Ofsted
raising standards
improving lives

Inspection of local authority arrangements for the protection of children

Doncaster Metropolitan Borough Council

Inspection dates: **8 - 17 October 2012**
Lead inspector **Mary Candlin HMI**

Age group: All

© Crown copyright 2012

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

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

Contents

Inspection of local authority arrangements for the protection of children 2

The inspection judgements and what they mean 2

Overall effectiveness 2

Areas for improvement 2

About this inspection 5

Service information 5

Overall effectiveness 7

The effectiveness of the help and protection provided to children, young people, families and carers 9

Leadership and governance 15

Record of main findings 19

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 Doncaster Metropolitan Borough Council is judged to be inadequate.

Areas for improvement

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

Immediately:

- ensure that appropriate and timely action is taken in respect of child protection concerns referred to children's social care in line with statutory requirements
- ensure statutory visits are undertaken within the required timescales and that children are seen and spoken to alone
- ensure that all decisions made by managers take full account of the risks identified and the needs of all children residing in the family; and the rationale for decisions made is clear, recorded and evidenced
- ensure strategy meetings have a multi-agency focus and input to enable all relevant information to be given full consideration in planning what action needs to be taken to safeguard children
- improve the quality of assessments to ensure that risk and protective factors are taken into account and subsequent planning and decision making processes are child focused
- ensure children and young people are able to contribute effectively to their assessment and the care planning process

- improve the quality of child protection and child in need plans ensuring they are child focused, with specific and measurable outcomes to monitor progress and reduce risk
- ensure there are sufficient social workers and managers to undertake child protection work; and that they have the necessary skills and experience to identify and manage risk and undertake child protection enquiries to an appropriate standard.

Within three months:

- ensure staff supervision complies with the council's supervision standards regarding workload management, personal training and development and that records demonstrate that regular critical supervision has taken place
- ensure the cultural needs of children are addressed in the assessment process and are fully reflected in care planning
- ensure written agreements are underpinned by assessment, used appropriately and can be understood by families
- the Local Safeguarding Children Board to ensure the application of Doncaster multi-agency threshold guidance through audit compliance by member agencies
- ensure performance management information contains sufficient details of performance including appropriate qualitative and quantitative analysis of child protection work and is provided to all strategic forums including the Safeguarding Children Board so agencies can be effectively held to account
- ensure management arrangements for the integrated family support service are in place to provide clarity of leadership for the service
- the Local Safeguarding Children Board business plan to include all key priorities for the Board
- The Local Safeguarding Children Board sub-groups to have realistic and effective work plans. Progress against agreed objectives to be regularly reviewed and monitored
- improve communication and information sharing between the strategic boards, including the Children's Trust, Local Safeguarding Children Board and the Improvement Board.

Within six months:

- ensure that all partners are engaged in providing a fully integrated early support service for children, young people and families that provides a consistent service and reduces the demand for statutory intervention.

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 five of Her Majesty's Inspectors (HMI).

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

Service information

9. Doncaster Metropolitan Borough Council has approximately 69,100 children and young people under the age of 18 years. This is 22.85% of the total population. The proportion entitled to free school meals is 16% above the national average. Children and young people from minority ethnic groups account for 10% of the total population, compared with 25% in the country as a whole. The largest minority ethnic groups are Pakistani (13%), other Asian background (7%), Indian (7%), African (7%) and White and Black Caribbean (7%). The proportion of pupils with English as an additional language is 6.3%, below the national figure.

10. At the time of the inspection there were 508 (0.74%) children who were the subject of a child protection plan. This had increased from 375 in July 2011, the highest ever recorded in Doncaster. The categories of abuse leading to child protection plans are: neglect at 284, (56%) emotional abuse 164 (32%), sexual abuse at 27 (5%) and physical abuse at 33 (7%).

11. In November 2011 Doncaster established the children's multi-agency and referral and assessment service known locally as CMARAS, which provides

an integrated referral and assessment service. The targeted family support service (TFS) is responsible for delivering services to vulnerable children and their families. The integrated family support service (IFSS) was established in 2011, is delivered through 21 children's centres and extended services and schools. There is an emergency out of hours service providing cover for the borough.

