

Inspection of local authority arrangements for the protection of children

West Sussex County Council

Inspection dates: 11 - 20 February 2013
Lead inspector: Bill Wallace 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 West Sussex 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 West Sussex County Council, the local authority and its partners should take the following action.

Immediately:

- ensure that existing plans to improve the timeliness of initial child protection conferences are implemented and effective.

Within three months:

- ensure that outcomes of section 47 enquiries include a summary of activities and a clear outline of concerns in order to clearly identify key issues and findings
- ensure that chronologies which reflect the most significant issues in a child's life are available on all files and used systematically to inform practice
- ensure that assessments are based on evidence-based reasoning and clear analysis of the impact of the caring arrangements on a child's well-being and development, and plans specify exactly what needs to change and by when to meet their needs
- ensure that children are involved in all plans for their help and protection in a meaningful way through sufficient preparation, consideration of the appropriateness of the time and venue of

meetings, and the provision of advocacy arrangements where appropriate

- ensure that the supervision of social workers and other staff working directly with children is reflective, challenging, focused on ensuring good outcomes for children through meaningful intervention, and that performance reviews reflect what the staff member needs to do to achieve this in all aspects of casework
- ensure that child protection plans include contributions from relevant partner agencies, and are specific and measurable with clearly identified timescales
- ensure that all assessments and plans consider and reflect equality and diversity factors
- ensure that all children and young people who no longer require statutory child protection services have access to a timely, effective and well-coordinated package of help and support which meets their individual needs and sustains improvement in their circumstances.

Within six months:

- in partnership with other agencies, develop and implement an overarching strategy for early help and preventative services which ensures that there is a diverse, wide ranging and accessible early help offer and that all children and young people receive well-coordinated multi-agency help early on in the emergence of problems
- ensure that the outcomes of audits together with the views and feedback from children and young people systematically inform service design, development and continuous improvement.

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 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. West Sussex is almost 80% rural although the bulk of the population (close to 80%) live in the urban areas along the south coast and in a series of market towns inland, as well as the large town of Crawley on the Surrey border. The county has a total population of 807,000,
10. The areas of the county with the highest percentage of under 18s are Crawley (23%), Horsham (21%) and Mid Sussex (22%).
11. West Sussex has approximately 163,000 children and young people under the age of 18 years. This is 20.2% of the total population. Minority ethnic groups account for 14.8% of the total population, compared with 20.2% in the country as a whole.
12. Some 12.1% of 0-15 year olds are estimated to live in income deprived households; this is lower than the national average of 18.4% but the county includes some areas of social deprivation where the rates are higher than 1 in 3.

13. At the time of the inspection, there were approximately 3976 cases open to children's social care services and 395 children were on child protection plans.
14. Early help in West Sussex is provided by a range of services through 45 children and family centres, augmented by mobile service delivery serving rural areas. In partnership with local organisations, these centres offer universal access to key services and targeted support for families with identified needs.
15. The council has refocused its youth services to deliver early intervention and prevention, targeted and specialist services, and has established, together with partner agencies, a family support initiative under the government's troubled families agenda.
16. Initial contacts with children's social care services are managed by the children's access point (CAP), and those identified as requiring further social care assessment are transferred to one of two area-based referral and assessment teams (R&A). Children and young people assessed as requiring social care support or protection then transfer to one of the council's intensive family support teams (IFS), children looked after teams, children with disabilities or Gatwick children's team for those children arriving as unaccompanied asylum seekers. An out of hours service responds to children and young people who require support or protection out of normal office hours.

