Somerset County Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the local safeguarding children board[1]

Inspection date: 20 January 2015 – 11 February 2015

Report published: 27 March 2015

The overall judgement is that children's services are inadequate
There are widespread or serious failures which cause children to be harmed or at risk of harm and in the delivery of services for looked after children and care leavers which result in their welfare not being safeguarded and promoted. Leaders and managers have not been able to demonstrate sufficient understanding of failures and have been ineffective in prioritising, challenging and making improvements. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[2]

The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Inadequate
	2.1 Adoption performance	Requires improvement
	2.2 Experiences and progress of care leavers	Inadequate
3. Leadership, management and governance		Inadequate

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

[2] A full description of what the inspection judgements mean can be found at the end of this report.

Contents

The local authority

Summary of findings

Children's services in Somerset are inadequate because:

Leadership, management and governance

- There has been a corporate failure to keep children safe in Somerset. The continual churn in the senior leadership team over the last ten years, including eight different Directors of Children's Services, has inhibited the development of the service, severely restricted the local authority's progress and, as a consequence, is seriously affecting the quality of services to children and families.
- Oversight, scrutiny and challenge from corporate leaders has not been sufficiently robust. Chronic instability at all levels of the organisation, poor practice and a culture of mistrust have been allowed to persist.
- The Improvement Board has been ineffective. Four changes of Improvement Board chairs over a period of two years have contributed to a lack of a rapid and purposeful response to the findings from previous Ofsted inspections and the Department for Education (DfE) Improvement Notice.
- A high number of locum staff used to cover managerial and social work posts, and the continual changes in the workforce, have limited the authority's ability to achieve a consistently acceptable standard and quality of social work practice.
- Services to protect children at risk of child sexual exploitation are underdeveloped; the scale and the prevalence of the problem are not sufficiently understood across the partnership. When children go missing, return home visits are not routinely undertaken and findings are not used to prepare and plan for better interventions and services.
- Partners are not fully committed or contributing effectively to the safety and protection of children and families. The partnership has failed to establish a shared understanding of the arrangements for early help and thresholds for children's social care are set too high.

Quality of Practice

- High caseloads, unassessed risk, poor management oversight, children not being seen often enough by their social workers and cases closed too soon, are illustrative of some of the serious and widespread failures to adequately protect children in Somerset.
- Achieving permanency for children lacks direction and purposeful oversight from the Independent Reviewing Officer service. A heavy reliance on the use of locum staff and high caseloads means that there is considerable delay and drift in achieving permanency for some children.
- Support to help care leavers into education and employment is insufficiently coordinated and the number of care leavers who are not in education employment or training (NEET) is high.

What does the local authority need to improve?

Priority and immediate action

Leadership, management and governance

1. Provide stability, quality and experience in the senior leadership team and strengthen corporate governance arrangements and scrutiny to ensure a better oversight of children's social care.

2. Provide sufficient capacity across the workforce to ensure that case loads are reduced, risk is appropriately assessed and acted upon, and social workers have sufficient time to spend with children and families.

3. Strengthen management oversight of social work practice to ensure that all children receive a service which is sufficient to address their identified need.

Partnership

4. Ensure that all partner agencies fulfil their statutory duties and safeguarding responsibilities toward vulnerable children.

5. Strengthen the partnership's approach to children missing from home, care or education and at risk of child sexual exploitation and ensure that information is collated, shared and tracked so that the scale of the problem is well understood, and that there is a sufficient range of interventions in place to support children and young people at risk.

6. Ensure that police safe and well checks and return home interviews are routinely undertaken to enable sufficient information to be gathered to improve the protection of vulnerable young people and to support the disruption of child sexual exploitation activities.

7. Progress the early help strategy more swiftly, ensure that it is well embedded in practice across the partnership and that thresholds for services are better understood and implemented to reduce the number of inappropriate referrals and re-referrals to children's services.

Quality of Practice

8. Provide a sufficient range of placement choices for children to achieve a better match, reduce the need for them to move school and enable them to stay closer to their families.

9. Ensure that the Independent Reviewing Officer (IRO) service has a better oversight and provides effective challenge where children are experiencing too much delay and drift in achieving a permanent family.