Overall effectiveness

Inadequate

12. The overall effectiveness of the local authority arrangements for the protection of children in Doncaster is inadequate. During this inspection a significant number of cases were brought to the attention of the local authority where urgent action was required, including initiating child protection enquiries to accurately assess the presenting risk and protect the children and young people concerned. In addition, during recent months, the local authority has been unable to allocate all the work that requires statutory social work intervention. This inspection identified 382 unallocated child in need cases. Further audit work by the local authority clarified that this number was actually 244 by the end of the inspection. Analysis of a sample of these cases by inspectors identified a number where it had not been recognised that children and young people had experienced or were at potential risk of significant harm. These cases were referred back to the local authority. Also the council's own audit identified 41 cases where urgent strategy meetings to protect children were required. In contrast, some examples of good practice were identified by inspectors including timely assessments, effective work with families in diverting them from statutory intervention and the management of complex cases through the risks management panel. However, in too many cases professional practice was poor, management oversight ineffective and risk to children not identified or progressed. Consequently Doncaster cannot be confident that all children known to the children and young people's services are safe.

13. Strategic oversight by the Improvement Board and the Doncaster Safeguarding Children's Board (DSCB) has also failed to provide the necessary leadership and scrutiny to satisfy itself that the high number of unallocated child in need cases known to the council have been adequately risk assessed. These failings undermine the effectiveness of the local authority's audit activity and management case review arrangements. This does not enable senior managers and the DSCB to have a clear and confident picture of the strengths and weaknesses of child protection services.

14. In response to the concerns raised by inspectors the Director of Children and Young People's Service took immediate and appropriate action aimed at ensuring that all children known to Doncaster Children and Young People's Service are safe. The local authority put in place an immediate plan of action on 11 October 2012 to address the failings identified in this inspection and set up a social work team to take responsibility for all unallocated cases. Additionally, the local authority put in place an immediate performance framework which will ensure regular reporting on progress and quality to the Director of Children and Young People's Service.

15. In March 2009 the Secretary of State issued an improvement notice due to the systemic failures across children and young people's services which resulted in the children and young people known to Doncaster Metropolitan Borough Council not receiving the necessary help and support to secure their protection. Strategic leaders and partners fully acknowledge the historical failures across children and young people's services and the need for change and improvement. Since the government intervention, Ofsted has undertaken a safeguarding and looked after children inspection and two unannounced inspections of the council's contact, referral and assessment arrangements for children and young people. Concerns with regards to the quality of practice in protecting children have been raised in these previous inspection reports.

16. This inspection found some areas of development identified in the inspection of safeguarding and looked after children services in 2011 have not been fully addressed. These include the continuing high number of children and young people with second and subsequent child protection plans. While the voluntary sector is represented on the Safeguarding Board, influencing the wider voluntary communities in the delivery of the safeguarding plan remains a challenge. The last unannounced inspection undertaken in January 2012, found that the area of priority action identified at the previous inspection of contact, referral and assessment arrangements in January 2010 had been completed. One area for development which related to social work capacity had not been dealt with and was identified in this inspection as a continuing cause for concern.

17. The scale of the challenges faced by Doncaster Metropolitan Borough Council (DMBC) for many years has been far reaching. Until the appointment of the current Director of Children and Young People's Service in 2010, there was a lack of consistent strategic leadership and direction. Since 2010 the children and young people's service has benefited from a stable senior management team. However, the council has struggled to secure a full complement of permanent head of service positions across the children and families service. The council has made progress in this aspect and from 5 November 2012, apart from one post, all children and families head of service positions will be in place. The authority acknowledges preventative services are not yet fully utilised, and recognises the need to escalate the pace of planned change within the integrated family support service and the need to provide clarity around the management arrangements for the service.

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

Inadequate

18. The effectiveness of the help and protection provided to children, young people, families and carers is inadequate. Children and young people are not sufficiently protected because risks are not consistently managed. There are systemic and unacceptable delays in ensuring that their needs are met in an effective and purposeful way. The high number of child in need cases without a named social worker means the local authority cannot be confident that these children have had their needs met or are protected.

