robustly undertaken within children's services and that themes as well as individual case issues are systematically tackled and are reported to senior managers
- ensure that protocols and practice to safeguard children prior to their birth are effective
- ensure that chronologies are up to date, and that historical information is fully considered in determining current actions and planning
- ensure that no undue delay occurs in cases that should transfer between the contact referral and assessment service, the locality teams and the early intervention or universal services
- ensure that the views of the child are routinely obtained and considered within assessments and case planning.

Within six months:

- Ensure that there is sufficient social work and management capacity within the contact referral and assessment services, with suitably experienced and competent staff.

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

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

11. Referrals to Children's Social Care are managed through the First Response Team (FRT), which includes a Multi-Agency Safeguarding, Screening and Tasking Team (MASSTT), based at a police station, and including the common assessment framework coordinator and social workers undertaking initial assessments, section 47 investigations and core assessments. Following assessment, cases requiring child protection

or child in need of support are transferred to one of four locality teams or the Disabled Children's Team (DCT). The teams are linked to two commissioned specialist services: support services for young people at risk of sexual exploitation and missing children.

12. Strategic oversight and coordination is provided by the Calderdale Safeguarding Children Board (CSCB) and its sub-committees. Referrals which require a multi-agency response, but do not meet the threshold for children's social care, are considered by one of the four early intervention panels within the localities. These panels have developed a collaborative model of providing services, which includes health partners and schools, to provide access to and coordination of a range of early intervention services. Services provide a continuum of family support; through 16 Children's Centres delivered from 21 sites, the Family Intervention Team, the Targeted Youth Support Team and targeted youth offending workers.

Overall effectiveness

Inadequate

13. The overall effectiveness of the arrangements to protect children in Calderdale is judged to be **inadequate**. This is an authority under notice to improve following an Ofsted inspection of safeguarding arrangements in 2010. In December 2012, an Ofsted inspection of the Council's arrangements to protect children judged the quality of practice and overall effectiveness to be inadequate. A well-informed peer review undertaken in November 2012 accurately detailed key strengths and areas that required further consideration. The council requested Ofsted re-inspect the services in February 2013.

14. Clear strategic vision and leadership are in place, and these are underpinned by a well-informed assessment of local need. Strategic partnerships are developing well, supported by a clear Single Integrated Improvement Plan (SIIP). However, the Council's self-assessment prepared for this inspection was not accurate and was overoptimistic in gauging the impact and pace of change.

15. The Director of Children's Services (DCS), appointed in April 2012, together with a recently appointed experienced senior management team have appropriately established the foundations for improving the service. Areas for development from the previous Ofsted inspection and the peer review have been tackled, with clear plans in place and actions taken. In a few areas this has resulted in significant improvements, albeit from a very low baseline. However, many improvements are still at an early stage of implementation, or are not embedded consistently. More significantly, some key areas for development identified in the previous inspection persist or have deteriorated, despite being under the close scrutiny of a variety of strategic and operational groups.

16. Crucially the contact referral and assessment services for child protection and children in need are not sufficiently safe or secure. Significant deficits in the quality of work and the management oversight within these services were identified within this inspection. This was an issue that had been identified in the previous inspection in December 2012. As a result children and young people are not protected, risks are not consistently identified or managed and decision-making in the application of child in need and child protection thresholds is not consistent. Also case recording lacks clarity about decisions and actions taken and insufficient account is taken of historical information when assessing risk to children. The voice of the child is often not evident in assessments and case planning. As a result the quality of practice is inadequate.

17. The significant failings in the quality of practice is present despite the council and partners' focus and oversight on these services through a range of strategic bodies including the improvement board, the Calderdale

Safeguarding Children Board (CSCB) and the council's scrutiny committee and senior management. Performance management systems are in place, which provide the council and its partners with a host of data to enable strategic and operational groups and managers to monitor the effectiveness of services. Extensive case audit systems within social care services are established and are regularly conducted. The data, trends and analysis from these are regularly reported through operational and strategic groups. The systems established should have enabled senior managers to identify the significant shortfalls in the quality of practice and management oversight within the contact referral and assessment services identified in this inspection. However, they were not effective and senior managers were not aware of the unsafe practices. As a result leadership and governance are inadequate.

