Inspection of local authority arrangements for the protection of children
Shropshire

Inspection dates: 19 November to 28 November 2012
Lead inspector Martin Ayres HMI

Age group: All
# Inspection of local authority arrangements for the protection of children

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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.

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<th>Outstanding</th>
<th>a service that significantly exceeds minimum requirements</th>
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<tr>
<td>Good</td>
<td>a service that exceeds minimum requirements</td>
</tr>
<tr>
<td>Adequate</td>
<td>a service that meets minimum requirements</td>
</tr>
<tr>
<td>Inadequate</td>
<td>a service that does not meet minimum requirements</td>
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Overall effectiveness

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

Immediately:

- conduct a joint agency audit of contacts and referrals that have been closed in the past six months to ensure that decisions are robust and that children and young people are receiving an appropriate level of service.

Within three months:

- develop and implement a revised threshold document involving all partners to ensure this is clear and fully understood across all services
- ensure that education services and voluntary sector are fully and appropriately represented on the Local Safeguarding Children Board
- ensure that there are separate assessments which are recorded for all children in the family and all family members
- ensure strategy meetings and discussions involve all key partners and are fully recorded
• implement the new format for child protection plans to ensure these set clear aims and objectives which are measureable and can be understood by parents.

**Within six months:**

• establish a coherent case recording system that facilitates management oversight, accurate recording of decisions in all aspects of cases and facilitates the consistent use of historical information

• ensure that information relating to the wishes and feelings of children and young people are fully utilised within individual planning and strategically to develop services

• enhance current audit systems to ensure there is greater scrutiny of plans and engagement of all partners in the processes.

**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 of Her Majesty’s Inspectors (HMI), a local authority seconded inspector and an additional inspector.

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

9. Shropshire has approximately 68,100 children and young people under the age of 19 years. This is 22.4% of the total population. The proportion entitled to free school meals is 13% which is below the national average but in line with similar local authority areas. Children and young people from minority ethnic groups account for approximately 5.1% of the 0-19 population compared to 16.7% of England overall. Shropshire has 152 schools comprising of 118 primary schools, five infant schools, five junior schools, one all through school, 18 secondary schools, three academies and two special schools. There are also 42 local authority maintained nurseries.

10. At the time of the inspection there were 200 children or young people who were the subject of a child protection plan. This represents a slight increase from 193 in 2010/2011. These comprise 89 females and 105 males and a further six unborn children. Of these, 39.5% are aged under five years, 32.5% are aged five to nine years and 25% are 10 years or older. The highest initial categories of abuse at registration during 2011-12 were emotional abuse and neglect with 42% each, followed by physical abuse at 9% and sexual abuse at 6%.

11. A customer service centre deals with enquiries regarding the wide range of council services. All contacts and referrals in respect of children in need or at risk of harm are passed to an initial contact team (ICT) in Shrewsbury where early decisions on cases are taken. Assessments are also undertaken by an initial assessment team (IAT) and long term teams where cases are already known. A team for disabled children and young people responds to known cases and also undertakes enquiries and assessments.

12. Early help services are provided through an extensive range of provision across the county either directly managed by the local authority or commissioned from other agencies, including independent sector organisations. There is increasing use of the common assessment framework (CAF) and team around the child (TAC) to deliver locally coordinated early help services to children and young people.

Overall effectiveness

13. The overall effectiveness of the arrangements to protect children in Shropshire is judged to be adequate. The council and partners are working together to ensure that appropriate action is being taken to identify and protect children and young people from significant harm. Safeguarding awareness within the council and partners is strong, leading to appropriate action to protect children and families where there are significant concerns. The ICT is ensuring timely action to protect children and young people at immediate risk of harm although in a few cases
management decisions and rationale for closure or transfer to early help services were unclear. Considerable effort is being made to extend services to provide early help to children and families and to reduce the need for higher level interventions. A wide range of directly provided and commissioned services are in place which are working effectively.

