Inspection of local authority arrangements for the protection of children

South Tyneside

Inspection dates: **13-22 May 2013**
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Age group: All

Website: www.ofsted.gov.uk

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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 South Tyneside 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 South Tyneside, the local authority and its partners should take the following action.

Immediately:

- ensure that all child protection enquiries comply with statutory guidance and children's potential need for protection is responded to promptly and recorded fully
- ensure that all strategy discussions are recorded on the child's electronic record including full information from all key agencies, and that, where appropriate, all subsequent actions and plans are also recorded, enabling oversight and review of all investigations by managers.

Within three months:

- ensure that all social workers within children's social care have manageable caseloads and that management oversight is robust
- ensure that all assessments of children's needs are timely, accurately identify risk and protective factors, and are overseen by managers to ensure that agreed actions are carried out promptly
- ensure that all plans to improve children's outcomes set out specific measurable activities and desirable goals with timescales, so that families and professionals are clear about what to do to achieve the goals and progress can be properly measured

- ensure that management analysis and decision-making is included within the documentation provided to parents, so that they have a full understanding of why decisions have been made

- ensure that case recording not only describes the process of visits and meetings with family members including children's views, but that this informs analysis of the child's circumstances and supports purposeful intervention

- ensure that children and young people are, where appropriate, actively supported to attend their child protection conferences and are routinely encouraged to access advocacy services

- ensure that all staff across the partnership are advised of and follow the guidelines in relation to procedures for children who are missing

- the local authority and the police service to review notifications of child concerns sent from the police to children's social care.

Within six months:

- ensure that chronologies on children's files are up to date and utilised effectively in the assessment process so that full account is taken of historical matters within current assessments and intervention plans

- ensure that case file audits explicitly address how well a child's individual identity needs are addressed in assessments and plans, remedial action is identified where gaps are found, and staff are equipped to understand and proactively address children's diverse needs including their ethnicity, heritage and culture

- ensure that children and young people's views and feelings about the interventions they receive are routinely recorded in their case files

- ensure that the local community is well informed about private fostering requirements including those for whom English is not a first language and minority ethnic communities

- ensure that the of a lack of named GP for the South Tyneside Safeguarding Children Board is resolved by the Clinical Commissioning Group

- improve the scrutiny of child protection services by elected members so that members can be assured of their robustness.

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. Inspectors were aware during this inspection that serious allegations of a child protection nature were being investigated by the appropriate authorities. Actions taken by the setting in response to the incident were considered alongside the other evidence available at the time of the inspection to inform inspectors' judgements.

8. The inspection team consisted of four of Her Majesty's Inspectors (HMI) and one Seconded Inspector.

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

Service information

10. South Tyneside has a population of 148,100 including 29,600 children and young people under the age of 18, representing 20 per cent of the total population. Of these children and young people 7.3 per cent are from minority ethnic groups, with more than 18 community languages spoken. The largest minority ethnic communities are Bangladeshi, Indian and Arab.

11. South Tyneside has significant areas of deprivation, with 31 per cent of children living in poverty. Of the 18 wards in the council area 15 have more children living in poverty than the United Kingdom average of 20.2 per cent. In the eight wards with the highest levels of deprivation the percentage of children living in poverty ranges from 30.7 to 45.3 per cent

12. Early help for children and families in South Tyneside is provided through a range of direct and commissioned services. Services are arranged so that the majority of universal and specialist early help services are delivered in 12 children's centres and integrated family support teams. In addition, the Common Assessment and Advice Team provide support to children with additional needs.

13. Contacts and referrals for children's social care support are managed by the council's Referral and Assessment team. Once it is determined a children's social care service is required, an assessment of need is undertaken by this team. A team of social workers undertake child protection enquiries and initial and core assessments. An out of hours team provides emergency response and intervention, supported by flexible family support arrangements. Services for children assessed to be in need of protection or requiring a child in need plan are managed and delivered by three planning teams and a specialist joint children and adults with disabilities team

Overall effectiveness

Adequate

14. The overall effectiveness of local authority arrangements to protect children and young people in South Tyneside is **adequate**. Since the inspection of safeguarding and services for looked after children in May 2012 progress has been made in strengthening arrangements for identifying children and young people at risk of significant harm and responding to their needs. In the course of this inspection no children or young people have been identified where it is judged that they are not being adequately protected. Where inspectors raised concerns about plans for children, the local authority responded promptly with clearly articulated reasons for existing arrangements which were judged satisfactory, or set out swift plans to review arrangements to ensure their robustness.