18. Whilst progress has been achieved in developing early intervention services and increasing partner engagement in the common assessment framework, team around the child and early intervention panels, to positive effect. However, this is outweighed by the ineffectiveness of assessment and planning within the contact referral and assessment services for the most vulnerable children. As a result the effectiveness of services is inadequate.

19. Stability of staffing at senior and middle management level has been recently secured within children's services. Recruitment and retention strategies are clear, and action taken has had some positive impact in recruiting new social work staff. A significant reduction has been achieved in the use of agency staff, which enables improved continuity and consistency of social workers with some families. However, the contact referral and assessment service has the highest usage of agency staff which further negatively impacts on its effectiveness.

20. Elected members have significantly increased their interest, involvement and understanding of issues affecting vulnerable children. The lead member for children's services is proactive in championing the vision for children and families and in ensuring that members across all parties maintain a close scrutiny of children's services. This was an area for development at the last inspection.

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

Inadequate

21. The effectiveness of the help and protection provided to children, young people and their families and carers is **inadequate**. Children and young people are not sufficiently protected as risks are not consistently identified or managed. Inspectors found inconsistent decision-making in the

application of child in need and child protection thresholds. In some cases, a timely and effective response to ensure risks were fully assessed was not evident. Additionally, case recording lacked clarity about decisions and actions being taken, with insufficient account being taken of historical information. As a result it was not always possible to track the rationale for some decisions and actions or to readily determine that children or young people were being helped at the right level.

22. Too many enquiries into the Multi-Agency Safeguarding Screening and Tasking Team (MASSTT) are unnecessarily held to gather further information when the thresholds for statutory intervention are met. This process contributes to delay and is unsafe as risks are not identified or responded to in a timely manner. In a number of cases seen by inspectors there was undue delay in children and young people receiving services and in others the assessment of risk was not sufficiently robust and as a result some cases are closed inappropriately or assessed as children in need when child protection processes should have been initiated. Consequentially some children and young people have been inadequately protected.

23. Early help services are well configured. Positive outcomes were seen by inspectors for a significant number of children, young people and their families and carers who received early help. Universal services such as schools, health visiting, midwifery, children's centres and voluntary agencies identify and assess well the need for additional support to children, young people and their families or carers and ensure an early offer of support and help. A range of parenting programmes is in place to support children and families at risk, either identified through the Common Assessment Framework (CAF) process or referrals directly through social care. Courses such as the freedom programme, and strengthening families and communities contribute effectively to increasing parents' capacity to develop positive relationships with their children and to build parent's self-esteem, leading to positive change.

24. The CAF, Team around the Child (TAC), and Family Group Conference (FGC) processes are being increasingly used by partner agencies. The quality of CAFs seen is adequate overall, and some clearly demonstrate the voice of the child. However, too many do not demonstrate an understanding of the impact of their situation from the child's perspective. Some effective and outcome-focused planning in relation to TAC and child protection plans was seen, which enables parents to understand the reason for services involvement and to improve the quality of their parenting. However, within the First Response Team (FRT) planning for children in need is inconsistent. In some cases there is no evidence of planning and where plans are in place they are not consistently outcome focused or reviewed in a timely way. Inspectors saw cases where weak planning and a lack of rigour in management oversight led to drift and delay in meeting the needs of those children and young people.

25. Where concerns are referred to Children's services for children who are already receiving help through a CAF or child in need plan, they are given a proportionate response. Inspectors saw examples of such cases being 'stepped up' appropriately through the early intervention panels and also 'stepped down' where risks had diminished in the course of on-going work.