19. A marked increase in the volume of contacts and referrals and a significant increase in the number of children on child protection plans over the past 12 months has severely impacted on capacity and further weakened services to children and young people and families. The local authority acknowledges the high rates of re-referral to CMARAS and the need to review thresholds and improve partnership working.

20. Management oversight is inconsistent, lacks rigour and consequently children and young people at potential risk are not always identified. Although there is a timely response to referrals requiring urgent action, in too many cases this did not always lead to appropriate intervention or the effective protection of children. In addition, where needs have been assessed there is delay in progressing some decisions, which results in services not being implemented and drift in the planning for some children. These deficits are compounded in some services due to the reduced capacity of managers, the high volume of work and social workers holding high case loads. In some cases children and families are experiencing home visits by different social workers which prevents meaningful and effective relationships being developed between the social worker, children and their families. The inconsistent planning and service delivery to children and young people often contributes to poor joint working arrangements. Consequently, effective action is not routinely taken to meet children’s needs, to identify escalation of risk or progress made by families, or provide timely support.

21. Inspectors observed some areas of practice where individual workers and teams were undertaking effective work with children and families. Families reported to inspectors that they valued the support received and that they felt that help was responsive to their needs. However, the variability of practice and management of risk meant that in too many cases need was not being appropriately responded to and outcomes for children and young people were poor.

22. Written agreements and expectation letters are sent to parents which explain what needs to be done to effect change. This assists some parents in understanding the help they receive. However the content of some agreements do not always fully reflect the individual circumstances of the family. Children and young people are involved in their assessments through interviews and creative direct work but there is little evidence of children and young people's views directly impacting on planning or influencing decisions made about their lives. Assessments do not always sufficiently focus on the child or young person's perspective on their experience.

23. Individual workers are responsive to the needs of the local community including Traveller and Polish families and the impact on families where disability features in their lives. In some cases assessments and plans identify the family's full range of needs including race, culture and religion.

24. The local authority is progressing towards fully integrated early help services. The IFSS, established in April 2011, has brought together seven separate services under the management of the 0-19 provision. This forms part of a one team working strategy, which is in the very early stages of implementation. The four integrated family support area teams are at different stages of development, with some teams not yet fully utilised to meet local need. The local authority is not yet delivering consistent multi-agency preventative work across Doncaster.

25. Children's centres are all now under local authority governance and have been brought within the IFSS. A high proportion of centres have been inspected by Ofsted with all being at least satisfactory and two judged as outstanding. The breadth and quality of the data available to children's centres has improved enabling better targeting of vulnerable families.

26. Some effective work for individual children and families is taking place and this was seen at team around the child (TAC) meetings and in groups for parents of teenagers. The local authority are developing ways to evaluate the effectiveness of the IFSS and the council's recent findings show that in just under 66% of cases early help interventions are having a positive impact on family outcomes. In another 10% of cases families had been signposted to other services. However, the service is not yet having an impact on reducing the number of families requiring statutory intervention from children's social care.

27. Much work is still needed in order to ensure the common assessment framework (CAF) and eCAF are fully established and effectively underpinning the early help offer. For example, only 12 eCAFs have been raised since its introduction in April 2012. Universal services' experiences of the effectiveness of CAF are highly variable and there is a lack of clarity regarding when and how to implement the process. This results in some partner agencies making inappropriate referrals to children's social care

thereby delaying the offer of early help for some children and families. Although the quality of CAF remains too variable some are leading to effective coordinated work, including for children with disabilities, which is making a difference to families and is valued by parents. For families with changing levels of need, step down procedures are not yet secure, which means that families can be left unsupported when a child protection plan ends and in some cases their situation deteriorates. When difficulties arise partners are not yet consistently using the dispute resolution process to escalate concerns to children's social care.