14. Leadership across the partnership, including political leadership, is ensuring that safeguarding and child protection have priority within council, police and health services. There are good examples of effective joint working with a range of independent sector organisations who also give safeguarding high priority. The council and partners have access to documents in respect of thresholds for service access. However, these are not being used consistently across the partnership and systems to monitor compliance are not yet fully embedded. The Local Safeguarding Children Board (LSCB) is operating at an adequate level. The new independent Chair is setting clear priorities and building joint processes for performance management and quality assurance. Children, young people and their families reported that they feel services have been supportive and helpful in bringing about change.

15. In recent years good progress has been made to establish a stable and well-motivated workforce. Staff indicate they feel well supported and have good access to training and staff development opportunities. Caseloads are at an acceptable level and no cases are unallocated. Staff supervision is regular although it is not being recorded in ways that fully demonstrate professional challenge and case reflection. There is strong commitment to effective joint working and this is exemplified through individual and strategic planning. Work is advanced in establishing a multi-agency approach to dealing with contacts and referrals, including domestic violence cases. The police are deploying officers to operate within the initial contact team in children’s social care.

16. Previous inspections and a recent peer review have identified problems with the recording system within children’s social care services in that it is not user friendly. This inspection has reached the same conclusion. Staff reported they find the current recording system to be unhelpful in maintaining an holistic view of cases and services. While it is acknowledged that the council is developing a corporate recording system the consistency and quality of some recording remains an immediate issue for resolution. Although inspectors saw some initial and core assessments that were comprehensive and of good quality, the overall picture was inconsistent. Similarly child protection plans are not always written in ways which clearly set out aims and objectives so that parents can understand what is required of them.

17. Processes for dealing with child sexual exploitation and children who go missing are well established. Similarly joint arrangements for tracking potential offenders against children are operating in a satisfactory manner.
with good attendance at relevant meetings by key agencies and professionals. Records demonstrate that social workers are seeing children and young people and, if necessary, seeing them alone. Wishes and feelings of children and young people are being captured within records but this information is not routinely utilised to enhance strategic planning.

18. Auditing, quality assurance and performance management systems are in place and being utilised across the partnership. However, aspects of performance management are not sufficiently robust, including auditing, to ensure there is greater consistency in planning, recording, decision making and in the application of defined thresholds.

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

Adequate

19. The effectiveness of the help and protection provided to children, young people and their families and carers is adequate. Appropriate and effective action is taken to protect children and young people at risk of harm in the majority of cases and no cases were identified where children and young people were felt to be at immediate risk. Robust systems are in operation within health services, including hospital accident and emergency, health visiting and midwifery to identify children and young people who may be at risk. Similarly, schools, police and the general public are acting appropriately to recognise and report concerns about the welfare of vulnerable children and young people.

20. In some instances there was too much reliance on parents without a full assessment of needs and parenting capacity being undertaken. Additionally, some case recording lacked clarity regarding decisions and actions being taken, with insufficient account being taken of historical information. As a result it was not always possible to track the rationale for some decisions and actions or to readily determine that children or young people were being helped at the right level. During the inspection the council officers were asked to review some sampled cases to ensure and confirm the children and young people were safe.

21. Parents who met with inspectors stated that they understood why concerns had been raised for their children’s safety. They spoke positively about the level and coordination of support, advice and services provided by social workers and partner agencies. Parents accessing a range of early help were similarly positive about the services and support they received. Young people subject to child protection plans and early help who met with inspectors reported that they valued the support provided by workers across the partnership. For example, three young people who received services from the Oswestry Housing Project spoke strongly about the
difference this had made to them in providing stability to enable them to move forward in their lives.

22. Services are designed and delivered to reflect the rural nature of Shropshire. Meetings, for example, take place in children’s centres and schools that are accessible and familiar to the families using the services. Access to interpreters is available for children, young people and their families for whom English is not their first language, with assessments and reports being usefully translated where required. Although details about the ethnicity and religion of families are routinely recorded it is not always possible to determine how this is being reflected in planning. Insufficient consideration is given in assessment to issues of diversity and how these are fully considered within action planning. Good attention is given to the needs of children and young people with learning difficulties and/or disabilities.