26. An appropriate range of services is provided to meet the diverse needs of the local population. Parenting programmes are available in Urdu and Eastern European languages and the Insider Guide (parenting support) programme is available to parents of disabled children, which promotes resilience and positive change in families. Inclusion Coordinators, based in children centres, work well with the parent/carer forum to ensure that suitable local provision is available to disabled children and their parents. Inspectors saw interpreters being used to promote the full engagement of parents, carers and children.

27. Appropriate arrangements are in place to protect children with disabilities. The standards of casework, recording, direct work and management oversight with children and families subject to child protection was of an adequate standard or better. The diverse needs of children subject to child protection processes within the team are well met, in close collaboration with partner agencies.

28. Clear commitment is demonstrated by practitioners and managers to working in partnership with parents. In some cases this leads to effective outcomes to enable children to remain at home with their parents. Parents spoke positively of the support that they receive through children's centres and some parents report that they understand the reasons for intervention and find the support and help that they have been offered to be effective.

29. In some cases children and young people at risk of harm are appropriately identified and provided with effective protection. However, inspectors saw a number of cases where it was not evident whether children who were subject to children in need intervention had been seen for extended periods of time. The majority of these cases were in the First Response Team (FRT) where the lack of robust management oversight, poor recording and a failure to recognise and act upon increased risk led to children being exposed to on-going and unassessed risk, particularly in cases where there is domestic violence or neglect. Consequently it was not clear whether children receive the appropriate level of intervention.

30. The council's pre-birth protocol for undertaking assessments encourages early referrals from partner agencies to ensure that sufficient time is allowed to undertake assessments. However, inspectors saw examples of pre-birth assessments within the FRT where significant drift had occurred which resulted in insufficient time for the formulation of a full and informed assessment of the risks to the unborn child. As a result the

opportunity for early pre-birth planning and engagement with the parents and assessment of key risk factors had been lost.

31. Weekly transfer meetings are held between the FRT and locality team managers to ensure the timely and smooth transfer of cases between the teams. However, some cases are not transferred in a timely manner due to case recording and case summaries or assessments not being up to date or absent. Consequently some children and families experience delay in receiving timely interventions and in responding to risk and need.

32. Clear multi-agency protocols are in place to identify and respond to children and young people who go missing. Return interviews are appropriately undertaken by Barnardo's, and where necessary additional help is provided to children, young people and their families from social care or early intervention services. The council has effectively raised awareness and broadened the range of agencies involved in children missing from education to enable young people missing education to be supported to attend school more quickly. The secondary schools behaviour and attendance collaborative panel ensures that school places and managed moves keep children in education and promote their safety.

33. Over the last six months significant improvements have been secured in information sharing, monitoring and interventions for children at risk of sexual exploitation. Multi-agency interventions reduce risks for some young people, with some effective preventative work undertaken. Awareness raising and training have led to an increase in referrals relating to the identification of risks of child sexual exploitation (CSE), and are routinely referred to the CSE Operations Panel. The CSE Operations Panel has a range of relevant statutory and voluntary organisations, including the Barnardos' Missing Children project. The Children's Society's Safe Hands project provides an accessible service to young people involved in or vulnerable to CSE in supporting them to make positive changes and choices in their lives. However, assessment and planning on some individual cases within children's social care is not yet sufficiently robust.

34. At the time of this inspection there were no children or young people known to the local authority subject to private fostering arrangements. The council has taken action to raise awareness of private fostering with partner agencies. However, this has not been effective and has not resulted in any children being identified as subject to private fostering arrangements.

The quality of practice

Inadequate

35. The quality of practice is **inadequate**. Practice within the Multi-Agency Safeguarding Screening and Tasking Team (MASSTT) and the Frontline Response Team (FRT) is inadequate. There are significant deficits in all key aspects of social work practice, such as case recording, assessment, planning and management oversight. Practice within this part of the service is unsafe, with significant delays in assessing risk and putting plans in place to protect children, and this has led to some children being inadequately protected. The quality of practice is better within the locality social work teams, where practice is at least adequate and has improved overall since the last inspection. The quality of practice within the early intervention services is also of an adequate or higher standard.

