Inspection of local authority arrangements for the protection of children

Torbay Council

Inspection dates: **25 February – 6 March 2013**
Lead inspector **Christopher Sands HMI**

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 Torbay Council is judged to be **adequate**.

Areas for improvement

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

Immediately:

- ensure that a robust oversight of the children with disabilities service action plan is in place with regular monitoring
- review all children on child protection plans for two years or more to ensure that adequate progress is being made and that no children are subject to plans unnecessarily
- ensure that language used within assessments, reports and plans is jargon free and appropriate to the child, young person and family
- ensure that casework supervision is used to track progress effectively on child protection plans
- ensure that strategy meetings, discussions and child protection section 47 enquiries are signed off by a senior manager to support practice improvements and consistency.

Within three months:

- ensure that actions and timescales are included within the Health and Wellbeing Board strategy document to enable the Board to become effective in monitoring and supporting the improvement progress

- ensure that improvements in the quality of practice are securely evidenced and embedded through the implementation and monitoring of quality practice standards
- ensure that the Public Law Outline has become fully embedded within practice and is being used to best effect
- ensure that changes in social worker following the removal of a child protection plan are undertaken at a time most appropriate to sustain improved outcomes and which is right for the family
- ensure that the advocacy service is used to best effect by enabling more children and young people to attend and for their voice to be heard at child protection conferences
- ensure that children in need plans are in place for all children receiving services and that the plans are clearly set out with measurable actions and outcomes
- ensure that child protection plans are clear with measurable actions and outcomes on which to support monitoring of progress
- ensure arrangements are in place to actively recruit permanent child protection conference chairs
- ensure sufficient capacity to meet statutory requirements for private fostering arrangements
- ensure greater clarity between the individual responsibilities of the Torbay Safeguarding Children Board and the Children's Improvement Board.

Within six months:

- ensure that services for perpetrators of domestic abuse who are not known to the youth offending or probation services have access to services to address their patterns of abuse
- implement a systematic approach to gaining the views of children, young people and their carers at different stages of intervention and to use this in monitoring, evaluating and planning service delivery
- ensure that the learning from audits and complaints is embedded within practice through a systematic mechanism of audit and quality assurance.

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 four Her Majesty's Inspectors (HMI) and two local authority secondees.

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

Service information

9. Torbay Council has approximately 27,700 children and young people aged 19 and under[1]. This is 21.1% of the total population. The proportion of state-funded pupils entitled to free school meals based on the January 2012 School Census is above the national average (Torbay 17.6%, national 16.9%). Children and young people from minority ethnic groups account for 6.3% of the total statutory school age population, compared with 25.4% in the country as a whole. The largest minority ethnic groups are Mixed (1.3%), Any Other White Background (0.8%) and Asian (0.6%). The proportion of, state funded, compulsory school age pupils whose first language is believed to be other than English is below the national figure (Torbay 3.2, national 15.2).

10. At the time of the inspection, 199 children were subject to a child protection plan. Children's social care teams were providing support to 1003 children and young people. Children's social care services which undertake child protection work include a safeguarding hub consisting of a

[1] *Census 2011. Office for National Statistics*

dedicated contact and referral centre and two initial response teams, five safeguarding and family support service teams, a children's integrated disabilities service, an intensive family support service, one family centre, which undertakes pre-birth assessments, and an out of hours emergency duty service. Prior to the inspection, the child protection aspect of work with children with disabilities was transferred to the safeguarding and family support service.

11. Early help and support is managed through family services. The help and support is provided through a wide range of services including three children's centres, two locality teams and the Family Intervention Project. At the time of inspection, family services was being restructured to create a new integrated service delivery model based around:

    - A Better Start (0-5)
    - A Good Childhood (5-11)
    - Good Prospects (11+)

    The new model creates a family solutions service (0-11) and an integrated youth service (11+). Access to these services is managed through the safeguarding hub, integrated working coordinators and a multi-agency allocation panel process.