Areas for improvement

Quality of Practice

10. Ensure that there is sufficient capacity within the Local Authority Designated Officer (LADO) service to deal with the increase in the number of referrals and ensure that all decisions made are supported by a clear rationale.

11. Ensure that the needs of all the children in a family are considered and assessed separately.

12. Prior to cases being closed, ensure that risk is addressed and families and partner agencies are informed.

13. Ensure that records of all planning meetings in relation to child protection concerns such as strategy meetings, child protection conferences, core groups and Public Law Outline and legal planning meetings, clearly document the decisions made and actions to be taken.

14. Raise awareness across the partnership of private fostering arrangements and ensure that privately fostered children are identified, their needs are assessed and, where necessary, action is taken to ensure that they are safe and to promote their wellbeing.

Adoption

15. Ensure that social workers have the necessary experience and are sufficiently skilled to deal with complex adoption cases.

16. Ensure sufficient medical adviser capacity is available to enable provision of timely adoption medical advice and consistent attendance at adoption panel meetings.

Care leavers

17. Consider how the findings from the LSCB and Safeguarding Adult Board (SAB) Learning Review may be used to improve services for care leavers in Somerset.

18. Work with all housing providers to improve and increase the range and geographical spread of accommodation for care leavers.

19. Ensure that all care leavers have a pathway plan with specific actions and timescales which they can contribute to and understand.

20. Provide health history and information for all care leavers.

21. Drive forward initiatives in education, employment and training to reduce the number of young people who are not in education, employment or training.

The local authority's strengths

22. Despite the lack of progress over a number of years to improve services, social workers work hard and have remained resilient and determined to improve outcomes for children and families,

23. Recent social work practice is of better quality. It focuses on the needs of children, it is supported by clear management oversight, and case notes are detailed, analytical and help to inform decisions about children.

24. Inspectors have confidence that the current senior leadership team know what needs to be done to make Somerset a safer and better place for children and families, and are starting to make progress to secure better outcomes for children.

25. The Troubled Families Programme (TFP) is good and is successfully improving the lives of 870 families.

26. The children in care council meets regularly and is a very active group. The young people involved can easily identify where they have had influence and where they know they have made a difference, including helping to appoint a new Director of Children's Services and informing foster carer training. Two councillors and members of the corporate parenting board help to run groups on Sundays.

27. The local authority is beginning to improve the sufficiency and choice of placements for looked after children. The fostering service offers a range of specialised fostering schemes for looked after children. These services are providing a strong, specialist resource for children with the most complex needs, and are achieving some good outcomes. Every foster carer spoken to said they would recommend fostering for Somerset council.

28. Measurable improvements have been made in assessing the health needs for looked after children.

29. Foster to adopt work has resulted in some very young babies being placed quickly in placements that could become their long-term adoptive homes, minimising placement moves.

30. The local authority has success in securing permanence for older children and in keeping brothers and sisters together.

Progress since the last inspection

31. The last Ofsted inspection of the local authority's services for looked after children was in June 2012. The local authority was judged to be adequate. Services for these children have deteriorated since that time and are judged to be inadequate in this inspection.

32. An inspection of the local authority's arrangements for the protection of children was undertaken in June 2013. The arrangements were judged to be inadequate, and they are still found to be inadequate in this inspection.

33. Many urgent and crucial recommendations from these inspections have not been addressed.

34. Leaders and managers are working hard to improve services for children and young people. The permanent appointment of a new Chief Executive in May 2014, a new interim Director of Children's Services in November 2014 and the appointment in September 2014 of a new Improvement Board chair are showing some early signs of leading to recovery. Whilst the scale of the challenge for children's services remains significant, there is a sharper focus on reducing organisational churn, strengthening performance management and championing the needs of children.

35. Services have been too slow to develop a shared partnership approach to the safeguarding agenda, and a collective response to protect children at risk is lacking. Shortfalls in the quality of practice are still evident in a number of cases.

36. The local authority has failed to strengthen early help arrangements and to ensure that thresholds for early help and social care services are clearly defined and widely understood so that children and their families benefit from the right help at the right time. Access to early help services is unclear and thresholds for accessing services are not widely understood across the partnership.