28. Work is on-going to ensure that educational provision is effective in safeguarding children. Strategies have been revised and are operating in relation to elective home education and are being implemented. However, the targeted reduction in numbers of home educated children has not yet been achieved. A high proportion of Traveller children are home educated and good relations with this community have been established. Systematic tracking of children missing education is now taking place and numbers have reduced well from 389 in September 2010 to 97 currently. Children missing education are referred to children's social care appropriately. Provision for children excluded or at risk of exclusion has being restructured with the closure of one pupil referral unit and the establishment of two additional resourced centres for primary aged children and four learning centres for Key Stage 3 pupils. However, restructuring is continuing for Key Stage 4 pupils and the current quality of educational support provided by pupil referral units is satisfactory overall.

29. Evidence of agencies working well together is variable. The co-location of the police, but not health, within CMARAS enables timely strategy meetings. However, this is not always the case in the long term TFS social work teams. When a child is allocated a social worker or IFSS worker there is often good multi-agency working which cover children's needs including leisure and talent, which can result in good outcomes for that child. The participation of agencies in case conferences, strategy meetings and core groups is variable and therefore overall effectiveness of these interventions is weak.

The quality of practice

Inadequate

30. The quality of practice is inadequate. Inspectors identified a significant number of cases during this inspection where children and young people have not been protected and were at risk of significant harm. Case records indicate most children and young people who are the subject of assessments and on-going service provision are seen by social workers. However, in a number of child protection cases the frequency of statutory home visits is inconsistent and at times there were significant gaps in the

visiting sequence. This prevents social workers from making an accurate assessment of the risk or the progress families are making in protecting their children. Where contact is consistent and regular and effective relationships have been established, records still do not consistently demonstrate that children are seen alone or that their views contribute to their assessment. In addition, case records do not always demonstrate that children and young people's voices are heard and that their experiences are fully taken into account and acted upon. In some cases seen recording was too focused on the needs of the adults rather than the children. In a number of cases seen by inspectors this led to social workers being overly optimistic in assessments of parents' capacity to meet children and young people's needs.

31. The quality of referrals by universal services across the partnership to children's social care is highly variable. The CMARAS now has a stable team of staff to manage referrals. A clear threshold document is in place to support them in screening all contacts and referrals and provide professional advice to ensure the appropriateness of the referral and if the service threshold has been met. However, despite this progress a large number of referrals by professionals require further work in order for safe decisions regarding the welfare of children and young people to be made. The quality of common assessments is variable, ranging from inadequate to good. There remains some confusion across the partnership regarding when to raise a CAF and the purpose of some of the CAFs seen by inspectors was unclear and did not lead to effective multi-agency working. However, some contain clear action plans which are reviewed at TAC meetings and provide effective early support for families.

32. The out of hours service and CMARAS respond in a timely way to new referrals and the initial screening of domestic violence referrals is mostly timely and effective. Where it is judged that a child protection investigation is required there is an effective and timely initial response made which is supported by a robust system for strategy discussions and information sharing with the police. The co-location of police colleagues within CMARAS enables frequent strategy meetings to take place. Other teams based in different locations rely almost exclusively on telephone strategy discussions. As a result there is no provision in place to ensure that where appropriate a multi-agency meeting is convened to share available information. This limits the investigation and actions to be taken to safeguard the children. All child protection enquiries are undertaken by qualified social workers. However findings in relation to significant harm are not always clear and do not always lead to the appropriate outcomes for children and young people and in some cases seen children and young people were not appropriately protected. Child protection enquiries often result in the drawing up of written agreements. However, an over reliance on the use of written agreements means in some cases this is not always based on a full risk assessment and too much responsibility is given to parents to monitor their own behaviour. In some cases written

agreements were seen to be too generic and non-specific which reduces their potential impact. Inspectors saw other cases where the existence of a written agreement was stated as the reason not to hold an initial child protection case conference but the rationale for this decision was not evident. Where the use of written agreements is effective social workers recognise the value they have as part of an overall protection plan.