Overall effectiveness

12. Overall effectiveness is **adequate**. The remodelling of the social work service at the point of receiving contacts and referrals has contributed to a significant improvement in timely and appropriate decision making. Redirection to the common assessment framework (CAF) process is leading to more children and families receiving effective help.

13. The Torbay Safeguarding Children Board (TSCB) has developed and successfully implemented the 'child's journey' which has enabled an increased understanding of thresholds and levels of need. Feedback from partner agencies confirms that this is having a positive impact and has also increased the partnership's confidence and engagement in children's social care services.

14. Children, young people and their families are being helped more effectively through appropriate decisions being made at the point of contact in children's services for a CAF resulting in an increased use of the CAF. Targeted support service interventions, more efficient assessment and care planning processes combined with allocation resource panels are all contributing to more effective support services which are delivering improved outcomes.

15. Sharing of information between partner agencies is becoming more effective and is well supported with schools and some other agencies having access to the basic information on the council's electronic information system. This enables agencies to see which services are already involved and whether a CAF has been completed.

16. From the point of the new leadership team being established and a revised improvement plan being put in place, a comprehensive audit of children's social care case files has been conducted. The principle reason for this was to ensure that children and young people were being appropriately protected. This audit has resulted in the identification of poor practice and decision making in the past (referred to within this report as the legacy) with remedial actions being taken. For example, re-assessments being undertaken leading to some children being placed on a child protection plan or being subject to care proceedings. The inspection noted the improvements made in current social work practice with the benefit of comparing past practice with more recent work. However, the overall quality of practice remains variable. The council now has in place standards which are to be used to intensify the focus on improving the quality of practice. The inspection did not identify any systemic failures leading to children being inadequately protected and no cases were referred back to the senior managers where children were identified as not being appropriately protected.

17. Leadership and governance arrangements are adequate and are showing signs of delivering improved services and outcomes. For example, through

the restructuring of services which has resulted in an increased focus on earlier identification and intervention, improved partnership working and more consistent decision making at the point of contacts and referrals being received. The council acknowledges that the pace of change in some areas has been slower than expected, for example in achieving a consistency in the quality of practice. due in the main to the need to establish a clear structure for service delivery combined with recruiting permanent staff. The council is now in a stronger position on which to accelerate the pace of change and improvements.

18. The extent of change required affects the whole of the children's social care service. There remains a vulnerability to continuous improvement particularly through the numbers of agency staff. However, the council's workforce strategy and actions being taken to actively recruit staff is proving effective and has resulted in a significant reduction by 50% in the use of agency staff. The council is in the early stages of succession planning within its children's social care workforce.

19. The council's response and that of the Local Safeguarding Children Board (LSCB) to an increase in the numbers of privately fostered children has been slow. The council is challenged by the high numbers of children and young people travelling to the area from abroad to attend language courses, some of whom are at a very vulnerable age. To address this, the council has very recently increased the capacity of the private fostering service. However, only a third of newly notified children received statutory visits on time last year. This, and inconsistencies in the quality and format of privately fostered children and young peoples' records, mean there is potential to miss children and/or not identify emerging risks.

20. The combination of past inspections, external audits and a peer review has resulted in the council having an increased understanding of their responsibility for children's social care services and the need to drive forward improvements. Using the learning from their inspection experiences and a real sense of the need to improve the lives of children and young people, the council has made appropriate decisions to continue to invest in these services, including increasing the numbers of social workers within a climate of challenging financial constraints.

21. Performance management is becoming effective with the council's own unvalidated data showing signs of sustained improvements being evidenced in a number of areas. For example, higher conversion rates of referrals to initial assessments indicating a more consistent understanding and application of thresholds and the number of contacts which proceed to CAFs has increased significantly compared to the previous year. The percentage of re-referrals has reduced and is in line with statistical neighbours. The timeliness of initial and core assessments has improved significantly from a very poor completion rate during 2011/12 with initial assessments currently comparable to statistical neighbours.