23. A wide range of universal early help services are being redeveloped to meet more targeted needs as part of the council’s early intervention strategy ‘Back to Basics’. The council has also recently introduced an ‘early help assessment framework’, and appointed three early help advisors. They are social work qualified and will offer support and advice to partner agencies in addition to acting as consultants to agencies completing the early help assessment. Professionals across the partnership report that there is positive impact of comprehensive packages of support provided in a timely manner. Panels have now been established to further enhance this approach.

24. Agencies are able to secure priority for children and families with whom they have concerns to access universal services and activities so that early assessment and support can be secured. The use of the CAF is increasing and in the majority of cases is used effectively to identify children at risk of harm or in need of protection and to target early support in a timely way. The use of the CAF to deliver effective intervention below the threshold for children’s social care involvement is easing the pressure on statutory social work. However, inspectors saw some cases which had been closed, diverted to the CAF or stepped down prematurely when further assessments were appropriate to determine whether statutory intervention was needed. The CAF was also used in some cases as a vehicle for making a referral to children’s social care rather than assessing need and coordinating a suitable package of support.

25. Team around the child (TAC) meetings are being used effectively to coordinate multi-agency work to identify needs and risks for children. The engagement of social workers and partners in support of children, young people and families is generally good and aided by the improvements in workforce stability. This is facilitating better service continuity and engagement.
26. Outcomes for those children, young people and their families and carers who received early help are generally good. Targeted support, including parenting programmes, is resulting in positive change and is reducing the risk of harm to children and young people. For example, the Freedom Project is responsive and available to support women who are victims of domestic abuse. Commissioned services provided by Barnardo’s have been successful in engaging children, young people and their families and carers leading to positive changes in behaviour and offering effective parenting support as well as parenting programmes, direct work with children and young people, behaviour management and family group meetings.

27. A coordinated strategy to support teenage parents is established with clear pathways for referrals to appropriate services. Groups for young parents are held at different venues across the county, including children’s centres and community venues. The groups are well attended by a wide range of parents, including some children who are subject to child protection and children in need plans. The group offers a range of good support and advice including healthy eating, budgeting, sexual health, substance misuse and parenting. Information packs for teenage parents have been produced by young people to provide advice and details of a range of agencies who can provide support. Parents spoke positively of all these services and provided examples of how they had been helpfully directed to other relevant services through the group. For example, one young parent had been supported to access ‘Care to Learn’ child care provision to enable her to attend college and subsequently gain several qualifications. Other parents gave examples of support they had received with housing and parenting through the group work and from specialist midwives and health visitors. Other case files provided further evidence of good outcomes as a result of these interventions, including the stepping down from statutory intervention to TAC.

28. Information on children and young people who go missing and/or are at risk of sexual exploitation is shared effectively at an early stage. Comprehensive multi-agency procedures, supported by a ‘practitioner’s tool kit’, are in place to manage cases of child sexual exploitation. The procedures include guidance on agency responses to high, medium and low level concerns with good processes in place for joint working. Child sexual exploitation multi-agency meetings are chaired by a senior manager to ensure joint working and effective information sharing. However, the quality of recording in a few cases was not of a sufficiently good standard to ensure actions and responsibilities remain clear and measureable. Inspectors noted that a few cases presented to the child sexual exploitation panel which did not fully meet the criteria for referral could have been better handled in other ways. Multi-agency risk assessment conferences (MARAC) are held regularly and are effective. The Detective Constable who attends MARAC also ensures good communication with public protection panels.
Early help for older children and young people is increasingly being set in the context of continuing support in order to reduce barriers to continuing achievement. There are explicit links between help and narrowing the achievement gap, particularly for individuals in identified groups where there are known and severe barriers to achieving their full potential. For example, young carers of parents with disabilities are identified through good information sharing which is ensuring that good quality personalised help is provided. Intervention in the majority of cases is proportionate and families are not subjected to formal child protection intervention when this is not necessary. The identification of children with additional needs and requiring targeted support is well evidenced, although some ambiguity exists in respect of levels of service access and application of statutory intervention.