15. Improvements have been made in key areas, such as agreeing thresholds for intervention across the partnership and ensuring independent line management arrangements for child protection conference chairs (IROs) and the South Tyneside Safeguarding Children Board (STSCB). Good efforts are made to ensure that lessons learnt from serious case reviews and other serious incidents are embedded in the practice of all practitioners across the partnership. This is supported by good supervision for social workers. However, there is more to do to achieve improvement, to ensure that child protection plans are specific and contain measurable outcomes to which core group members are accountable.

16. Social work practice and its management and oversight is characterised by variability. In the teams supporting children requiring longer term help and the children and adults with disabilitiesteam, caseloads are manageable, management oversight of practice is generally good, and the plans for children are mostly sufficiently detailed and specific to enable progress to be tracked. In contrast the workloads in the referral and assessment service and the duty hub vary significantly, and are consistently higher than other teams. High volumes of incoming contacts and referrals results in some aspects of practice being prioritised over other areas. Similarly, recording of child protection, section 47 enquiries, does not set out a clear account of decision making including consideration of risk factors, historical issues and next steps. Recording overall is sometimes too brief to provide sufficiently full account of activity and lacks analysis which could impact adversely on case planning. Delays in recording of work leads to delays in management authorisation of agreed actions on the electronic system. Caseloads therefore risk being maintained at an artificially high level, with children not receiving consistently prompt services because of delays in transferring cases.

17. Elected members, the Chief Executive, the Director of Children's Services (DCS) and senior partners work well together and are driving forward

strategic plans and priorities for children across the local authority area. The council operates a select committee structure where children's issues are considered as part of the 'people' committee.. Children's services have been significantly protected from spending cuts that other aspects of council services have experienced. The council is also committed to generating employment, and the Chief Executive reports that approximately 3,000 external jobs have been created despite a 25 per cent reduction in council posts, linking this to the council's child poverty reduction strategy and increasing children's life chances.

18. Early help arrangements are well embedded and appropriately targeted on families with the greatest need. Early help is recognised as a priority for the council and its partners and is one of its key strategic priority areas. The Early Help Delivery Plan, which is scheduled for ratification in June 2013, is detailed with clear timescales, links to higher level strategic plans, demonstrates ambition and includes the authority's commitment to ensuring service delivery at a time of increasing demand and diminishing resources.

19. There are clear arrangements in place to 'step down' to a Common Assessment Framework (CAF) and team around the child (TAC) support arrangements from child in need or child protection plans where the lead professional is a social worker. This ensures that families are able to maintain improvements with increasingly less intensive support arrangements on a gradual basis. Ten of the twelve children's centres have been inspected by Ofsted between January 2011 and December 2012 with most judged as good for overall effectiveness and safeguarding. Parents report high satisfaction with services they receive.

20. Although private fostering information features on the STSCB website, referrals are currently low. The local authority is aware of the need to increase awareness of private fostering across the whole community, including minority ethnic communities and families for whom English is not their first language.

21. The STSCB is properly constituted, independently chaired, well attended by all relevant partners and drives forward improvements in safeguarding services for children and young people. The Board ensures that lessons are learnt from a wide range of sources including: serious case reviews, serious incidents, and other commissioned reviews such as peer reviews and multi-agency audits of practice. The training programme sponsored by the Board is well received and its value is exemplified by all schools within the borough continuing to provide financial support despite diminishing budgets. The Board benefits from knowledgeable lay membership and the challenge provided by a robust and well resourced 'Junior LSCB' which ensures it maintains a child-centred focus. The Board lacks a named GP which is a deficit. However, compensatory measures go some way to ameliorating this with good participation from health

partners and aligning the work of sub-groups across the Children and Families' Board and the Health and Wellbeing Board.

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

Adequate

22. The effectiveness of help and protection provided to children, young people, families and carers is **adequate**. When children who are referred to children's social care are identified as potentially in need of immediate help and protection, swift action is taken by the referral, advice and assessment team (RAAT) to ensure they are safe. Where there is no clear immediate risk to children, the responsiveness of social work activity varies in terms of time taken to complete assessments and gather information from partner agencies. However, there is effective work to protect children undertaken by the council and other agencies. No children were identified by inspectors as being left at risk of immediate harm.