33. Social workers who spoke to inspectors identified the positive impact of CMARAS, including an increase in the stability of the team and a clear management structure with managers available for advice. They report they are now better placed to provide a more effective service for children and families. However, challenges remain in ensuring case work is transferred swiftly and accepted by the receiving team in a timely way to ensure all children receive a prompt and effective service.

34. The timely completion of assessments has fluctuated over the past 12 months. The timeliness of initial assessments has shown a marked decline this year from 86% in March 2012 to 76% in August 2012. While the performance has recently improved it still remains low at 76% and below the local authority's own target. The timeliness of core assessments has also shown a significant decline from 86% in March 2012 to 74% in July 2012. The local authority acknowledges that the decline in performance is linked to the increase in contacts and referrals, which has impacted on capacity within front line services. This was further compounded by a period of high sickness absence in the summer where over 200 days were lost to sickness absence and management capacity within CMARAS was reduced from four to two team managers for a period of four months. Improving timeliness of assessment remains a key priority within the local authority's improvement plan.

35. The quality of initial and core assessments remains extremely variable with the majority being inadequate. In too many assessments there was a lack of focus on the individual children and young people in favour of the adults in the household. These assessments invariably failed to identify all the potential risks to the children and young people concerned, including to their siblings and in some cases led to children's needs not being met.

36. Inspectors saw some satisfactory assessments and in a number of cases good examples that had a clear focus on the needs of children and young people. In some assessments historical information and brief chronologies were used to good effect enabling social workers and managers to consider how past behaviours within families had the potential to influence current social work practice and support the decision making process to protect children. Where there was a clear analysis of need, outcomes and recommendations were appropriately identified.

37. The effectiveness of initial child protection conferences, core group meetings and review conferences are too variable. Meetings observed

were in general facilitated by experienced and skilled chairs, with the emphasis placed on safeguarding the needs of the children enabling all participants, including the young person, to contribute to the outcomes and recommendations made. In contrast in one meeting observed the child protection conference failed to identify historical child protection concerns that had not been investigated. Conference reports are not routinely distributed to families in a timely way to enable them to consider the content and to make an effective contribution to the meeting. On one occasion the case conference report was seen to contain confidential information that was inappropriately shared with all parties at the meeting.

38. Inspectors saw a number of child protection plans where there is a lack of a clear focus on risk and how this is to be reduced. This included examples of plans for sibling groups that did not have sufficient focus on each individual child, with a high use of professional jargon and non-specific goals. Contingency planning was not evident on a number of child protection plans and where the contingency was stated this usually referred to a legal planning meeting being required. In some cases, where little progress was evident, legal planning meetings took place in a timely way, in others delay led to children and young people being left in unsatisfactory and risky circumstances for too long. Child in need plans were too variable in quality with a number of plans being very poor, objectives were too generic with too much jargon. In a number of cases plans did not focus on meeting the individual child's needs and progress and the impact of the plans was hard to assess. Where plans were seen to be thorough they were seen as effective tools to assist in promoting and sustaining positive change for children and young people. Step down planning was evident in some assessments. However, plans were not always well coordinated and did not translate well in effective practice.

39. The rigour of management oversight provided by first and second line managers is highly variable and results in lack of continuity in case management, planning and decision making. Social workers reported feeling supported by their managers who they described as visible and approachable for informal case discussions. Supervision records indicate that formal supervision does not always take place and when it does it is largely task centred. Inspectors saw little evidence of reflective supervision or appropriate challenge and feedback on casework. In such a highly pressurised environment where caseloads are very high insufficient emphasis is placed on the well-being of the workforce and capacity issues. The decision making of a number of first line managers has not been of the required standard. In the cases returned to the local authority for review during this inspection the quality assurance processes employed by second line managers have not been effective in identifying weaknesses leaving children in some cases exposed to risk. Case recording is generally clear and timely but drifts towards being too descriptive and activity focused. The new electronic recording system has only been in place for a

few weeks and is consequently causing some difficulties in maintaining case records.