22. The council does not yet have a systematic method for gaining the views of children, young people and their carers. Currently, views are obtained on a specific issue or service basis rather than routinely collected views at particular stages of intervention. Children, young people and their families vary in their views about services. Some parents are positive about the help they receive, praising staff for being reliable and helpful, even in complex situations where there had been considerable concern for their children. However, in contrast, the continuity and effectiveness of intervention has been hindered for some children and families by frequent changes of social worker and some parents find the number of professionals involved overwhelming at times.

23. The number of complaints has fallen and most are resolved promptly. Complainants' concerns are regularly discussed by senior managers and lessons for service improvement are identified. There is not yet a systematic mechanism for checking whether learning from complaints has been embedded in sustained improvements to practice.

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

24. The effectiveness of help and protection provided to children, young people and their families and carers is **adequate**. Early intervention is a clear priority for the council and its partners and vulnerable children and young people are helped to access a good range of support services. Through the oversight of the Children's Improvement Board (CIB), the council and partners are working towards full implementation of an integrated service delivery model which is the shared vision and plan for improved early identification and intervention and also includes services for children in need. Recent improvements supported by the successful implementation and adoption across the partnership of the 'child's journey' have clarified the referral criteria and established a single point of contact for both early help and children's social care services. As a result, the majority of children now benefit from timely and effective help. Risks and protective factors are assessed and well managed and more families are being offered support, some of whom may not have received a service in the past.

25. The impact of intervention on children's lives is not yet consistent. Where risk is recognised, assessments and child protection plans are focused on the child's experience and are used well to secure parental engagement. In these cases, families respond well to support, resulting in improvements in children's safety, engagement in learning, health and wellbeing.

26. The council is actively addressing the issue of poor social work practice in the past, the consequences of which are still apparent in some cases. For these children, past weaknesses in assessment and poor supervision have

resulted in drift and delay, with social workers failing to intervene with sufficient rigour to engage and challenge parents and carers effectively. Where this has been identified, corrective remedial actions have been put in place.

27. Current practice is proving more successful in identifying risks and intervening at an earlier stage. However, in balancing the legacy impact with current demands, the council will need to maintain their close vigilance on casework and performance to ensure decisions and casework are contributing to effective outcomes for children and young people.

28. Effective information sharing and coordinated early help has resulted in imaginative and flexible solutions and more personalised programmes for some families. A good range of support services commissioned by the council helps to support and safeguard vulnerable children and young people. Services include advocacy, counselling, a one stop shop run by a voluntary agency which includes substance misuse services, homelessness prevention, support for runaways and help for young people at risk of child sexual exploitation (CSE). Commissioned services have clear service specifications setting out their purpose and intended outcomes and they generally achieve positive results.

29. The council commissions a service for children exposed to domestic abuse. However, there is currently a gap in provision for perpetrators of all ages who are not known to the youth offending service or to probation. As a result, opportunities to intervene early to safeguard children who are exposed to domestic abuse can be missed. A draft domestic strategy is currently being written and the council has confirmed that, as result of this inspection, service provision for this group of perpetrators will be made available. The timescale for delivery is yet to be set.

30. Families have given positive feedback about some specific child and family services, including the council's intensive family support and family group conferencing services. There is evidence in some cases that these are improving the engagement of previously resistant families. In general, the involvement of children and parents in helping to assess the impact of the help and protection they receive is limited to ad-hoc examples rather than being embedded more systematically and dynamically within the council's quality assurance processes.

31. A recently developed children's participation strategy sets out clearly the council's commitment to increase children's involvement in shaping services. There is some use of parents' and children's views regarding services, particularly in relation to children with disabilities. However, this approach is not always clearly evidenced in casework with individual children and families.

32. Families are helped to understand the intentions of the help and protection they receive, although this is not achieved consistently. For

example, some parents seen complained of professionals using too much jargon. Overall, parents value openness and honesty and accept challenge, even where there was considerable concern for their children.