37. Restructuring to specialist assessment, safeguarding and looked after children's teams in four geographical areas in 2013 has resulted in greater clarity of roles within children's services.

38. There are examples of good work, with some social workers delivering high quality child focused work. A recent restructuring of children's services, and the introduction of the Signs of Safety model of managing risk, have enhanced the quality of some of the work undertaken.

39. The quality of work in the children with disabilities service has improved in recent months as a result of more focused management support.

40. Although there is some way to go, the local authority is able to demonstrate progress in strengthening fostering services since the last inspection. The fostering service has a strong team of skilled, committed carers.

Summary for children and young people

- Somerset County Council is not providing good enough services for the children and young people they need to support, protect and care for. However, since new bosses came into the council last year things have started to improve, but there is still a lot to do and everyone who works with, or has responsibility for children and young people, needs to work better with the council to improve things.
- The difficulty in recruiting permanent staff has meant that children experience too many changes of social worker and, as a consequence, they are not always able to build a strong relationship with them. Social workers are too busy and have too many children to care for, so they are sometimes not able to visit children as often as they should. When social workers do have enough time, inspectors have seen that children are listened to and that what they think matters.
- Inspectors know that some children receiving services from Somerset County Council experience too many changes in their lives. For example, they experience too many placement and school moves and, for some children, this has involved long journeys to get to school.
- Children and families do not always get the support they need at the time when they most need it.
- Social workers, police officers and health care workers do not always have a shared understanding of how to protect children from risk, and they need to work better together.
- It takes too long for decisions to be made, to make sure that children have a permanent family.
- The virtual school, and the schools that children and young people attend need to make sure that they support children better and that they are well prepared for their exams, so that they can get good results to help them to get jobs and gain training or places at college or university.
- There should be a better range of accommodation available for those young people who are ready to leave care.
- When children make a complaint, the local authority needs to respond much more quickly to try to resolve problems.

Information about this local authority area[3]

Children living in this area

- Approximately 109,000 children and young people under the age of 18 years live in Somerset. This is 20.2% of the total population in the area.
- Approximately 15% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 11.5% (the national average is 17%)
  - in secondary schools is 10.3% (the national average is 14.6%).
- Children and young people from minority ethnic groups account for 3.5% of all children living in the area, compared with 19.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are White Other, Mixed and Asian/Asian British.
- The proportion of children and young people with a first language other than English:
  - in primary schools is 5.0% (the national average is 18.7%).
  - in secondary schools is 3.6% (the national average is 14.3%).
- Polish is the most common non-UK nationality in all Somerset districts and Polish-born residents now account for 1% of Somerset's overall population. There are significant pockets of Polish-heritage residents in parts of Shepton Mallet, Yeovil, Minehead, Taunton and Bridgwater. A large traveller and Eastern European population seeks seasonal work in the agricultural parts of the county, but is not resident.

Child protection in this area

- At 31 January 2015, 3,607 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 4,037 at 31 March 2014.
- At 31 January 2015, 472 children and young people were the subject of a child protection plan. This is an increase from 412 at 31 March 2014.
- At 31 January 2015, no children were reported as living in a privately arranged fostering placement. The number at 31 March 2014 was too low to be reported and was suppressed.

[3] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Children looked after in this area

- At 31 January 2015, 482 children were being looked after by the local authority (a rate of 44 per 10,000 children). This is a reduction from 488 (45 per 10,000 children) at 31 March 2014. Of this number:
  - 129 (or 26.8%%) live outside the local authority area
  - 48 live in residential children's homes, of whom 40% live out of the authority area
  - 10 live in residential special schools[4], of whom 6 live out of the authority area
  - 357 live with foster families, of whom 24.1% live out of the authority area
  - 17 live with parents, of whom 5.9% live out of the authority area
  - 1 child is an unaccompanied asylum-seeking child.
- In the last 12 months:
  - there have been 56 adoptions
  - 17 children became subjects of special guardianship orders
  - 305 children ceased to be looked after, of whom 8.9% subsequently returned to be looked after
  - 23 children and young people ceased to be looked after and moved on to independent living
  - 10 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates five children's homes. None were judged to be good or outstanding in their most recent Ofsted inspection. Two were judged to be inadequate.
- A recent multi-remit inspection took place in September and October 2014. The review found that services for the most vulnerable children and families in the local area were not of a good enough standard.