The quality of practice

Adequate

The quality of practice is adequate. The customer services team is effective in collating contact information and ensuring this is passed in a timely manner to ICT where decisions on actions arising from contacts and referrals are taken. On receipt of contacts and referrals the team manager in ICT identifies the actions required and most cases are allocated promptly. Priority is appropriately given to cases where children and young people may be at risk of significant harm. All child protection enquiries are carried out by qualified social workers. Strategy meetings are mainly telephone discussions between the police and children’s social care services and although agency checks are undertaken in the majority of cases, this is not entirely consistent. Strategy meetings are recorded and actions agreed but responsibility for actions are not consistently recorded or being measured. Additionally, strategy meetings minutes are not held within the electronic recording system which affects ease of access for staff and managers.

Decision making within children’s social care is undertaken by suitably qualified managers. However, management oversight of assessment recommendations and plans is not consistently evident on records seen. Supervision notes are stored separately from the electronic recording system which does not assist in gaining a coherent overview of the case and there is a lack of consistency in respect of the recording of management decisions that are made outside of supervision. As a result it is difficult in some cases to clarify whether managers have had sufficient oversight of decision making and accountabilities for signing off decisions and actions and their rationale are not fully clear.

Since the inspection conducted in 2010, a review of the emergency duty team has resulted in increased staffing and good arrangements for the
transfer of information from the team to the day time service. The team has access to the electronic recording system and inputs information directly on to case records. There is good liaison between the team and the day time service which is provided by the team manager. However, accountabilities for the team at senior management level are based within adult services and this is not aiding oversight of all actions by managers within children’s services.

33. Children and young people who are the subject of assessments and other interventions are, in the majority of cases, routinely seen, including alone where appropriate. This is facilitating awareness of the wishes and feelings of children and young people. The council has been successful in securing a stable workforce and this provides consistency for families and there is evidence of social workers developing and sustaining positive relationships with children and young people. Social workers use a range of techniques to work directly and effectively with children and young people, including those with a disability, to seek their views and understand their experiences to inform practice and decision making. However recording of their views is inconsistent. Some case recording and assessments represent children’s wishes and feelings very well, while others do not adequately represent children’s views despite direct work with children having actually taken place. In the majority of cases, case recording is sufficiently timely and up to date but the actual quality of case recording is variable, is too brief and lacks detail. Chronologies are not consistently up to date and are not always comprehensive. This is not aided by the recording systems within children’s services and the fact that some records are held electronically and others manually.

34. The timeliness of initial and core assessments is generally good. The quality of initial and core assessments ranges from adequate to good. The majority of assessments are comprehensive and most give appropriate consideration to children’s wishes and feelings. Where there are a number of siblings in a family their individual needs are not always adequately recorded as a separate assessment. Analysis within most assessments provides a thorough consideration of risk and protective factors. Many make good use of research to inform decision making although in some cases consideration of historical factors is insufficiently thorough. There is good evidence in most assessments of effective liaison with a range of professionals to ensure that assessments are holistic. Core assessments for children with disabilities are regularly updated to inform children in need planning.

35. Child protection plans are insufficiently detailed in setting specific and achievable objectives which are measureable. Although most plans clearly identify actions and outcomes, some of the outcomes are too general, making the monitoring of progress against objectives difficult to track. Additionally, the high numbers of actions identified on some plans reduces the clarity needed for parents and professionals to understand the priority
areas for change to reduce risks and what is required of them. The council is aware of this and is taking action to establish a new format for child protection plans. There is good multi-agency support to children in need planning and the majority of these plans are outcome focused and measureable.