Overall effectiveness

17. The overall effectiveness of the arrangements to protect children in West Sussex County Council (WSSCC) is adequate. West Sussex was issued with an improvement notice in March 2009 following the 2008 annual performance assessment which judged the county to be performing poorly. In addition, it was made subject of a further improvement notice in March 2011, following the inspection of safeguarding and looked after children which judged overall effectiveness and capacity for improvement of the council's safeguarding services to be inadequate. Both improvement notices centred on the performance of the child protection services. Since that time Ofsted has undertaken an unannounced inspection of the council's contact, referral and assessment arrangements for children and young people. This inspection, in August 2011, found that progress had been made since the previous inspection with no areas of priority action.
18. This inspection has not identified any systemic failures that have resulted in children failing to be protected. The council has a clear improvement plan to address recommendations from the 2010 safeguarding and looked after children inspection and accelerate its existing children's delivery programme. The Leader of the Council has ensured that the highest priority has been given to the improvement plan which continues to be subject to rigorous internal and external scrutiny. The Chief Executive Officer and Director of Children's Services, supported by unambiguous commitment by the Leader, cabinet and elected members have achieved improvements from a very low baseline to assure themselves that improvements are sustainable. The council has laid the platform for continued improvement through a number of measures including the appointment of a Head of Children's Services, continued internal and external scrutiny and investment in staffing.
19. The effectiveness of the Children's Trust Board, now the Think Family Partnership Board (TFPB), and the West Sussex Safeguarding Children Board (WSSCB) has improved. The independent Chair of the WSSCB is assertive in challenging and holding agencies to account and has secured support from all agencies, senior officers and elected members. A number of earlier problems have been resolved by the strengthened leadership provided by the WSSCB. For example, there is now ring-fenced designated doctor time for the WSSCB and the participation at meetings and in WSSCB activities by key agencies has now improved. The profile of the TFPB has increased, developing existing early help services by, for example, expanding the numbers of Family Intervention Project and Family Nurse Partnership workers and the development of the Think Family initiative. There is recognition of the strategic importance of developing early intervention and support services. However, the council and partners acknowledge that early help is still delivered through a largely disparate range of provision and that they must develop a more

coherent strategic approach to ensure greater consistency in its early help offer.

20. Senior leaders have created an open learning culture in which staff at all levels are fully engaged. This provides a focus on raising practice standards through improved supervision arrangements, quarterly quality assurance and performance workshops and compliance to procedures and guidance by social workers. This has led to significant improvements in the understanding and application of thresholds and risk and protective factors by staff. Organisational structures and the workforce have been reconfigured effectively to reflect the findings of previous inspections as well as national and local research. Social work staffing has been increased and this, together with the presence of more experienced social workers, has resulted in manageable caseloads.
21. There are clear improvements in the services offered to children, young people and their families since the last inspection. However areas of inconsistent practice remain, reflecting the scale of the historic challenges the council faced. These include variability in the quality of assessments, recording of some section 47 enquiries, and the effectiveness of planning. Through its performance management and audit moderation arrangements the council is aware of these inconsistencies and is taking steps to address them. There are also areas requiring further strategic development such as workforce planning for the wider children's workforce, developing an overarching strategy for early help and preventative services and utilising children's views to shape services.

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

22. The effectiveness of the help and protection provided to children, young people and their families and carers is adequate. No cases were identified in this inspection in which children are currently at risk or suffering significant harm.
23. Most children and young people at risk of harm are quickly identified and are promptly referred by partner agencies. They are robustly screened within the CAP service. Inspectors did, however, see some cases where there was undue delay in concerns being referred and others where decisions made within the CAP are not robust. In the majority of cases seen by inspectors the needs of children and young people are responded to in an effective and purposeful way. However, the level of re-referrals to children's services over the past year, at between 20% to 31%, remains high and at the time of inspection was 27%. The council and WSSCB recognises this is too high and are continuously reviewing these referrals but have not as yet identified any discernible patterns that would determine any specific action.

24. Too many initial child protection conferences are not sufficiently timely and this results in undue delay in formulating and implementing child protection plans and access to appropriate services. In a few cases there was undue delay in ensuring that child protection concerns were assessed and responded to but no children were found to be at significant harm. A high number of child protection investigations have been carried out over the past year which have resulted in no further action being taken. However, senior managers regularly audit these cases and inspectors found no cases where children have been subjected unnecessarily to child protection processes or to be at immediate risk .
25. Robust child protection planning is evident in most cases seen and strategy discussions or meetings are routinely and appropriately used in which the police and children's service always engage. Health partners routinely contribute information to strategy discussions but do not routinely engage in them. Police engage in all strategy discussions or meetings, including those in which they have no involvement and where there are no criminal concerns. This has provided improved scrutiny and challenge, however in some cases there was undue delay in undertaking child protection inquiries or convening initial child protection conferences.
26. The overall quality of assessments is adequate, with risks clearly identified and responded to. However inspectors saw some cases which were not effectively case worked, overseen by managers, or sufficiently recorded to evidence the impact of social work intervention. This was exacerbated by child protection reports which in many cases were an amalgamation of case notes and did not succinctly identify key issues and risk factors and the clear identification of measurable interventions.
27. Child protection conferences are well chaired and well attended by appropriate agencies that are actively enabled to contribute information and assessment of risk. However, child protection plans are not consistently specific and measurable and are not always used by all relevant partner agencies within the child protection conference. In most cases seen core groups effectively engaged key partner agencies, parents and carers and appropriately reviewed and developed child protection plans.
28. At the time of this inspection 395 children were subject of a child protection plan. The percentage of children subject of a child protection plan for a second or subsequent time had dropped from 17% in March 2010 to 10% in September 2011, but has subsequently steadily increased again to 17% in December 2012. This is significantly higher than the England average of 13% and has been subject to multi-agency audit which identified the common themes for re-registration. All cases where children come back onto a plan are reviewed by senior managers.