36. Common Assessment Framework (CAF) work seen by inspectors is overall of an adequate standard. Parents report that they are fully involved in the assessment. However, a significant proportion of CAF's do not sufficiently capture the voice of the child. CAF plans are of variable quality and the majority of plans are not specific with measurable outcomes. Team Around the Child meetings take place regularly and a variety of agencies undertake the lead professional role. However, progress with individual plans is not effectively monitored or recorded.

37. The MASSTT includes police, health and social work professionals in screening contacts and referrals and this enhances multi-agency information sharing. However, inspectors found significant drift and delay in decision making on contacts and referrals and the lack of timely and effective identification and management of risk in many cases. In the majority of cases seen, the screening of contacts did not include consideration of historical information and thresholds for children in need and child protection are not consistently applied and recognised in a timely way. Management oversight is inadequate and there is not a clear assessment and rationale for decision making in many cases seen. The quality of referrals from partner agencies is too variable. High quality detailed referrals were seen from schools and health visitors; however, referrals from some other professionals and agencies were of a poor quality.

38. Strategy meetings, mostly undertaken within the MASSTT, are timely between children's social care and the police once the threshold for child protection has been recognised. However, there is limited involvement of other agencies. The quality of the recorded strategy discussion is poor in the majority of cases and lack of detail on historical information and risks to the children so that there is not a clear audit trail for the decision. Timescales for actions to be undertaken are seldom stated, actions are not always followed through and in some cases the planning of section 47

enquiries is not robust. In addition there is little evidence of challenge by social care staff to police decisions, where these may not be in the interests of the child.

39. In the majority of cases seen by inspectors, the recording of section 47 enquiries is inadequate. In some cases there is no information about the section 47 enquiry and no evidence of management oversight. The quality of decision making following a section 47 enquiry is therefore not robust.

40. The quality of practice in the First Response team (FRT), which undertakes assessments, is inadequate. There are significant delays in completing a high proportion of assessments seen by inspectors. Assessments do not consistently identify all risks and are not always sufficiently analytical. A lack of robust assessment and decision making on open cases where risk has increased results in undue delay in protecting children. Thresholds for children in need or in need of protection are not consistently recognised or applied. This leads to undue delay in planning and intervention and to some children and families not promptly receiving appropriate services to meet their needs.

41. The council has taken action to improve the FRT since the last inspection; however, this has not been effective. There has not been sufficient focus on ensuring robust management oversight and on ensuring that social work practice is safe. Social work capacity within the FRT has been significantly increased, which is a positive development. However, over-reliance on agency staff continues as the council has not been able to recruit and retain sufficient, permanent and experienced social workers within the team. Staff turnover is high in the FRT and this leads to a number of families experiencing changes in social workers, which is exacerbated by cases remaining in the team longer than is necessary as workflow is not effectively managed. Caseloads have reduced overall since the last inspection, however some caseloads remain high. The council has been successful at reducing and protecting caseloads for Newly Qualified Social Workers (NQSW's) this is a significant improvement from the last inspection.

42. There is insufficient management capacity within the FRT and also significant deficits in the quality and robustness of frontline management. Delays in managers signing off work and a lack of recorded management oversight and direction results in drift in too many cases. Management directions are not always followed through and some cases are closed prematurely without risks being fully assessed. Supervision is not sufficiently robust or regular within the FRT and not all cases are discussed on a regular basis with managers. Inconsistencies in practice and recording by social workers and poor practice is not sufficiently identified or challenged by managers. In addition, there is a lack of robust prioritisation within cases and caseloads. Following the last inspection, practice supervisors no longer undertake casework as advanced

practitioners now support social workers with complex casework and this is a positive development.

43. Practice and systems are not operated in a child centred way and often do not sufficiently consider the experience of the child. A few examples of better quality assessments were seen by inspectors which were analytical and clearly identified the key risk factors. Case recording is poor in a significant proportion of cases and therefore it is not always possible to be assured that children are safe. It is not always evident from case records that some children are seen or seen alone and consequently the voice of the child is not evident. Significant undue delays in visits to some children were seen by inspectors. Children in need plans are not always in place and the quality of children in need plans is too variable. Good arrangements are in place for communication and information sharing between the out of hour's service and children's social care services. However, poor case recording within the FRT means that the out of hour's service does not always have access to full or up to date information on case records.