Other information about this area

- The Interim Director of Children's Services has been in post since November 2014.
- The chair of the LSCB has been in post since September 2012.

[4] These are residential special schools that look after children for 295 days or less per year.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Inadequate

Summary

There are serious and widespread weaknesses in the provision of services to safeguard children in Somerset. Since the last Ofsted inspection in 2013, services have not improved sufficiently and, as a result, some children are not adequately safeguarded and protected.

Early help services are not developing quickly enough despite this being identified as a concern in the last Ofsted inspection. Thresholds to social work services are set too high, referrals are not accepted or are quickly closed despite risk remaining, and there is a lack of preventative services across the partnership to support vulnerable families.

Poor quality decision making and assessments, lack of management oversight and a high number of short-term staff in the local authority contribute to unassessed risk, and a high number of repeat incidents of harm.

The response to child sexual exploitation across the partnership is poor. Coordination of this issue has only recently begun. Information from across the partnership relating to children missing from home, care and education is not aligned, making it difficult to meet children and young people's needs for support and protection or to know the scale of the problem in Somerset.

Private fostering arrangements are not being identified and action to raise awareness of the need to notify children's services of such arrangements is underdeveloped.

Partner agencies are not fully taking on their responsibility for supporting vulnerable children and young people in the community. There are very serious concerns about the lack of availability of Avon and Somerset Police to work with the local authority to protect children. Delays by a local hospital in communicating its concerns about children further compound the lack of a joined up approach to safeguarding children.

Despite this, there are examples of good work, with some social workers delivering high quality child focused work. A recent restructuring of children's services, and the introduction of the Signs of Safety model of managing risk, have enhanced the quality of some of the work undertaken.

There is improved work in the Children with Disability team. There is also good work to address domestic abuse through the Multi-Agency Risk Assessment Conference (MARAC) meetings, and to prevent homelessness amongst young people across the partnership.

41. Although identified as a weakness during previous Ofsted inspections, early help services continue to be insufficiently developed to provide a satisfactory level of additional support to the thousands of children and young people living in Somerset who are likely to need it. Early help hubs, part of a local authority initiative 'Get Set', are developing, though progress in achieving full staffing has been slow and is not yet complete. Access to resources to help families, and prevent their needs rising to levels when social workers should intervene, is patchy around the county. For instance, multi-agency 'One Teams' enabling families to access small grants and local guidance to access universal services, only operate in two areas of Somerset.

42. Collecting robust performance data from early help services across the county to help identify needs and ensure that the right services are commissioned, is proving a challenge for the authority. Ofsted inspections of two children's centre groups, last year, showed a further deterioration in those services, which are now judged to be inadequate. Although there has been some improvement in the take up of the Common Assessment Framework (CAF) since a multi-agency re-launch of this way of working in April 2014, the wider group of agencies, including health and schools, are not consistently taking responsibility for supporting vulnerable children and young people. This contributes to the escalation of need within families and adds to the pressures on children's social care services.

43. Targeted early intervention through 'Family Focus', as recorded as part of the national Troubled Families programme (TFP) is good, successfully improving the lives of 870 families as at August 2014. For instance, there is evidence of effective, stable relationships with families. Information sharing about risks is routine in participating agencies, including the police, Department of Work and Pensions, health services, schools, local and district authorities. Data shared between the partners involved show that targeted intervention has brought measurable reduction of risk of harm for children in the programme, including improved school attendance and reduction in offending. The Somerset programme is now an early adopter of the next phase, in which it aims to help over 2,900 families in the next five years.

44. Concerns about children from members of the public and other agencies are raised with Somerset County Council through Somerset Direct, and acted upon by experienced social workers. However, inspectors identified a significant number of cases where a decision to take no further action was inappropriate, being based on too little information. In a few cases, this left children at risk of further harm. Although the local authority had identified poor practice, it had not been addressed in sufficient depth. As a result of inspectors' findings, the local authority immediately reviewed decision making in over 2,500 closed cases from the previous two months through which they found over 200 cases which they needed to re-open. Inspectors sampled a number of the decisions that the council had reviewed and found that the process was not robust in identifying all of the cases needing further work.