29. Help and protection for children who go missing from home or school are well coordinated between key agencies including the police, social care, education and the voluntary sector. Strong partnership work to protect children is underpinned by clear policies and procedures and regular and effective information sharing. Agencies are keenly aware of the potential risks to children from child trafficking through Gatwick airport and from sexual exploitation. Specialist help and support for children who may have been sexually exploited has been commissioned to meet this need through the Sussex Be Safe programme and are effective. Children who are educated at home are also tracked and monitored robustly. Welfare and protection concerns are identified and acted upon quickly through an established triage system between education and social care.
30. Processes to step up concerns from universal services or common assessment framework (CAF) to social care are established and work well. However, processes for step down from child protection or children in need to the CAF or universal provision which would benefit children, young people and their families are not as well embedded.
31. Early help and preventative services are available across the county, but currently lack an overarching strategy for their coordination, evaluation and further development in relation to agreed priorities and identified need. The local authority recognises this as a key gap. Professionals in the local authority and in partner agencies are committed to working together to provide early help for vulnerable families. Progress has been made since the last inspection in developing shared practices and procedures, including those underpinned by the CAF and the eCAF system. Multi-agency working is becoming more established at local level, for example through the Children and Young People's Planning Forums (CYPPF).
32. The number of CAFs has increased steadily since the last inspection, with a relatively high proportion started by schools, particularly primary schools. However, the numbers of health professionals and early childhood practitioners taking the lead remains low and very few CAFs are started or led by youth support professionals or voluntary sector organisations. In the sample of CAFs seen by inspectors, children and young people's wishes and feelings were not consistently well represented or recorded. Ethnicity and disability needs are recorded in most CAFs, but do not feature well enough in plans.
33. The majority of parents are positive about their experiences and initial benefits of early help, including involvement in team around the child (TAC) meetings. However, little work has been done to evaluate the long-term impact on improving outcomes for children. While an increasingly wide range of support and preventative programmes are available, these do not consistently make up a coherent package of help for individual children with agreed timescales, success measures and clear pathways that children, parents and all the key professionals involved understand.

34. While most children's centres have good or better safeguarding arrangements, the quality of provision judged by Ofsted to date is mixed with only just over half judged to be good for overall effectiveness. The local authority is however taking steps to strengthen the contribution of children's centres to early help and preventative work. Feedback from parents through the family intervention programme, the family nurse partnership and family resource teams is generally positive about the support they have received, for example in building stronger relationships with their children and in preventing family breakdown. However, the local authority and its partners recognise the need for much greater coherence in support for the most complex families and this imperative is driving developments in the new Troubled Families programme.
35. Young people with high levels of need age 11 to 25, but who fall just below the threshold for social care services, have access to a number of youth support and development programmes. These include individual and group work for those overcoming domestic abuse, multi-agency work preventing youth homelessness and effective crime prevention programmes which have had a positive impact on reducing the numbers of young people who reoffend. Preventative programmes and activities are also delivered in schools in partnership with the police to help children stay safe.
36. Most children, young people and their carers understand the services that they receive. The large majority of children and families who receive early help and targeted support, for example through CAF/TAC arrangements or the work of family resource teams, are positive about their experiences and report that they have been helped effectively to make improvements in their lives. Parents feel they are made very welcome at children's centres and are able to access helpful information and advice from children's centre staff as well as meet with professionals such as health visitors and health promotion workers who provide specialist support on child health and well-being.
37. In most cases seen by inspectors the views of young people were not consistently or routinely captured or used in case planning or within child protection conferences and plans. Parents seen by inspectors had mixed views about the help they received, reporting that they were well prepared and engaged within the child protection conference and enabled to actively participate, that they were treated respectfully and listened to by their current social workers. However, they expressed dissatisfaction with changes of social workers, some of whom they perceived had put them under undue pressure or had not been open and honest with them about child protection risks and processes.
38. The council provides some positive examples of children and young people's voices being at the heart of the assessment process in CAFs,