23. In cases seen by inspectors, good work is undertaken by the out of hours team which clearly and appropriately identifies and manages risk. Communication with the day services is effective and ensures continuity of services for families and children. Families experiencing serious difficulties out of hours have a prompt response from the family support service. This enables children, in some cases, to remain at home with their families when otherwise they would have required alternative accommodation.

24. When it is identified that a child's needs have reached the threshold where an assessment by children's social care is required, initial assessments are commenced but are not routinely completed within accepted timescales. In some cases delays are extensive. Sometimes delays are attributable to administrative problems with managers in the RAAT not authorising assessments on the electronic record. In other cases there are inconsistencies in workers' understanding of what constitutes an assessment with some initial assessments consisting of multiple contacts which could be more properly considered as a core assessment. Despite this, in the majority of cases, these variations do not prevent work progressing or the provision of appropriate and helpful services for children, young people and their families. Although in a minority of cases seen by inspectors, help could have been provided more quickly while assessments were underway. Managers are aware of the improvements required in this area and have already started work to ensure there is more robust social work practice and management oversight.

25. The majority of child protection and child in need cases in the longer term social work teams, the planning teams, demonstrate consistent and robust case management which effectively reduces risk to children and young people. In cases where children who are subject to child protection plans

move out of the area there are effective systems to ensure transfer arrangements are undertaken in a safe and timely fashion. Arrangements to de-escalate children's support arrangements to that of a CAF plan or to increase oversight by stepping up to a child protection plan, are robust.

26. Examples were seen of very good work with children in need where effective direct work with families has been undertaken, supported by regular care team meetings. A sample of cases seen by inspectors showed the positive impact of interventions such as improved school attendance by children, and parental awareness of the impact of their behaviour on their children. In a minority of cases there is delay in information-sharing from key partners resulting in delays in formulating holistic and effective plans for children and young people. While thresholds are now being more consistently applied, the historical variation in application means that some children were referred to children's social care by partner agencies but did not receive an assessment of their need and suitable services. As a result, there have been re-referrals.

27. In the vast majority of cases when children are in need of early help it is well co-ordinated and delivers positive outcomes at every stage of the child's life. A wide range of effective services are commissioned by the local authority and its partners including family group conferencing and alcohol and substance misuse services for parents and young people. The advice, information and support service for young people affected by substance misuse, 'Matrix', was particularly valued by young people spoken to by inspectors. There is a wide range of effective and evaluated services for victims of domestic abuse such as the freedom programme. Services for perpetrators of domestic violence can demonstrate that their input has successfully reduced risk in some cases. A comprehensive range of helpful parenting support and preventative services are readily available and easily accessible within the community. This provides parents with early help as well as more targeted support for parents with higher levels of need and vulnerability through accredited parenting courses and outreach support. Parents attending a children's centre expressed a strong view that the wide range of support they receive through workshops and accredited programmes has raised their confidence to parent more positively.

28. Growing numbers of children and families are effectively helped by the CAF and TAC models of support. CAF arrangements are widely supported across the local authority and its partners. Good, effective work is co-ordinated by a wide range of lead professionals in multi-agency settings supported and overseen by the Common Advice and Assessment team (CAAT). Help is provided promptly by a range of services and concerns are identified and addressed effectively at an early stage. Evidence seen demonstrates that the help offered meets children's needs and improves their life circumstances. Individual children and families are appropriately matched to resources and support services via multi-agency panels which

meet regularly. The panels play a key role in ensuring consistency of referrals and the application of thresholds. All CAF cases looked at by inspectors showed the appropriate application of thresholds including step up/step down processes being instigated as children's needs increase or reduce. Children with the most complex needs and disabilities are provided with carefully designed bespoke services including short breaks services, overseen and regularly reviewed by the High Level Needs panel.

29. Parents spoken to by inspectors, including those whose children are or have been subject to formal child protection processes, are appreciative of the help they have received and understood what had needed to change and why. They are able to articulate what has changed for them and how their child's wellbeing and life chances have improved as a result of the help received.