33. In some instances, and in particular parenting assessments, social workers are drawing on research and exploring different ways of helping parents develop their understanding of the issues causing difficulties for their children and themselves. Where this participative approach has been taken, it has helped bring about more consistent parenting and improved family relationships.

34. Children engaged in child protection services have access to advocacy support through a service commissioned by the council from a voluntary agency. Examples were seen where children and young people have been helped effectively to contribute to decisions made for them and ensure their views are given serious consideration, for example when deciding whether a child protection plan is appropriate for them.

35. Interpreters, translation and language courses are available to assist communication with children and their families whose first language is not English. Responsiveness to other aspects of diversity, such as ethnicity, culture, religion and disability, is generally weak and variable. For example, a lack of focus on the implications of parents' learning difficulties can be a barrier to a full understanding of safeguarding concerns in some families. Where this is the case, help and protection have been less effective in improving outcomes for children and risks can persist despite involvement with the service over a long period. However, some examples were seen where good attention had been given to disability. For example, a parenting assessment was tailored to meet the needs of a parent with learning difficulties and some very sensitive and appropriate work had been undertaken when a child with severe disabilities was believed to be in need of protection.

36. The number of vulnerable children and families being identified and supported as having additional needs has increased the use of the CAF. Outcomes are generally positive for families. The council is at an early stage of using an outcomes measurement tool, the 'outcomes star'. Early indications of where this is being used show young people and families being actively engaged resulting in improved outcomes. Improved screening by the safeguarding hub and growing clarity on referral criteria and processes has improved the coordination of help once children no longer need social work intervention. This has contributed to reducing the need for high level services in some cases.

37. In most cases, help for children who need protection is ensured by agencies working together effectively. Operation Mansfield, an investigation into CSE, has heightened the awareness of the council and partners to CSE. Peninsula-wide procedures have been developed and a

local multi-agency forum has been established to strengthen joint working to help children in need of protection. However, at the time of the inspection, there was no council specific implementation plan. Multi-agency training has been delayed due to the availability of a designated member of staff from children's services. This has now been addressed with plans in place for the training to start in April.

38. Good attention has been given to reducing the incidents of children and young people who go missing, with children being seen by a voluntary agency after their first missing episode. The council has been effective in raising awareness and broadening the range of agencies involved in identifying children missing from education. As a result, young people missing education are being identified and supported back on roll and attending school more quickly, a large majority of these being within one month.

39. A few children have remained subject to child protection plans for a very long time as a result of a legacy of ineffective practice and poor management oversight. The council acknowledges that improvements in practice are not yet consistent. However, a stronger focus on early intervention, better initial decision making, more focused use of court proceedings where the level of risk is too high combined with a clear process to enable children to step down to a lower level of support where risks are reducing, all help to ensure that most children are now receiving the right level of service and are not subjected unnecessarily to child protection procedures.

The quality of practice

40. The quality of practice is **adequate.** The significant restructuring of children's social care in January 2012 has resulted in an effective safeguarding hub being established where the vast majority of contacts and referrals are received. Decision making for referral to children's social care or integrated services is now more timely and risk is assessed appropriately. Thresholds for access to services are better understood by agencies and supported through the use of the 'child's journey' model.

41. The increase in the percentage of referrals proceeding to initial assessment is further evidence that thresholds are more clearly understood across the partnership and applied consistently and effectively to ensure that the right children are receiving services. The use of the safeguarding hub enquiry form (SHEF) which has been developed to replace the CAF is becoming an effective mechanism for agencies to refer into the hub. The SHEF has been welcomed by agencies and is being used appropriately.

42. Decisions at the point of contact and referral are made by suitably qualified social workers. The location of two decision makers within the safeguarding hub provides a consistent approach to the management

oversight and decision making about referrals into children's social care services. Access to qualified social workers for advice to assist in determining whether to make a referral is readily available and agencies report positively about this accessibility. The out of hours emergency duty service provides an effective and timely response to referrals. Good support is available to families in crisis out of hours through the intensive family support service.