45. Other agencies expressed concern about the thresholds agreed by the LSCB and the challenges in getting children's services across the partnership to accept referrals. Many of the referred cases had complex factors underlying the concerns for the children including domestic abuse and parental violence, substance misuse and poor mental health. Inspectors found a lack of understanding amongst some social work staff and managers of the significant impact a combination of these issues can have on families. Some very worrying cases were not being accepted by children's social care services, with an unrealistic expectation that sufficient support would be provided by universal services. This results in children's needs not being met in a timely manner, and a significant number of re-referrals as family situations continue to be left unaddressed. Specialist support services are available, for example, to address substance misuse, but these are not readily accessible. In particular, families in South Somerset have limited access to some of the good support available elsewhere in the county.

46. A multi-agency safeguarding hub (MASH) meeting composed of the police, health and children's social care takes place every day to discuss cases referred. The capacity within the team to look appropriately at the volume of concerns referred each day is insufficient. The practice of the Avon and Somerset Police of referring every case which may have some relevance to children, without risk assessment and triage, deluges children's social care in a high number of inappropriate referrals. Many of these contacts do not specify whether children were involved or witnessed the incident. This makes it harder for the local authority to prioritise the families of those children who are most in need. During the inspection, inspectors also saw a large number (36) of cases of concern referred together in one batch from the Royal United Hospital Bath to Somerset Direct. These cases had not been referred in a timely manner to address need or any safeguarding concerns.

47. Somerset Children's Services have recently been restructured into specialist assessment, safeguarding and looked after children teams in four geographical areas. This has resulted in improved clarity of roles within children's services. Assessment work is therefore carried out in eight different teams. Some assessments are good and describe the views of children and young people well; other work does not consider all relevant risks.

48. Not all assessments are timely, and examples were seen where these had taken many months. The practice of including every child in the family in the same assessment does not help the understanding of each child's individual needs. The impact of cultural and diversity issues is not always recorded. However, in some cases, good consideration of the needs of Gypsy and traveller families was noted by inspectors.

49. A current social worker vacancy rate of 23.3% and an overall vacancy rate of 42.1% mean that there is a significant number of short-term staff from agencies employed across the local authority. The quality of some of their work is good but some is not of a good enough standard. A critical feature of many of the cases seen was the number of changes of key workers in a short timescale. Examples were seen of social workers carrying out visits and accepting explanations from parents which would undoubtedly have been challenged more robustly if the worker had a better awareness of the case. Many of the cases scrutinised by inspectors show significant gaps in visits to children and families and in contact with other agencies. This has made it harder for children and parents to build up meaningful relationships with social workers and undermined efforts to support families to make the changes required of them. There have also been numerous changes in the managers providing oversight of the cases which makes it more difficult to drive forward plans for children in a consistent way.

50. Local authority managers and social workers expressed grave concerns about the lack of availability of the Avon and Somerset Police to participate in strategy discussions and respond to urgent child protection matters. Inspectors saw two serious incidents in one day where the police were not available to respond. This lack of availability results in some children not being visited within the 24-hour maximum recommended in the *Working Together to Safeguard Children* national guidance. Local authority staff reported that there were a number of occasions where this had compromised children's safety.

51. The local authority has introduced the Signs of Safety model of protecting children but it is not yet fully embedded. In some cases, Signs of Safety work is completed well and is used to engage parents effectively. However, there is not a consistent understanding amongst social workers and other agencies of how this is to work, and some of the casework lacks rigour. In the main, the resulting plans are not sufficiently specific, lack consideration of all of the risks, and show poor prioritisation and no timescales. In a number of cases seen by inspectors, social workers and multi-agency colleagues had been over-optimistic about the potential for change or the capacity and willingness of parents to do so. Parents' claims that domestic abuse situations have recently been resolved, despite long histories of violence and intimidation, were too readily accepted.

52. Multi-agency child protection conferences are variable. Some meetings show effective engagement with parents and good multi-agency contributions; others lack direction and challenge. Conferences are not always minuted well, so in some cases there is no record of discussions or differences of opinion. With the frequent changes of social workers and managers, these meetings and their minutes are vital to ensure that plans are taken forward to protect children.