Leadership and governance

Inadequate

40. Leadership and governance arrangements are inadequate. The document *A Plan for Doncaster Borough 2010-2015* sets out the council's overarching strategy. The Children and Young People's Plan 2011-2016 is underpinned by clear priorities which are reflected in a range of strategic plans, including the Improvement Plan to drive forward the necessary changes. While progress is marked in some areas, the council acknowledges that children and young people's services remains fragile and features of the historical legacy of failures are still evident in some significant aspects of child protection work. The significant increase in the volume of contacts, referrals and the number of children on child protection plans over the past 12 months has severely impacted on capacity and further weakened services to children and young people and families. Consequently a significant number of children known to Doncaster Metropolitan Borough Council are potentially left at risk. The recent establishment of a multi-agency team within CMARAS is a significant step forward in partnership working and developing joint working arrangements with the police in responding to child protection concerns. The involvement of health partners in CMARAS has not yet been fully realised. Although recent improvement around referrals and timeliness of assessment has been achieved through CMARAS there has been an overall marked decline in the timeliness of assessments. There are also still examples of inappropriate referrals and slippage due to the increased volume of work and capacity issues across front line services.

41. There has been insufficient senior strategic management oversight of operational practice, which has resulted in the failure to fully recognise and appropriately respond to the potential risk of child in need cases without a named social worker. The council's own audit of unallocated child in need cases in July 2012 appropriately identified the need to address the issue of unallocated cases and the impact on capacity. This information was presented to Doncaster Children's Board in July 2012 with a proposal to address the issues in relation to unallocated work. However, the audit failed to fully identify the potential risk to children in need and respond appropriately. The management oversight of these cases was inconsistent and the response inadequate.

42. The council acknowledges preventative services are not yet fully utilised or embedded. Since January 2012 the IFSS has been without a permanent Head of Service and one of the two team managers and interim arrangements have not been in place. This has impacted on the development of the service. The arrangement for the management of the

IFSS is under review and the local authority acknowledges that there is a need for clarity around the management of the service.

43. The Chief Executive, Cabinet Member, Chair of Overview and Scrutiny Committee and the Director of Children and Young People's Services and the senior management team demonstrated a sustained and concerted commitment to delivering against the key priorities and in tackling embedded and cultural challenges faced by the council in improving child protection services. However, while the local authority and partners have a clear vision for protecting children this is not always sufficiently translated into effective front line practice or in improving outcomes for children and young people resulting in some children being left at potential risk. Senior officers and members give priority to protecting front line services and demonstrate evidence of investment in developing services to reduce workloads and capacity. This demonstrates commitment when set against the significant financial cuts to the council's budget. However, the council report that the main areas of risk are related to the budget for 2012- 2014 and appropriately identify the recruitment and retention of social workers.

44. The council has made marked progress in some areas of work in particular strengthening partnership working at a strategic level. Officers and members are visible and aware of the pressures on workers and recognise the need to take further action to address this. However there remains much to be achieved through the strategic partnerships to drive up standards in securing the protection of all children known to Doncaster children and young people's service. This includes ensuring the core functions of the DSCB are effectively carried out and deliver more effective oversight of front line practice. Strengthening communication and information sharing across the partnership between the Safeguarding Children Board, the Children's Trust and the Improvement Board is also an acknowledged area for further improvement by the council.

45. Governance arrangements and accountabilities are in place between the DSCB, the Director of Children and Young People's Services, the Chief Executive and the Cabinet Member and the Leader of the Council. However, the work of the Safeguarding Children Board has given insufficient focus to front line practice to ensure effective attention is provided to children and young people who are suffering, or at risk of, harm. The impact of the effectiveness of the work of the Safeguarding Children Board in holding agencies to account in protecting children is limited. The objectives set within the Business Plan for 2012 -2013 are insufficiently robust and the work plans of some sub-groups are absent or limited. The volume of the work being presented to the Safeguarding Children Board is very high and impacts on its effectiveness. The absence of full performance management information and a core data set across the partnership limits the scope of the Safeguarding Children Board's work, in setting realistic and achievable priorities and in the Board having

a full understanding of emerging concerns or progress made against key performance areas.