43. Responses to domestic violence referrals are mostly timely and are appropriately risk assessed on an individual referral basis. A few examples were seen where the need for assessment and direct contact with parents and partners would have been more appropriate. However, children were not being placed at risk of significant harm as a result of the decision not to conduct an assessment. The safeguarding hub receives all notifications of domestic violence incidents known to the police where a child is in the family. However, there is no standard baseline criterion to conduct an assessment where, for example, there has been a second or subsequent incident.

44. There is good use of strategy discussions and meetings with examples seen which were well attended by key professionals, outcome focused and had clear decision making and contingency planning in place. However there are too many telephone discussions involving only the police. In a few cases seen, a strategy meeting would have been more appropriate providing an opportunity for wider agency participation and, as a result, more information for consideration.

45. Section 47 child protection enquiries are undertaken by qualified social workers and overseen appropriately by managers. Recording of strategy meetings and section 47 enquiries is too variable. It is not always possible to identify clearly the content of the discussion and actions agreed. In some section 47 enquiries, there was little evidence of all agencies being contacted to inform the outcome of these enquiries. Recent examples confirm an improving picture using this information on which to base a decision. In the majority of cases seen, the outcomes of strategy meetings and section 47 enquiries were appropriate.

46. The responsibility for child protection enquiries within the children with disabilities service (CWDS) had recently been transferred to the safeguarding service with these enquiries being co-worked between the safeguarding and CWDS social workers. However, at the time of the inspection, some social care staff within CWDS remained unclear about responsibility for section 47 child protection enquiries. As a result of the peer review in June 2012, the council had a project plan in place within the Children's Improvement Partnership Plan (CPIP) to reconfigure the CWDS as part of the improvement plan. However, during the course of the inspection, and in direct response to concerns being raised by inspectors, senior managers made an immediate and appropriate decision to move

CWDS social workers and family support workers into the safeguarding service to ensure a robust and consistent approach was applied to child protection enquiries and CWDS social care casework in general.

47. In the majority of cases, assessments are timely. Assessments and plans for children in need are variable with many lacking focus and instances where plans have not been reviewed, particularly in the CWDS where many cases seen did not have a children in need plan. Some social workers report a number of cases where there has been a need to repeat assessments and re-focus work following periods of drift and which have been identified within case file audits as requiring remedial work. However some good examples of assessments have also been seen where effective help has been offered and there have been good outcomes as a result. CAFs evaluated were clear and included the views of parents and children with appropriate consent. They had a clear focus on programmes of work with defined outcomes delivered over a set time period.

48. Good quality parenting assessments are undertaken by staff specifically trained in this area of expertise. Examples were seen which demonstrated appropriate challenge to parents, use of messages from research to inform the assessment leading to good analysis and recommendations appropriate to evidence and findings gathered.

49. Recording is up to date in the majority of cases. However, the quality of recording is variable and in some cases lacks appropriate detail particularly concerning the voice of the child and the outcomes achieved during interventions. There is a prevalent and inappropriate use of acronyms in recording. Within some assessments, evidence was seen where the language used was inappropriate. The quality of recording and the use of recording to share information are enhanced by key professionals other than the allocated social worker, for example occupational therapists and staff within the intensive family support service, being able to record directly onto the electronic case file.

50. The use and quality of chronologies is variable. Chronologies are evident in many cases seen but in some cases have not been used to inform assessments. Some good examples were seen where historical information was used effectively to inform current planning and decisions.

51. The quality of child protection planning is variable with some plans lacking a clear focus and measurable actions, outcomes and timescales. In the better examples, using a more recently introduced format, plans were much improved, with identified risks, associated actions and actions clearly recorded. Some legacy examples were seen of drift including a small number of children on child protection plans for three years. An independent audit of all child protection cases was undertaken in May 2012 where there had been a plan in place for two years or more.

Remedial actions have been taken which have resulted in an increase in care proceedings and a reduction in the numbers of child protection plans.