30. Staff in a variety of settings including children's social care and children's centres, were able to describe vividly the methods used to engage with children, young people and their families and how their views informed assessments and planning. However, the recording of children's wishes and feelings is variable and in many cases does not do justice to the quality of the practice. Practitioners do not routinely consider the widest range of children's needs including their cultural, heritage and identity, unless these are explicitly presented. Recording of the ethnicity of children is absent in too many cases and this means that managers cannot be assured that full account has been taken of children's holistic needs when reviewing the suitability of services. This also limits the local authority's ability to ensure that its services are equally accessible to all sections of the community includes its largest ethnic minority groups of Bangladeshi and Sikh heritage.

31. Police notifications of individual missing children and their peer groups are monitored regularly at the effective multi-agency 'missing and exploited' meeting. These meetings, based on a successful proven model, are used to manage and take actions to reduce risk for children who go missing and young people who are exploited. Information and intelligence is shared appropriately and informs preventative actions. However, inspectors looked at case planning for one young person at potential risk of sexual exploitation who had not been referred to the panel, although receiving intensive support from children's social care and the youth offending service. Prompt remedial action was taken by senior managers in this case, but this omission suggests that the council and its partners need to satisfy themselves that staff across agencies understand and follow the good procedures in relation to children missing from home and education.

32. Appropriate procedures are in place to ensure children who are subject to private fostering arrangements are safe. Private fostering information is accessible on the council website and contains clear information for members of the public, older children, and carers. However, the number

of notifications is low. The local authority acknowledges that more needs to be done to promote awareness and understanding of private fostering particularly amongst ethnic minority groups and those who do not have English as a first language. Work is underway to improve awareness to address this issue.

The quality of practice

Adequate

33. The quality of practice is **adequate**. Thresholds for accessing early help and social work services are clearly set out in revised guidance which was launched in December 2012 and widely disseminated. Partner agencies report this to be helpful in assisting them to decide on the right level of service for a child, including when to refer to children's social care. Consistency in the application of thresholds is well supported by the CAAT team whose provision of readily accessible guidance and advice facilitates adherence to agreed thresholds. This advice is key for agencies when considering whether a case needs to be referred to children's social care.

34. The duty hub within children's social care provides good social work expertise and advice to agencies in determining the appropriateness of referrals. The majority of contacts and referrals are responded to in a timely manner. The quality of recording regarding the detail of contacts and referrals varies and sometimes is too brief, but in most cases is satisfactory. Appropriate decisions are made in relation to presenting issues. Where there are clear child protection concerns these are responded to promptly although the route by which concerns are responded to varies. Some are responded to by workers undertaking an initial assessment when a section 47 enquiry would be more appropriate. Similarly, some visits are being recorded as 'section 47 visits' which appear more consistent with initial assessment activity. Managers' decisions regarding the outcome of referrals are routinely recorded but the underpinning rationale for decisions and action is not always clear.

35. The high volume of child concern notifications from the police places significant pressure on the referral and assessment team at times and particularly on Mondays, when weekend activity undertaken by the police in relation to child concerns has to be processed. Currently the police send all notifications to children's social care including those which they have already assessed as not requiring a response from the local authority. Regardless of this, each notification requires significant administrative attention via uploading to the children's electronic recording system and social work and management oversight of agreed next steps. This creates a significant volume of work which hampers other aspects of practice undertaken by the referral and assessment team such as recording of work undertaken on child protection enquiries and assessments of children. Senior managers in children's social care are aware of the

situation and are in discussion with the police to address this. However, this is a practice across all the six local authorities covered by Northumbria police.

36. Child protection enquiries are always undertaken by qualified social workers and effective action is taken to ensure that children who are the subject of a concern are safe. The overall quality of child protection investigations is adequate although the variations in how these are recorded, included in different locations on the child's electronic record, makes it difficult to establish the sequence of events and reasoning for successive activities. Strategy discussions routinely take place between managers and the police but the brevity of some records do not always indicate they are being used effectively to plan child protection enquiries. Inspectors observed a timely, detailed and appropriate response to a child protection referral, but the good quality of this was not fully evident in the child's record. In a small minority of cases seen by inspectors the full range of agency checks did not appear to have been undertaken. The recording of strategy meetings, as opposed to strategy discussions, is good and evidences effective multi-agency partnership planning. While the police do not routinely attend strategy meetings, they provide written reports which enables full consideration of all background information. Overall, no evidence was found of children being left at risk of harm.