53. Generally, children and families are benefiting from the support of advocates. There has been an increase in the use of the advocacy support service to children and their families, from 331 children in 2012–13 to 545 children in 2013–14. Of these, 150 children were supported at initial child protection conferences and 349 at review conferences between January 2013 and December 2014. Signs of Safety assessments are completed during the conference and this improves the involvement of parents. However, there is variation on how this work is undertaken, in particular in how it is recorded. This does not assist the monitoring of progress.

54. Multi-agency core groups do occur regularly in most cases. There is significant duplication of recording between reports for different children in the same household who are being considered at core group meetings. Also, it is sometimes difficult to understand whether there have been any further incidents, what has been discussed, and whether there have been any changes to the plan to protect the child.

55. There are 472 children subject to a child protection plan. This is a significant increase since 31 March 2012, when there were 282, and since 31 March 2014, when there were 412. The March 2014 figure represents 37.9 children per 10,000 in the population at the time, below the regional and national rates of 40.3 per 10,000 and 42.1 per 10,000 respectively. The local authority has identified that the increase is due to greater consistency in child protection decision making in two of the offices, bringing them in line with the other two offices. Figures seen by inspectors confirm that most of the increase in numbers relates to these two offices. Eighteen per cent of child protection plans show that children are living in households where mental health issues, drugs and alcohol are significantly affecting the care that children receive. Emotional abuse, at 43%, is the highest category for children placed on a plan, with 34% of plans showing neglect as the main reason.

56. A significant proportion of children are subject to a child protection plan for a second time: 17.6% across Somerset in December 2014, an increase from 13% in December 2013. These plans are currently being reviewed so that the authority can satisfy itself that progress is being made and, where it is not, consider alternative action to protect the children. In December 2014, 3.4% (12) of child protection plans show that children have been subject to a plan for over two years; this is an increase on last year's performance, of 1.4%, though remains lower than statistical neighbours at 4.1% and the England average at 4.5% for 2013–2014. A review of these plans is currently in progress to ensure that they continue to meet the protective needs of the children.

57. The Somerset minimum standard for a social worker visiting children who are subject to a child protection plan is at least once every twenty-eight days. This pattern of monthly visits was seen to occur in many of the cases reviewed, but local authority data shows that in December 2014 only 63% of children had received all of their visits in accordance with this minimum standard, and in one office this was only 38% of children. In many cases, this means that social workers are not visiting children often enough to engage in effective direct work to promote change within their families. Recording of visits generally focuses on talking to children and observing how they present. Whilst this is important, it has resulted in many visits being solely welfare checks on families. One parent described only having 'announced visits', having his children spoken to and not him, and having no meaningful work done to help him in protecting his children. Recent audits describe 'purposeless visits' which fail to take forward child protection plans.

58. A number of parenting courses are available to support families subject to a child protection plan by helping to improve parenting skills, with Talking Therapies, Triple P and Parent Assertiveness courses running regularly. The size and rural nature of the local authority make accessing groups difficult for some families.

59. Social workers have high caseloads and describe 'struggling' and being 'challenged' by the work they are expected to do. However, in many cases, the current level of involvement by social workers and partner agencies is insufficient to ensure that children are safe and plans are progressed. This is partly due to the need to improve the quality of visits and engage in direct and meaningful work with families. This is not a consistent picture however as inspectors did see some very good direct work by social workers. Social work assistants also provide good practical help for families. Consultant social work posts have been introduced and these are assisting less experienced workers to assess and formulate plans. These posts have only recently been filled across the county, and there are some inconsistencies in how they work. However, social workers are reporting how useful consultant social workers are to them, in particular the training they run to help improve practice.

60. Recording by social workers is not consistent. There are some very good examples of records of visits, including seeking children's views, observations of behaviours and relationships in the family, and evidence of social workers trying to understand what it is like for a child to live in the household. The majority of assessments lack detail of the experience of children and young people and a robust consideration of risk. In a small number of cases, assessments are written to a high standard. In the main, reports completed to record multi-agency meetings such as strategy meetings, child protection conferences, core groups, PLO (Public Law Outline) and legal planning meetings have insufficient detail to clearly explain the reason for decisions taken. Chronologies and genograms, to enable understanding of the child's history and background, are not consistently completed and those on files vary in quality.