46. The Safeguarding Board has made some notable changes. Namely, social care procedures are delivered through an interactive website and arrangements for updating and accessing operational procedures are in place. Staff spoken to by inspectors demonstrate an awareness of how to access procedures, however, capacity issues within front line services have hindered full compliance. There is effective multi-agency training and there is close working relationship and representation on the Children and Adult Safeguarding Boards. The links between the child death overview panel and serious case review sub-groups are strong and provide for informed learning. In the context of the wider historical difficulties around partnership working and the high number of serious case reviews, progress has been made in forging and establishing relationships across the partnership and driving up improvements in some key areas. The Safeguarding Children Board is compliant with the safeguarding children and young people sexual exploitation guidance but development at operational level of the team is in its early days and the scale of the issue is not yet known by Doncaster. Young people's contribution to influencing the work of the Board is underdeveloped. The DSCB has two lay members who are active participants in the work of the Board. The voluntary sector is represented on the DSCB and supports the safeguarding agenda. However, engaging the wider voluntary sector agencies working with children and young people in the work of the Safeguarding Board remains a challenge and arrangements to improve engagement are not clear. Inspectors found the work of the Board is too remote from other strategic boards and operational practice and this limits its effectiveness and influence.

47. Performance management arrangements are not effective. The local authority has a performance management framework in place and as a result the council has a wealth of information across both local and national indicators. There are regular reporting arrangements in place to report to key strategic forums including the Improvement Board and Children's Trust. However, management reports are not sufficiently focused on the experiences of children and young people, current risks and needs, and the difference intervention makes. They do not contain sufficient qualitative details of emerging concerns. For instance key information in recent performance surgery management meeting minutes did not identify the high number of unallocated child in need cases. Also, the information and reports presented to the Improvement Board did not act as an effective alert. Consequently the Board did not identify the need to take decisive and immediate action in the management of these cases to ensure children were safe and this was a serious omission. There is no systematic internal managerial auditing of cases across the children and young people's service. The local authority has plans in place to rectify this from January 2013. Some slippage is reported by the Safeguarding

Children Board in progressing multi-agency audits. The safeguarding and standards service has completed a number of detailed case audits and the most recent one completed in July 2012 was of a very high standard and provided qualitative and quantitative analysis of practice and identified practice issues identified in this inspection along with some good practice.

48. The arrangements for operational managers to take forward actions from the audits are not fully utilised and hampered by the capacity of managers to complete the work. The Children's Trust Board is strong and effective in promoting the Child's Voice which delivers outreach support to families. The Children's Trust Board is chaired by a young person and interactive workshops promote the involvement of children and young people. Child's Voice is actively supported by members and officers. It has a strong focus on raising young people's aspirations, consulting with children and young people and enriching their experiences, but evidence of this influencing planning and decision making at operation level is limited.

49. Newly qualified social workers have a good induction into the service and have protected caseloads. However, across the whole staff group too many workers have high caseloads and management capacity within some areas is stretched. The council has firm plans in place to increase the capacity in children and young people's services and action taken by the council in response to issues raised by inspectors during the inspection led to the establishment of a new team to manage all the unallocated work. The majority of workers spoken to by inspectors said that managers are accessible and that they receive formal and informal supervision. Some staff reported low morale; others spoke very positively of the support they receive from managers. Senior managers and members are visible and encourage feedback and challenge from staff, partners and children and young people. In the majority of supervision files audited by inspectors, gaps in the frequency of supervision were marked. There are clear action plans to improve staff retention and support by reducing high caseloads, improving and monitoring the quality and consistency of supervision, support and training. A clear progression framework is being developed to systematically identify needs and promote organisational and professional development.

50. Doncaster has appropriately ensured vacant front line positions are covered by agency staff. However the lack of permanent staff at operational level and the high sickness absence rate in front line services have significantly impeded consistency in service delivery and the ability of workers to forge effective and sustained relationships with families. The lack of stability at both operational and team manager level identified by the council poses a significant risk, threatening continuity and remains a threat to taking forward the children and young people's service improvement plan, in spite of the council's concerted efforts to address this long standing problem.

Record of main findings

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