36. The council and partners have established thresholds for service access but there are inconsistencies in the way they are used in practice. Where children and young people are at immediate risk of significant harm appropriate and timely actions are taken. However there are fluctuations in the interpretation of thresholds within ICT and a degree of confusion on the part of some partner agencies about the use of CAF as a pre-requisite to making a referral to children’s services. The council is aware of this issue and has secured funding for new posts of early help advisors to be based in the ICT team to provide additional advice and support to agencies on referral pathways and service levels. Partner agencies are able to access advice through lead professionals within agencies or senior social workers in ICT, and most professionals report that this is helpful. Escalation procedures are in place in all agencies to raise case concerns and to deal with any disagreements.

37. Social workers report that they are supported well by their team managers and senior managers who are available for support and advice on cases, as and when required. Most social workers have manageable caseloads. Service managers are also visible and accessible. Social worker supervision is regular and access to staff training and personal development opportunities is good. Morale amongst staff is high and the council has a stable workforce of social workers with no use of agency staff. Newly qualified social workers have protected caseloads and regular supervision. Recording of case supervision is predominately task orientated and does not evidence challenge to improve outcomes for children.

38. Case conferences and core groups are generally well attended by partner agencies. Appropriate action has been taken to address lack of representation, including the development of the joint working protocol with adult services that has resulted in improved attendance. However, the attendance of children and young people at conference is low at 19%. An advocacy service for children and young people attending conference is provided by ‘Voice’ but only three young people have made use of the service in the past six months. The council has recognised this is an area for development and is in the process of producing a consultation pack for use by social workers to encourage higher levels of attendance. In the majority of cases parents attend conferences and the distribution of the social work report to parents within three days prior to conference is showing an improving trend. There is no expectation that agencies that have relevant information will all provide reports for child protection conference and this is reducing opportunities for parents to have time to consider all the relevant issues prior to discussions. Core groups are held
within timescale and chaired by social workers. Minutes of core groups are recorded well with evidence of the mapping of progress against child protection plans. Conference minutes are comprehensive and those seen by inspectors include detailed consideration of individual children’s need with appropriate contingency planning. Legal advice is available to social workers and their managers and the quality of reports to courts is consistently good. Legal advisers report that there is marked improvement in the quality of court reports over the last few years and this has been commented upon by the local Judge in proceedings and by children’s guardians.

**Leadership and governance**

**Adequate**

39. Leadership and governance arrangements are adequate. Safeguarding and child protection are given the highest priority within council services and across the partnership as a whole. Systems are in place within all agencies to ensure children and young people who are at risk of harm are identified and steps are taken to respond quickly to their needs. Cooperation between agencies, including health services, the police and independent sector organisations is generally effective. Incremental progress is being made to extend the range and depth of early help provision in order to support children and families in need before problems escalate. Political leaders ensure that services to protect vulnerable children and young people are appropriately resourced. The Corporate Director of People’s Services alongside senior partners provides effective and insightful leadership and demonstrate a willingness to learn from best practice elsewhere in the country.

40. Population data is being utilised to target services more accurately and various processes are in place to map local population needs and trends. Progress is being made in this regard and there are examples of effective services which meet the needs of children, young people and their families, such as children’s centres, housing and targeted youth projects. This is combined with awareness of current gaps in joint service provision and how these will be resolved. Recommendations arising from previous inspections and peer review have been substantially addressed. For example, a detailed action plan arising from the last inspection of private fostering arrangements has been implemented leading to improvements in service quality and effectiveness. However some issues, such as the lack of a user friendly and coherent case recording system within children’s social care services and clear understanding of service thresholds, remain to be fully resolved. Many initiatives, although demonstrating good potential, are relatively new and evaluation of their impact and outcomes is at an early stage.
41. Considerable progress has been made in recent years in respect of workforce planning. This is effective and has ensured more stable and improved staffing arrangements. There has been an increase in the number of permanent staff. Newly qualified social workers receive additional management support which includes induction training, protected caseloads and shadowing experienced colleagues. In-house training is comprehensive with high rates of staff attendance. Social work staff report that they feel well supported and motivation to work in the field of safeguarding is strong. Nevertheless, some of the systems to monitor staff performance against agreed standards and objectives are less well developed or being used inconsistently.