44. Insufficient social work and management capacity within the FRT is exacerbated by too many cases not being promptly transferred to locality teams when the threshold for social care intervention has been met. Instead further work is undertaken in FRT on these cases which should be undertaken within the locality teams.

45. Within the locality teams, which undertake work with children subject of child protection and child in need plans, the overall quality of practice is adequate or better and has improved since the last inspection. Improved outcomes for children were seen in a significant proportion of cases and children were appropriately de-escalated from child protection plans where risks had decreased. Cases which have experienced drift are identified and remedial action is being taken to address this. Overall there is good engagement by professionals with families on child protection plans. Social workers and their managers know their families well.

46. In the majority of cases seen in the locality teams well-coordinated multi-agency working has led to improvements in the child's situation and identified reduced risk. Regular core group meetings with good attendance by partner agencies enables robust communication and information sharing in these meetings. Effective work has been undertaken in some cases by the Family Intervention Team (FIT) through intensive and targeted family support. In the majority of cases there is regular visiting of children on child protection plans. Management oversight is regular with effective oversight of cases. However, management directions are limited and it is not always evident that these are followed through. Social workers have manageable caseloads which enables more effective work with families. The range of accessible performance information has improved and is being used more effectively to improve practice.

Supervision is regular within the locality teams and is increasingly reflective to enable a learning culture to be developed within the teams.

47. Assessments for children, subject to child protection plans, are not always up to date. Plans seen are adequate overall, although in the majority of cases plans are not consistently specific with clear measurable outcomes, which address all risks. A training programme is being rolled out to staff to improve the quality of plans and is beginning to have a positive impact. In the majority of cases specific contingency plans were not in place, although a few effective contingency plans were seen by inspectors. Electronic chronologies are in place, however in most cases they are not well constructed to enable professionals to quickly ascertain the history of the case. In the majority of cases seen, the quality of chronologies was judged to be poor. Case recording in the locality teams is at least adequate, it demonstrates that key elements of basic practice are being undertaken such as seeing bedrooms and observing the presentation and behaviour of children. The voice of the child is not sufficiently explicit in all recording, though in some cases there was appropriate recording of the child's views.

48. Child protection reports to conferences are too variable in quality. Some child protection reports are not of sufficient quality, some have key information missing, insufficient analysis, do not include a clear chronology and are not underpinned by a comprehensive up to date assessment. Insufficient management oversight leads to some child protection reports not being signed off by managers. The timeliness of sharing child protection reports with parents is improving but this is not yet consistent and too many are only shared with parents immediately before the conference, which does not enable them to be properly prepared.

49. Good multi-agency attendance at initial child protection conferences enables good communication and involvement of agencies in decisions on whether a child should be subject to a child protection plan. However attendance is not as consistent for review conferences, which the police rarely attend, even in cases where they have involvement. In some cases there is evidence of challenge by Independent Reviewing Officer's which have led to improvements in practice. The participation of children in child protection conferences is underdeveloped. Children rarely attend. The council has recently commissioned a voluntary organisation to support children in participating in conferences; however, it is too early to judge the impact of this service. Some positive examples were seen of the participation of young people in core groups.

Leadership and governance

Inadequate

50. Leadership and governance arrangements are **inadequate**. While the strategic priorities of the council are clear and ambitious the pace of improvement since the last Ofsted inspection in December 2012 has been slow in some key areas and insufficient in child protection services. The council has not effectively identified the deficits in the quality of practice within the Multi-Agency Safeguarding Screening and Tasking Team (MASST) and Frontline Response Team (FRT) service, and this undermines the accuracy of its self-awareness. Systemic weaknesses in these services which include; poor management oversight, and poor quality of practice mean that children are not adequately protected. Managers have not recognised or addressed these deficits.