37. The timeliness and quality of initial and core assessments remains too variable but most are adequate. The assessment exemplars on the child's electronic recording system are rarely completed in full by staff in the referral and assessment team and the progress of an assessment is often found in long, unfocused case notes. Delays in the completion of assessments impacts significantly on how casework is progressed and transferred to the longer term teams, and as a consequence, caseloads remain too high in the referral and assessment team. Children are regularly seen, seen alone where appropriate, and generally have an adequate needs assessment. The recording of analysis is sometimes too brief and lacks clear outcomes. Some assessments are good quality; they demonstrate how research informs practice with evidence of effective planning and clear recommendations being made to support children and families. Management decisions and actions are recorded on one part of the child's electronic record but are not routinely recorded on documents shared with families such as their assessment. Families therefore may not have the fullest information about why decisions have been made. Children's cultural needs are rarely evidenced within assessments which impact on meaningful planning and intervention.

38. CAFs, and the review of CAFs sampled, are of good quality, take account of children and families' needs through robust assessment and a full consideration of risk factors. Effective use of a scoring tool within reviews enables professionals and families to consider progress made and inform further interventions. CAF is used well by agencies to access multi-agency

support. TAC meetings are managed well, are outcome focused, and rigorously reviewed by lead professionals.

39. Some children have experienced multiple changes of social worker which has impacted on their opportunity to develop a trusting relationship with their social worker. Children's records do not show that social workers make use of a variety of communication methods or other tools to better engage with children. In cases where a meaningful relationship between social workers and children have developed, case files evidence that children's views are captured and effectively represented in assessments and planning. Good examples were also seen where children's views were captured and presented at child protection conferences via a 'wishes and feelings' questionnaire providing a powerful influencing force in decision making.

40. Child protection conferences are well attended by partners and facilitated by experienced chairpersons, resulting in sound decision making. Risks are considered fully and there is a strong focus on ensuring the needs of the child remain central. Core groups are similarly well attended by a range of professionals and parents. Parents are well prepared for conferences and those who spoke to inspectors clearly understood the purpose of the meeting as well as the reasons for recommendations and decisions made. The practice of young people routinely attending their own conference is not well embedded although inspectors saw evidence of children being invited to attend. An advocacy service for children and young people is available; however use of this service is scant within the child protection process. Senior managers acknowledge that work is needed to raise awareness of this service as a resource for children who are the subject of a child protection conference with most staff currently only utilising it for looked after children. Good arrangements are in place for IROs to provide formally recorded feedback to contributors to conferences. This helps drive improvements in practice, and this information is beginning to be aggregated to inform the wider improvement agenda within the council and its partners.

41. Children in need and child protection plans are of adequate quality overall. Some plans seen were very good and highly specific including measurable outcomes, timescales within which actions are to be completed, reflecting the individual needs of the child and their family. However, most plans seen are not specific enough and do not clearly link actions to expected reduction of risks. Many contain statements such as 'parent to work with social worker' without making it clear what this entails and to what purpose, making progress difficult to measure. However, despite this, cases sampled demonstrate that children make good progress, risk is minimised and a range of support services are provided which have a positive impact on families.

42. Case recording is mostly timely but varies in quality and detail and is sometimes too brief. Inspectors saw evidence of delays in social workers uploading case information on to the electronic system including recording statutory visits. Social workers were able to verbalise their involvement with families and often talked about a level of engagement and case analysis that was not evident in the electronic records. Some case records in the referral and assessment team are insufficiently detailed and do not set out the child's journey clearly. Case recording in the planning teams is generally better with evaluative recording which is up to date and gives a satisfactory account of work undertaken alongside progress achieved. Chronologies are present on most cases but historical risks are not always taken fully into account or used to inform ongoing work.

43. Management oversight of social work practice is not always evidenced within case records and is adversely impacted by the electronic recording system which does not support robust work flow monitoring. To compensate for its deficiencies, the local authority has created a second electronic system to capture documents that the primary system is unable to include. This dual system, supplemented by some hard copy recording, contributes to the difficulty of overseeing casework and ensuring progress is being made swiftly enough. The impact of this is that delays in progressing assessments cannot be tracked in 'live' time by front line managers. Senior officers are aware of this and plans to replace the current electronic recording system are at an advanced stage.

44. Social workers confirm that supervision is regular and talk positively about their experiences of supervision. They report that time is made available for reflective discussion and challenge. Staff supervision files are well maintained and provide evidence of appropriate discussion about staff development and wellbeing, caseload size and detailed discussion about specific children. Case supervision is however not routinely recorded on the child's case file although a few examples demonstrate good practice and clear recording of case direction and management.