where effective and sensitive work has been undertaken to help them to express their wishes and feelings and to contribute actively to reviewing the progress they are making. However, this is not consistent practice and is a recognised area for improvement identified in the last CAF audit.

39. Most cases seen routinely recorded the ethnicity, religion, language and any disability for the child but, in the majority of cases seen by inspectors, the relevance of ethnicity and cultural issues was seldom explored within child protection or children in need (CIN) assessments or case planning. A few cases were seen where cultural issues were well assessed, for example where a child exposed to domestic abuse in non-English speaking family was helped through an assessment which explored cultural as well as language issues in the consideration of risk. Interpreters are appropriately available and used to engage with families where required.

The quality of practice

40. The quality of practice overall is adequate. There are some individual examples of good practice on casework, including direct work with children and young people, thorough assessments and plans of high quality. However, there are also many examples where these standards are not met, and in the majority of cases seen the work was only of an adequate standard.
41. Thresholds for referrals are in place and a review of casework at the CAP identifies that professionals are referring children appropriately. Since the last inspection there is a much improved and 'shared understanding' within universal and targeted services of when and how to make referrals to CAP.
42. Thresholds are clear and pathways for cases stepping up and down between social care and early help have been agreed and are used effectively. For example, the new CAF Plus team is able to provide intensive support over an extended period of time for families with high levels of need, but who have not met social care thresholds. The route to escalate cases from the CAF is effective in most cases through the CYPPF where professionals are able to consult with qualified social workers to discuss and consider whether to make a referral. This alongside accessible and timely advice from the CAP is reported to have reduced the number of referrals resulting in no further action by the council.
43. New referrals are dealt with promptly by the CAP. New contacts including re-referrals are screened and appropriately addressed or redirected with a minimum of delay in the majority of cases. Decision making within the CAP is made by suitably qualified social workers and managers and is consistent. There are examples of regular, timely and effective strategy discussions which safeguard and protect children at risk of significant harm.

44. Domestic abuse referrals are screened and initially risk assessed by the police, and where they are high priority these are immediately addressed through strategy discussions. Assessment is further informed through the helpful presence of an IDVA (independent domestic violence advocate) within the CAP providing access to information within an external data base of domestic abuse cases. Strategy discussions observed provided a good opportunity for consideration of the wider needs of the child concerned, and implications for other children who may be at risk. However, they do not always include all relevant agencies and this means that in some cases critical information which may influence decision making may be missed. Records of strategy discussions identify the outcome and actions to be taken, by whom and within what timescales.
45. Section 47 enquiries are always undertaken by suitably qualified social work staff. Background checks and information gathering are carried out and the process of the investigation is recorded within case files in case notes and on section 47 report templates. However, there is inconsistency in the way section 47 outcomes are recorded. Some contain case note records with insufficient summary, analysis or identification of the key issues. As a result it is not always clear what the key issues or findings are.
46. Involvement and exchange of information between day time children's services and the out of hours service is effective. Some good examples were seen of information sharing between hospital staff and the out of hours service where children were on child protection plans.
47. Transfer from the CAP to referral and assessment teams works well, and where necessary case discussions accompany electronic records. Timeliness of initial and core assessments have improved, and all children in child protection and children in need processes have an allocated qualified social worker. In a minority of cases there were delays seen in initial and core assessments and this was a result of changes in staffing or staff absence.
48. Assessments are of variable quality, with most core assessments identifying risk and protective factors and reflecting relevant historical information about children and families, and a minority of examples demonstrated an effective analysis which informed future planning. However, too many were not sufficiently explicit in identifying the actual or potential impact of the relevant risk factors on children. Reports for child protection conferences also reflected a tendency to list risks rather than analyse or weigh them.
49. The quality of CAF assessments and recordings in the sample seen by inspectors ranged from good to inadequate, with the majority being adequate. The needs of children were sufficiently identified in most CAF cases. Too many plans were characterised by a list of tasks to be

completed or services to be provided but insufficient focus on the outcomes to be achieved by or for children.