52. Case conferences observed and case records of conferences demonstrated appropriate attendance by key professionals. However, there is a challenge in attendance by general practitioners partly as a result of the current high number of conferences being held. In a small number of cases seen and conferences observed, the decision for a child to be subject to a child protection plan was questionable with the possibility that a robust child in need plan would have been equally effective. Half of the child protection chairs are permanent employees, the other half being covered by agency staff. This is resulting in a lack of stability and contributing to variable quality in consistency of decision making and quality assurance. A pre-conference scrutiny and quality assurance process is in place which serves to mitigate this and to promote consistency of practice.

53. Child protection core group practice is variable with work seen that included the delivery of support services leading to good outcomes. However, during the observations of a very small number of core groups, the chairing of these was not observed to be consistently effective resulting in meetings that did not cover all the issues fully. Attendance by key professionals at core groups is good. The timeliness and frequency of core group meetings has improved. However, the quality of recording these meetings is variable. Some are recorded poorly making it difficult to identify and track progress and do not evidence sufficient attention being given to the detail of the plan. The template for core group recording it is not being used systematically across the service.

54. The Public Law Outline (PLO) is not being used to best effect. This is an important part of case planning in respect of care proceedings and ensuring that parents are fully informed as early as possible of concerns and the possible implications. The council is aware of this deficit and recently has introduced a framework to clarify PLO processes. The inspection did not identify any cases where the lack of the use of the PLO was resulting in children not being appropriately safeguarded.

55. Historically, some staff have lacked consistent management and guidance. This has resulted in a legacy of poor casework and drift in cases. This legacy is still being worked through and has resulted in a significant increase in child protection plans and care proceedings.

56. Recent work in teams is of an improved standard with evidence of remedial work undertaken in relation particularly to legacy work and adherence to timescales for assessments with evidence of appropriate decision making. In cases seen, no children and young people where inadequately protected or at risk of significant harm.

57. Evidence that children are seen alone and that an effective relationship is built with the social worker is limited. Whilst a small number of examples where seen of children consistently being seen alone, recording in other cases was too brief and assessments did not always provide evidence in this area. In some assessments, good examples were seen of children being listened to and their wishes and feelings being fully explored through direct work by the social worker, the outcomes of which help to inform decisions and assessments.

58. Many staff reported improvements in supervision practice. However, there is a legacy of poor practice in this area particularly in CWDS. In most current examples seen, supervision has been taking place on a regular basis. Case discussion and decision making is recorded on the electronic social care records system. In some examples, supervision entries were brief and showed little evidence of challenge or consideration to the progress being made in relation to child protection plans. In most personal supervision files seen by inspectors, personal and professional development was given an appropriate focus, previous discussions were tracked with actions by staff and the manager clearly recorded along with evidence of identification and work on performance management issues.

59. An advocacy service is available for children who are involved in child protection processes. Examples were seen where this has been effective in supporting their attendance at child protection case conferences. However, the attendance of children and young people at case conferences is an area for development.

Leadership and governance

60. Leadership and governance are **adequate**. Following a number of inspections and service reviews and a formal notice to improve, the council has a clear understanding of its effectiveness, strengths and areas for development. The council, its partners and the relatively new senior leadership team have risen to the challenge to address identified weaknesses in service delivery. The stimulus to advance the progress made has gathered momentum and the need to accelerate the pace has been recognised by the senior leadership team. Through the CPIP, ambitious, essential and necessary strategies in relation to the provision of child protection arrangements and targeted early intervention services for families have been implemented.

61. The children's trust arrangements are in the process of being established within the Health and Wellbeing Board which becomes fully operational from April 2013. As such, the Health and Wellbeing Board is not yet in a position of maturity to provide effective scrutiny and challenge to drive forward the extensive changes and improvements needed within children's social care services. Whilst the children and young people's plan remains in place for the foreseeable future, the predominant plan and partnership

approach used to drive service improvement is the CPIP with oversight by the CIB.