61. A high number of cases are closed far too quickly by social workers without sufficient consultation with other agencies or with the families concerned. For example, in some cases seen by inspectors where children had been subject to a child protection plan, decisions had been made to bring the plan to an end and close the case immediately when there were no further reported incidents, even though children continued to be at risk and had unmet wider need. Consequently, a high proportion of cases (29%) are re-referred due to similar concerns re-emerging; this is well above the England average of 25%. Local authority performance data show that this has been a consistent pattern for the previous two years.

62. Management oversight is not sufficiently robust. There are some good examples of management involvement in the assessment and safeguarding teams, but it is not consistent. Supervision does occur but it is not always regular. Over the last year, there has sometimes been a gap of many months in workers' supervision. Some supervision recording have good analysis of risk, consideration of support and planning whilst other supervision is limited. Managers do not focus sufficiently on providing reflective supervision, nor on ensuring that the basic social work tasks are completed. For example, regular visits in a timescales that reflects the concerns, direct work with parents, consideration of cultural issues, seeing and talking to children and young people, reduction of risk and taking forward the plan, core groups occurring, liaison with other agencies and good quality recording.

63. The most recent child protection work seen by inspectors carried out by the Children with Disability teams was of a good standard, with risks well assessed, acted upon and recorded. Cases sampled by inspectors indicated that, up until six months ago, work in these teams typically involved delays in actions being taken, gaps in recording and poor supervision, resulting in children not having their needs met in a timely manner. The quality of these services has improved as a result of more focused management support.

64. There is a significant lack of joint working across the partnership to safeguard children missing from education. Arrangements to collate and track information about children missing from education are coordinated within schools, and children's whereabouts are tracked and recorded by the Education Attendance Service. Good use is made of the School2School register for exchanging information with other authorities and checking school transfers within the county. However, this information is not shared or linked to police and children's social care data, and staff in the Education Attendance Service do not routinely refer children to the police or children's services when they have completed all their enquiries and cannot find a child. This leaves children in unassessed situations and potentially at risk of harm.

65. Inspectors observed critical information being shared across the partnership at the child sexual exploitation MASH group, but this is a new process and is not yet fully embedded in practice. The collation of information from the education service for the meeting was crude and relied heavily on someone telephoning schools for names of children known to go missing or considered at risk. This lack of a coordinated response across the partnership is inadequate in meeting the safeguarding needs of children missing education.

66. A total of 572 children are currently receiving elective home education, of whom 13 are subject to a child in need plan and are being regularly monitored by children's services. Twenty children are not in full-time education; none are looked after children. The Education Attendance Service is monitoring these children closely. In some cases the Traveller Education Service is supporting children of a school age to access formal education.

67. Arrangements to address child sexual exploitation are underdeveloped. Partnership arrangements are being strengthened through the LSCB, but it is too early to see the impact of this. A multi-agency group has been established to coordinate action to safeguard individual children at risk of child sexual exploitation but it has only recently met for the first time. The intention is to provide an environment in which professionals can take complex cases for discussion to ensure a more coordinated approach across the partnership, with known associates being linked, hot spots identified and effective action taken to disrupt child sexual exploitation activities. Avon and Somerset police have been successful in prosecuting known offenders.

68. Local authority performance data shows that, year on year, the number of missing notifications is reducing. However, despite this, the scale of the problem is still not fully understood across the partnership. Data and lists about children missing from care, home and education are not aligned. A total of 364 missing from home, education or care notifications were received by the police in 2014. Safe and well visits by police do occur, and provide some insight into what is happening across the county, but they are not systematically evaluated and, consequently, the outcomes of these visits do not robustly inform practice.

69. While all the young people involved were offered return interviews, in only 33 cases (9%) did they agree. This low number makes it less likely that individually focused, effective safety plans are put in place. .It also does not support the timely identification of possible patterns and trends of activity emerging, to enable a robust partnership response to protect children. The local authority has not evaluated the outcomes from return home interviews to assess any patterns and trends that are emerging, to enable it to prepare and plan for better interventions and services. Without knowledge of children's views, experience and activities whilst missing, it is not possible to plan to improve their safety.