50. Although not always recorded on the relevant section of the forms, children are regularly seen and seen alone where appropriate by social workers who often have a good relationship with them. In the children with a disability team there are some good examples of a sensitive understanding of children's needs. The local authority acknowledges that this is not sufficiently embedded practice and remains an area for development.
51. Records and observations of case conferences demonstrate that these are effective multi-agency information sharing forums, and well attended by relevant agencies although not all contributed fully to the plan in some instances. Plans evidenced a wide range of resources used to undertake direct work with children and families, to support assessment activities, provide parenting education and information, and planned programmes for both perpetrators and victims of domestic abuse. Work within multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conference (MARAC) processes is also well embedded, with examples of an effective joined up approach between them and children in need and child protection planning processes. Where substance use and parental mental health issues are identified, relevant professionals are engaged in the statutory processes. Where children are affected by domestic abuse, and experience substance misuse or mental health issues themselves, services are available to undertake direct work and provide effective support.
52. The quality of care planning is variable. Children in need and child protection plans reviewed were mostly outcome focused, although it was not always sufficiently clear how objectives achieved would help and protect children, within timescales which meets the child's needs. Not all plans clearly identified what would be different for the child once the plan was achieved, and this is linked to the child's needs not always being clearly identified in the assessment.
53. Visits to children on child protection plans and children in need plans are regular and within timescales set out in the plans, and child protection visits conform to the local authority's expectation which is every 10 working days. There are some good examples of engagement with children, but the records do not always show the purpose of the visit in relation to the plans, making it difficult to understand how the intervention is meeting children's needs.
54. Case recording on electronic files is mostly up to date, although in too many cases seen there was no chronology or the chronology was not current. In some child protection cases reports from case conferences and core group minutes were not on file, making it impossible to see decisions

made, how they were arrived at, or how plans were being taken forward. In most cases core groups had been held, but the progress of plans was not on file in some cases, over a month later. This would make effective management oversight difficult to achieve, and make it difficult for an out of hours worker to understand the current position.

55. Management oversight of case work was evident on most electronic case files, either as individual decisions, signing off assessments, or supervision notes. In some cases well recorded management decisions, the reasons for these decisions and a review of work undertaken since the previous supervision were evident, but this was in the minority of cases. Child protection conference chairs review cases they are working with, and provide a layer of quality assurance outside of direct line management. There were examples of case audits on some files and some, but not all, identified actions that needed to be taken. Some examples were seen in the CAP team where manager's decisions were constructively challenged by other managers at the point of transfer, and as a result decisions regarding appropriate actions on cases were changed.
56. The quality of social work supervision files was inconsistent, with some good examples of well structured monthly supervision which included personal development and case discussion. However there was little evidence of reflection or challenge evident in files reviewed, although most were at least adequate. In discussion with inspectors, social workers described feeling well supported and benefitting from readily available ad hoc consultations with managers. Social workers also reported having ready access to training and professional development opportunities.

Leadership and governance

Adequate.

57. Leadership and governance are adequate. The council has made significant progress in its response to the safeguarding findings of the November 2010 and September 2011 inspections and to the improvement notice. Determined and hands-on leadership by senior council officers with strong political support have ensured that child protection services have improved from the previously low baseline. The council has appropriately prioritised improvements in its referral and assessment response. A far-reaching restructuring has seen the introduction of the CAP in June 2011. While the council has been successful in improving timeliness and quality, it is aware that much work remains to be done. For example, re-referral rates remain too high and the quality of assessments needs further improvement. The local authority and its partners are implementing ambitious strategies for further development, such as the Troubled Families initiative.