62. The CPIP is wide ranging. It is based upon a simple but complex principle of needing to tackle all service areas. Inevitably this has resulted in a comprehensive plan which is designed to strengthen and build on existing partnership arrangements. It demonstrates the scale of the changes required combined with the Council's aim to reshape services significantly and ensure their sustainability. A robust project management approach and appropriate reporting mechanisms through to the CIB and elected members ensures sufficient rigour and oversight of the plan. The pace of change is gathering momentum and the level of challenge required to support the continued improvements resulted in the appropriate decision to appoint an independent person as chair of the improvement board.

63. The council's corporate plan clearly prioritises the need to improve safeguarding for children. An up to date joint strategic needs assessment (JSNA) has been completed which is now being used to inform the Health and Wellbeing Board's strategy and priorities. The draft health and wellbeing strategy which appropriately includes safeguarding children as a priority, thus reflecting that of the council, has recently been approved by full council. However, specific actions and timescales on which the Health and Wellbeing Board can measure progress across the partnership for achieving the safeguarding priority have yet to be identified.

64. The strategy for preventative services through an integrated model of service delivery is in place and is also embedded within the CPIP. Working in partnership with the council, the public health service is leading on the development of community hubs through which local services and support can be accessed and from which community based commissioning can be informed.

65. The council's chief executive functions are undertaken by a chief operating officer (COO) who maintains a close oversight on progress of the improvement plan through formal line management arrangements with the senior leadership team and by being a member on the CIB. The COO is an interim part time appointment and the current post holder is also the director of adults' services. Whilst there has been no evidence to date, this has the potential to lead to a conflict of interests between the competing demands of adults' and children's services and other council services. Appropriately, during the time of this inspection, full council had approved a new senior leadership structure which includes a dedicated COO post for four days a week.

66. Accountabilities are clear and well established between the Mayor, lead member and the director of children's services. The lead member is well informed on both a formal and informal basis. Learning from the past has heightened the awareness of elected members and increased their

oversight of children's services. Elected members are taking an active interest and oversight including visiting staff in offices to ensure that the improvement programme is maintained and delivered in a purposeful way.

67. Confidence in the senior leadership team is wide spread and significant achievements can be measured in the re-design of the service and the focus on improving social care practice. Staff consistently report positively on the accessibility and visibility of senior managers and demonstrate an understanding in the need for change.

68. Creating a stable workforce with sufficient capacity, skills and experience to support senior managers in implementing the improvement plan has delayed the speed of progress and impeded the development of good quality practice and services to families. The council has increased the number of social workers by 20% and, through the redesign of teams, has reduced significantly the span of responsibility for team managers.There is clear evidence that robust and vigorous recruitment activities are now being effective reducing the dependence on the use of agency staff by half. However, the proportion of agency staff remains too high across the service which may undermine the progress to achieve continuity, consistency and stability.

69. Newly qualified social workers are well supported in their development through an effective induction process, protected caseloads and a mentoring scheme. The allocation of school headteachers acting as individual mentors to managers is a particularly good example of partnership working and collaboration. This innovative approach strengthens the council's desire to provide a learning culture across the partnership on which to build a workforce equipped with the skills to deliver and sustain the improvements.

70. The reconfiguration of services combined with increased staffing has resulted in workloads now being at a manageable level with regular monitoring and oversight of these by the senior leadership team.

71. The TSCB is meeting its statutory responsibility. All statutory agencies are represented and members of the board have sufficient delegated authority to effectively represent their organisation. Attendances rates by some key partners need to improve to support a more strategic collaborative partnership approach to the work of the board. Partnership arrangements with the voluntary sector are being reinforced through the development of a communication strategy to ensure all voluntary organisations are engaging with and fully participating in TSCB activities. The board is actively recruiting two lay members supported by a job description, induction programme and a mentoring scheme where new members will be mentored by experienced participants to support their learning and development.