Leadership and governance

Adequate

45. Leadership and governance across the partnership is **adequate**. Senior managers have ambitious strategies which they are implementing in relation to the provision of child protection and early help which are shared and owned across the partnership. The replacement for the Children's Trust, the Children and Families Board, has clear links into the South Tyneside Partnership as well as other high level strategic partnerships such as the Health and Wellbeing Board and the STSCB. Both the Children and Families Board and the STSCB have coherent and detailed plans. The former having a strong and appropriate emphasis on poverty reduction strategies as a key approach to improving children's

welfare across the authority area. The Children and Families' Board has also driven progress in specific areas of practice such as recently ratifying a 'high risk protocol' to ensure coherence of approach towards young people who engage in risky behaviours. The Chief Executive expresses strong support for the leadership team within Children, Adults and Families. His support is exemplified by an active role in protecting funding for this service, participating in recruiting senior managers including the chair of the STSCB, and involvement in a recent review of nursery provision across the borough to better re-focus the early help offer for families with the greatest need.

46. There are clear accountabilities and reporting arrangements between senior officers and elected members, particularly the Lead Member for children. The council does not have a committee specifically concerned with children's issues, and the 'People' Select Committee is open to the public and has a wide brief. The committee has considered children's issues within its work programme but the span of its interest means that child protection issues receive only a proportion of its attention. Communication between senior officers and members is facilitated by regular meetings between the DCS and the Lead Member, supplemented by detailed written briefings setting out relevant national and local developments. More detailed discussion and scrutiny from members has been encouraged by the DCS via a recent closed session of the People Select Committee. This enabled members to be informed of and discuss more sensitive issues regarding child protection. The Lead Member has occupied this role for a relatively short time period since last year and while she expresses great interest in child protection work, her role encompasses children's social care as well as education provision. This, coupled with other constraints on her time, means that the level of scrutiny from elected members regarding child protection services is limited and requires improvement.

47. The local authority and its partners have developed appropriate priorities based on a detailed and sophisticated understanding of local needs drawn from various sources. Examples include: a refreshed joint strategic needs analysis; the recent child poverty audit needs analysis, analysis of obesity data and services, and the Youth Offending Service health audit. Good resources exist within the council to support the compilation and analysis of needs as well as support for shaping strategic plans and priorities, and ensuring there is synchronicity between them.

48. The STSCB meets its statutory duties, is independently chaired, well attended by an appropriate range of partners and proactively addresses a wide range of safeguarding issues well although it continues to lack a Named GP representative as the previous Primary Care Trust were unable to recruit to this role. Recruitment is now the responsibility of the Clinical Commissioning Group. This shortfall is mitigated by strong links with health partners but remains an area of weakness. There has been a

smooth transition between the retiring and the incoming chairperson, contributing to continuity of business. Given the progress made in a range of areas, coupled with the recruitment of a new chairperson, the Board is undertaking a timely review to sharpen its focus and ensure its arrangements are fit for the future, for example, reviewing the configuration and purpose of its sub-groups and developing its forward plan.

49. There is good work with other LSCBs where relevant, for example, working sub-regionally to develop an agreed response to child sexual exploitation. This is an example of effective arrangements manifested in the local Exploited and Missing Children' sub-group, and has included not only awareness raising activities across the partnership, training on skills of engagement with children and young people and the development of a risk assessment tool. Another example of the Board's effectiveness is its leadership in raising awareness of domestic violence across the partnership which led to a 40% rise in referrals from partner agencies to MARAC, the multi-agency risk assessment conference that oversees plans to manage the most serious risks of domestic violence. There is good co-operation between the STSCB and the Adult Safeguarding Board, currently exploring opportunities to further embed the 'think family' model. An example of this is the current pilot project, co-locating an adult mental health specialist within the children's referral and assessment team and duty hub, to enable swift assessment of parental mental health issues and provision of services to the whole family.