51. Since the last Ofsted inspection in 2012, strong leadership by the Director of Children's Services (DCS), enhanced by permanent appointments to the senior management team has promoted a sense of stability, progress and enthusiasm amongst staff and partners. This has resulted in all the areas for development being tackled and some improvements have been effected in a number of areas. For example in the locality teams supervision and case discussion is regularly provided, the timeliness of assessments has improved and increasing numbers of staff have been trained to develop specific and measurable case plans. Despite these improvements fundamental weaknesses in the contact referral and assessment services persist.

52. The council's Chief Executive prioritises child protection services and actively engages in strategic oversight through the Improvement Board and through regular meetings with the DCS and with the Chair of the Calderdale Safeguarding Children Board (CSCB). The Lead Member for children services actively promotes children's issues amongst elected members, and this has led to significant improvement in member engagement with children's issues since the last inspection across all political parties. The council are supportive of children's services, for example by providing additional resources in response to increased demand on the FRT. The lead member actively engages with senior managers to monitor current performance and has been proactive in meeting frontline staff who report improved morale. Clear arrangements are in place to report and scrutinise performance information at the most senior level. However, the lack of robust performance information and over reliance on quantitative information has not enabled strategic managers to identify and act on significant performance issues with the MASSTT and FRT.

53. The CSCB has not been sufficiently effective in driving change since the last inspection despite a number of positive developments; in particular it

has not effectively monitored and challenged the quality of frontline practice. Whilst some audit activity has been undertaken by members of the CSCB this is not systematic or regular and has not enabled the Board to recognise the significant weaknesses in key frontline child protection services. The CSCB receives a range of reports, audits and presentations on the work undertaken by its partner agencies, for example through reports and monitoring by independent reviewing officers. However, there has been insufficient challenge of the information provided by children's social care to the CSCB which has not enabled the Board to gain an accurate picture of current deficits. The CSCB recognises that it needs to be smarter in its selection and interrogation of the information it receives from partners and that it has not been sufficiently robust in comparing its performance with national and statistical neighbours and learning from good practice elsewhere.

54. Commitment from all partner agencies to the work of the CSCB has been strengthened since the last inspection through the increased engagement of senior officer's from children's services. The Head of Children's Services now chairs the prevention of harm sub-group and children's services are now appropriately represented in all CSCB sub-groups. There is overlap in the membership of the CSCB and the improvement Board, which facilitates communication between those representatives who sit on both. However, the efforts to reduce duplication and increase efficiency between the improvement board and CSCB have led to the scope and influence of the CSCB being diminished.

55. Performance management of child protection services is inadequate. A wide range of performance information is routinely available to managers within children's services at all levels, and is regularly interrogated to identify and address case specific and thematic services issues. However this is over reliant on quantitative information which at times is not accurate, for example where case recording by social workers is not up to date, or where dates for undertaking work do not match. Case files are routinely audited within children's services, however, these audits primarily measure a number of processes and few have qualitative comments, actions or clear information about the experience and outcomes for the child. The quality of the auditing overall is poor with no effective bench marking despite a system of cross checking of audits. Where audits do state actions required records did not demonstrate whether these actions were followed through or subsequently checked. A few audits did identify some of the poor practice identified within this inspection in relation to individual cases, although these were not identified as systemic failings.

56. An extensive workforce recruitment and retention strategy has been developed following the last inspection, with a smart workforce development strategic action plan. A permanent senior management group is now in place. Within the FRT there has been a lack of stability

and capacity at team and practice manager level together with high staff turnover and over reliance on agency staff. Effective action to recruit new social work staff has resulted in an increase in the appointment of permanent social work staff. However this is balanced by a similar number of social workers leaving the service, some as a result of performance issues. Those recruited are mostly newly qualified social workers (NQSW's) or are less experienced than those leaving the service. The support to newly qualified social workers has improved since the last inspection. NQSW's have protected caseloads and those seen by inspectors report that they are well supported.

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