58. The local authority and its partners share high ambitions for the provision and further development of early help and preventive services. They have substantially reorganised key resources such as children's centres and youth support services. While many of the component parts of a high quality early help offer are in place, with some well-established, there remains a lack of coherence and robust strategic oversight that holds partners to account for agreed priorities. The integrated services team provides strong county-wide leadership for much of the early help agenda, as well as practical advice and well-regarded expertise for schools, health practitioners and other agencies at a local level. There is more to do to harness fully the capacity and skills of voluntary and community sector organisations. The systematic use of management information and evaluation in early help and preventive work is insufficiently developed.
59. Governance arrangements are clear, with accountabilities and responsibilities well defined. The Children's Trust has very recently been replaced by the TFPB and early indicators suggest an improved focus on strategic development. Links with the WSSCB are in place and respective roles well understood. All main partners are actively engaged in shaping provision for children and families, and there is strong support and leadership at political and senior officer levels.
60. Under the leadership of its independent Chair, the WSSCB has improved significantly and now meets its statutory responsibilities in providing leadership, oversight, challenge, quality assurance and training. There is evidence of accelerated improvement in effectiveness in the last year in particular, with quality assurance and performance management arrangements that are fit for purpose, an improved profile and a well-structured training programme. However, these improvements require consolidation over a sustained period to ensure the realisation of their full potential. WSSCB members are clear about their accountability and that of their agencies for safeguarding and child protection. WSSCB now applies a coherent range of quality assurance mechanisms it uses to ensure that agencies prioritise child protection and operate safely. These align well with the local authority's own approaches. However, the WSSCB acknowledges that while it understands and influences compliance and quality of practice, it is not yet in a position to identify and understand the impact of child protection work at child level. It has identified this as a priority for further development.
61. The council has improved performance management arrangements significantly since the last inspection. The introduction of a new electronic social care record enables routine performance reporting on key performance indicators. Managers and staff in children's social care get weekly performance reports to enable them to benchmark and take action to resolve shortcomings. A Quality and Performance Management Board oversees this work at a strategic level. Alongside this, an audit moderation group (AMG) operates on the quality of practice, collating individual

audits, ensuring consistency and identifying learning. These forums involve managers from different levels and their findings are disseminated to practitioners and managers through performance management workshops. Overall there is now a robust approach to performance management that enables the recognition of trends and themes and the dissemination of learning. This has delivered improvements, especially in the last year, but there remain areas of inconsistency, for example in the quality of assessments, consideration of equality and diversity factors and supervision.

62. WSSCB multi-agency audits have led to challenge and improvement. For example an audit of core groups found a high percentage not recorded in the electronic social care record. Subsequent action has led to a significant improvement in just three months.
63. CAF quality assurance and auditing processes are in place, but not embedded. The last audit accurately identified weaknesses in CAF such as the variable quality of outcome-focused plans and insufficient voice of child in assessments. Effective action is underway to tackle weaknesses in the e-CAF IT system which is not user-friendly for young people or practitioners.
64. The strong focus on performance management ensures that staff at all levels receive regular feedback on individual, team and service performance. Structured training programmes are explicitly linked with improvement and are available in line with personal development reviews. The recognition of the need for continued improvement is well understood. However, this is relatively recent and the impact on the overall quality of work and outcomes for children, young people and families is not yet consistently evident.
65. A range of documents provides evidence that feedback from children, young people and parents is sought by children's social care and services providing early help. These cover both the evaluation of case-level delivery and service planning. While documents seen indicate feedback about the impact of services is largely positive, they lack analysis, lessons learnt and future focus. As a result, the links between service user views and service development are unclear and partners agree that the collective voice of children in strategy, service development and design is not sufficiently heard.
66. Extensive use has been made by the WSSCB and the local authority of audits, and their findings have been used to ensure that lessons are learnt and standards improved, for example in relation to core groups. Similarly, findings from previous inspections and peer reviews have been used to drive strategic and operational improvements in a systematic way that has resulted in, for example, improved performance against key indicators such as the timeliness of assessments.

67. Staffing budgets have increased from the time of the last inspections and there is a higher percentage of experienced social workers. The local authority acknowledges that recruitment and retention of qualified social workers is a challenge, but there is sufficient flexibility in the workforce to allow redeployments across services and locality boundaries to meet changing needs. Social work caseloads are manageable and there is good access to structured learning pathways. Supervision is regular and in most cases frequent, and the use of performance development reviews is well established. While supervision presents an overall improving picture, there is variability in quality, with some records showing little evidence of critical reflection and challenge. Individual workforce plans are in place in different strands of the provision, such as youth support and early years but there is no overarching and agreed workforce plan in place for the wider children's workforce in the provision of early help services. Schools and other agencies report good access to a rolling programme of training, for example on thresholds and safeguarding, as well as specialist areas such as neglect, substance misuse and attachment.

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 |