50. The local authority and its partners understand their strengths and weaknesses and areas for development. Appropriate action is taken to overcome barriers to improvement such as staff concern about the imminent redesign of children's social care services, by ensuring effective communication arrangements are in place. In particular, the Head of Service for children's social care has significantly led the way since taking up post in October 2012 in redesigning the service to improve its effectiveness and degree of management oversight. Staff have been kept fully informed and consulted about the proposals for change, and ongoing feedback is being facilitated by a practitioners' group. The new structure is yet to be introduced but progress is already evident in some areas with key strategic building blocks in place. This includes the revised threshold guidance, performance management instructions, and key senior managers being recruited. The local authority's intention to deliver improved services within children's social care is supported by the confirmed financial investment and progress towards securing a new electronic recording system which will enable good monitoring of workflow, caseloads, progress on each child's case, and ease the recording of activities by workers. However this is not scheduled to be implemented until March 2014 and the quality of case recording requires urgent improvement.

51. Performance management and evaluation is undertaken by senior managers in children's social care to oversee and proactively manage pressures in the system. A recently launched quality assurance framework sets out a systematic and challenging programme of routine quality assurance activity. The audit tool ensures that qualitative measures regarding social work practice are included as well as process measures, such as timeliness. At the present time, given the limitations of the current electronic recording system, frontline managers are provided with weekly performance reports. However, this is currently retrospective, somewhat limited, and unable to influence performance at the referral and assessment element of social care which requires constant review of rapidly changing circumstances.

52. The local authority and its partners initiate strong and challenging arrangements to ensure continuous improvement. The local authority sponsors a Children's Improvement Board, chaired by a director from a high performing authority, to provide a 'critical friend' to its improvement plans. This board meets regularly and its minutes evidence robust discussion and challenge of change activity. The local authority's willingness to learn from peers is evidenced by a recent peer review of safeguarding services, the recommendations of which have already been incorporated into forward plans. The strong culture of openness to learning means that although the authority's most recent serious case review was in 2010 the lessons learned from this continue to be actively discussed to ensure they are fully embedded. Learning from serious incidents is considered carefully and disseminated widely, and the STSCB undertakes multi-agency audits of areas of practice identified as needing specific scrutiny such as a recent audit of section 47 activity. Single agency audits of practice within children's social care have led to improvements in practice. For example, a robust review of all children in need cases resulted in an overall reduction from 791 in November 2012 to 259 in March 2013, bringing the authority into line with its statistical neighbours. This was completed safely with the application of consistent thresholds and step up/step down arrangements. This is an example of a highly rigorous audit leading to clear outcomes, however other internal audits are less clear and do not set out detailed recommendations for improvements. Nevertheless, there is evidence of a learning culture which is continuing to sharpen its performance management arrangements.

53. Managers in children's services are effectively ensuring that key targets are being achieved safely. This includes improving prevention and support services to reduce the number of children who need to become looked after, embedding the CAF and early help offer. Management oversight of resource allocation and key decision-making has also improved via multi-agency panels. This includes a pre-proceedings panel to ensure children who require legal intervention have their cases progressed swiftly.

54. There is much positive work in leadership and governance across the partnership, and evidence of senior managers finding ways to tackle weaknesses in the service with a clear plan for future service improvement and whole scale re-design. However, the weaknesses in the referral and assessment service are contributed to by insufficient management oversight on an ongoing basis to guide key decision making, and ensure activity and recording of activity progresses at a timely and coherent pace. The pathways and processes used to underpin activity in this team, including section 47 work, are not consistently applied and there is no routine consideration of potential legacy issues of poor decision-making informing current assessments and plans for children. During the inspection additional management resources for the team were put in place, the local authority having previously identified the need for this . While this is welcome, the impact cannot yet be evidenced.

55. There is a good emphasis on children and young people's views and ideas helping to shape services such as the Junior LSCB and the Youth Parliament currently looking at developing a 'phone app' for safeguarding for young people. The Junior LSCB group regularly attends the main STSCB to set out their priority issues and challenge the adult Board to respond to these. Young people also partake in interviews for staff including setting their own questions for senior appointments in children's social care, and the Youth Parliament is currently scrutinising services for young carers. More embedded impact can be seen with the use of the questionnaire used to capture children and young people's views for child protection conferences which was heavily influenced by young people. The friends against bullying (FAB) group has led on a charter which has been endorsed at a full meeting of the council and subscribed to by all the schools in the borough.

56. There is effective workforce planning, including succession planning, and senior managers have been recruited to drive forward the restructuring within children's social care. The workforce is relatively stable with few frontline vacancies and there are appropriate systems in place to support social work professional development. There is a wide range of appropriate training opportunities across the partnership.

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