72. Learning from serious case reviews (SCR) is at an early stage and is a positive contribution to supporting a learning culture and overall improvement in social work practice. The on line e-bulletin is in its infancy. However, its impact in supporting the learning and development framework is evident. Social workers reported that the findings from a recent SCR have challenged their professional assumptions and stereotypes resulting in a greater awareness of vulnerability and the need to be vigilant where children are at risk of CSE. Messages from research and SCRs have informed an effective poster campaign helping to raise awareness of some critical issues which impact on families and social work practice. The TSCB acknowledges that there remains much more to do to ensure it becomes an effective conduit for challenge and learning. A core performance data set informs the TSCB of current practice across the partnership. It supports partner agencies in understanding the work of each agency, strengthening their knowledge and ability to challenge each other.

73. The benefits of multi-agency audits and training are improving working relationships across the partnership, building confidence and a better understanding of the safeguarding agenda. At the time of this inspection, Children Act 2004 section 11 audits to monitor and evaluate compliance of the council and partner agencies with their specific and general duties in respect of safeguarding have been undertaken across the partnership. The findings have yet to be analysed. There is now a growing self-assurance and a stronger focus on safeguarding activities across the partnership further strengthening the prominence of the board and ensuring it plays its full part in driving the improvement agenda.

74. There is some emerging evidence of a potential lack of clarity between the work of the CIB and the TSCB. This was identified within the peer review and some examples were also evident during the inspection. To ensure this does not impede progress, clear lines of responsibility and accountability need to be established so that the CIB does not inadvertently undermine the work of the safeguarding board.

75. A comprehensive suite of performance data includes relevant data from the health service and the police. Improvements in the unvalidated council's performance figures for January 2013 include the percentage of referrals progressing to initial assessments, an increase in CAFs, a reduction in re-referrals, assessments being completed within timescales and initial child protection conferences being held within 15 days. More work is yet to be done to reduce the number of children on child protection plans although this is steadily reducing.

76. The council has been undertaking a systematic programme of case file audits as part of the CPIP and which is reported regularly to the CIB. By December 2012, 500 cases had been audited which has included all those where there was a child protection plan and 200 children in need cases.

This audit activity was established specifically to ensure children were safe and has been effective in identifying a legacy of poor practice and decisions which have lead to remedial actions being taken, resulting in an increase in child protection plans and care proceedings.

77. Weekly performance meetings led by the senior leadership team ensure progress against key performance targets is closely tracked and areas of growing concern identified and responded to. Team managers receive weekly performance reports and access to live data to monitor the performance of individual teams and members of staff. However, applying this consistently can prove problematic where agency managers are newly appointed.

78. A quality assurance framework is in place with a phased introduction that is working towards a regular auditing programme across all service provision including weekly audits, monthly overview meetings, auditing of child protection cases both internally and by independent auditors and as standard all managers auditing three cases per month. The need for continuous oversight of practice during the improvement programme is exercised diligently by the senior leadership team which holds a regular 'Friday audit' to sample cases where themes and patterns have been identified through other auditing processes.

79. The phased introduction of the quality assurance framework has been slower than expected and reporting on the findings of those audits undertaken is in its infancy. To support the accelerated learning and development programme senior managers need to ensure findings from audits are firmly embedded within practice. A programme of themed audits and auditing against recently implemented practice standards is in the developmental stage.

80. Throughout the inspection, the senior leadership team demonstrated an open approach and a keenness to learn. This learning culture was evidenced strongly within conversations with individual staff. An example of using this dynamic learning to improve services was seen in the senior leadership's response to inspectors' concerns about the standard of practice within the children with disabilities team. Whilst a project plan was already in place, decisive and immediate action was taken to address these concerns supported by a robust action plan.

81. The voice of children and young people has been used effectively in the preparation of the revised improvement plan to form the priority objectives. Following a series of consultations with children and young people, there is a proposal for a children and young people's sub group working alongside the TSCB to ensure their voice is heard within the safeguarding agenda. However, securing the views of children and families is not sufficiently well embedded on a dynamic basis through regular feedback and evaluation mechanisms, for example, at specific

points during and after interventions to inform service planning and delivery.

Record of main findings

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