42. The Local Safeguarding Children Board (LSCB) is meeting its statutory responsibilities adequately and an independent Chair has been in post for approximately 12 months. Governance arrangements are in place, although a protocol is still in draft relating to the respective roles of governance between the Chair and the Children’s Trust. The Chair meets every three months with the Corporate Director of People’s Services, the Lead Member for Children’s Services and bi-annually with the Chair of the Scrutiny Committee. This is ensuring that accountabilities are clear and there are good examples where the LSCB Chair is using the annual safeguarding report to hold relevant bodies to account, for example in respect of domestic violence screening processes. Representation on the Board is stable although representation from education, the voluntary sector and children and young people is less consistent. The number of sub-groups has been reduced from 14 to 10 although some appear to be task and finish groups. Audits of compliance are undertaken and there is an annual quality assurance checklist to monitor agencies’ compliance with safeguarding arrangements. However, audit and evaluation, including multi-agency auditing, are under developed. A good range of joint training is available and well utilised by the council and partners but the multi-agency training needs analysis is less well established.

43. An adequate complaints procedure is in place for parents, families and children and young people to raise concerns about the quality of services they receive. Over the last year 11 complaints were received, all from parents relating to factual inaccuracies in assessments and lack of information sharing, for example not receiving assessments in a timely manner. Although the council collates data relating to complaints and most are resolved at the first stage, the aggregated information is not being fully utilised to inform service developments. The council recognise more work is required to refine the complaints process including a system to report on outcomes and improvements as a result of listening to the voices of service users.

44. Priority is being given to ensure the wishes and feelings of children and young people are captured in all aspects of work, including assessments and planning. However, the systems for aggregating this information for
wider planning purposes is at an early stage. The work of the Local Authority Designated Officer (LADO) is adequate. This role is established in the council and with partners, although it was acknowledged that the reach to some agencies, including the independent sector, the faith sector and special schools, is too restricted. The evaluation of learning from investigations is also limited and does not link coherently with organisational learning and development opportunities. The LADO produces an annual report for the LSCB but the quality of the report is inadequate in the context of learning and service improvement.

45. An audit tool and audit programme has been in place since September 2011 with an expectation that all managers participate in this work. Team managers undertake cross-team audits to facilitate peer challenge in addition to auditing work in their own teams. Additionally, service managers audit a selection of cases. Summaries of audit findings are then reported to the Safeguarding Practice Group. However, independent scrutiny of performance is lacking and there is no clear process to monitor that actions arising from audits have been fully implemented. There are also examples of joint case auditing involving partner agencies but the focus for this activity is not specifically defined and does not routinely evaluate the effectiveness of service access arrangements or quality of decision making prior to cases being closed. Social work staff and partners in the police and health report that there are good arrangements in place to learn lessons from local and national cases and staff across the partnership demonstrate good awareness of key national issues and are applying these in their practice.

46. Performance information is mostly accessible and available to all managers within the council. A raft of performance information is available via performance scorecards which are tailored to meet the needs of middle and senior managers and the Children’s Trust and the LSCB. A more concise dashboard of performance information is in development and has been well received by managers and partners. Service managers have access to Performance Plus which is an electronic system holding relevant data through which managers can drill down into individual performance indicators. Team managers can interrogate the electronic recording system and produce data pertaining to individual social workers’ performance. However, there is no performance indicator for child protection statutory visits. Team managers also have access to a child protection tracker system which has a number of fields denoting when children were placed on a plan, the first review and when children were last seen. This enables managers and reviewing officers to gain quick oversight of child protection work taking place across their area. Performance information is received by the LSCB and progress is being made to make this is more relevant to day to day practice, management oversight and ensuring levels of services are correctly balanced.
Record of main findings

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