70. Within children's services, data on children in care and children on a child in need plan show that 17 children and young people are considered at risk from repeat episodes of missing. The local authority list shows that the police are not routinely informing children's services of missing episodes. In some cases seen by inspectors, there has been a good response to child sexual exploitation and missing concerns using screening tools to assess risk, including use of a screening tool with some parents to enable them to identify potential risk factors. In other cases, including some involving children subject to a child protection plan where child sexual exploitation has been identified as a risk, screening tools have not been fully utilised and actions have not been taken to ensure that children and young people are safe. Where the screening tools have been used, inspectors saw some very good practice.

71. At the time of the inspection, all cases open to the assessment, safeguarding and looked after teams were being reviewed using the child sexual exploitation screening and risk assessment tool to identify any concerning factors. Any children identified through the process are to be referred to the child sexual exploitation MASH group for a more coordinated response across the partnership. However, this process will only address the needs of those children known about. Further consideration is being given to how the group can identify those children who are at risk but are not open or known to any agency. It is early days, so the scale of the problem remains unclear until this review and further work is completed.

72. The capacity of the targeted youth support team to respond to vulnerable young people is limited. For example, there are too few support groups for all of the young people identified as at risk of going missing and of child sexual exploitation. However, a multi-agency child sexual exploitation conference was held in December 2014 to raise awareness, and training is ongoing to improve knowledge and skills across the workforce. Disruption activities and harbouring notices have been used by Avon and Somerset Police and are starting to make an impact to secure the safety of children and young people, and there have been successful prosecutions. The police have secured additional resources to support the child sexual exploitation MASH in tracking known associates and linking them to activity across Somerset, including links to particular children and groups. Social workers and partner agencies are now beginning to talk about the issue and are working together to better identify the scale of the problem. The police have carried out work with the licensing authority on taxis, and this is being extended to hotels and bed and breakfast accommodation.

73. Arrangements to identify, support and monitor children and young people who are privately fostered in the local authority are inadequate. Awareness-raising about this key group of vulnerable children who are not living with family members is poor, resulting in no children being identified and safeguarded through these arrangements for the last two years.

74. The LADO, who coordinates the response to concerns about professionals who work with children, has had a significant increase in allegations received, from 272 in 2013–14 to 405 in 2014–15. The work of the LADO is of variable quality. Some LADO cases are robustly managed with timely, clear decision making and action planning. In others, where it has been decided to take no further action, decisions are not supported by a clear rationale and records lack detail.

75. There are four MARAC groups working in the different operational areas across Somerset to identify support for victims of serious domestic abuse incidents. Operational managers report significant improvements in multi-agency commitment. However, probation service representatives do not attend meetings as often as they should, and the quality of ongoing work with families by all partners between meetings is variable. Minutes of MARAC meetings show that full discussions take place at the monthly meetings, with risks identified and actions put in place to support highly vulnerable victims of domestic abuse. These actions include contacting other local authorities where adults may have contact with children from previous relationships. Drug and alcohol misuse features in many of the cases discussed. Drug and alcohol services are commissioned to provide a good range of support services to parents, including outreach services and structured treatment programmes. Local authority data show that drug misuse is more prevalent across the county with 715 parents accessing a structured drug treatment programme, in comparison to 208 parents accessing a structured alcohol dependency programme.

76. Effective work is helping to prevent homelessness amongst young people. The emergency duty social work team, covering adult and children's services, and the adolescent intervention team (Team AIT) provide out-of-hours support across the county. These services have seen a significant rise in referrals due to family breakdowns and young people presenting challenging behaviour. Team AIT reports considerable success (in 92% of cases) in responding to crisis and preventing young people from becoming homeless. There are monthly homelessness prevention panels, Night Stop emergency accommodation and supported lodgings. Link social workers also work with the young people and, when appropriate, with their families, to create the conditions for a return home. A commissioned service provides accommodation and has a non-eviction policy. The service assesses the level of support young people need and can offer a range of solutions. For example, Frome Foyer has 12 beds and two emergency beds for those in need of high levels of support. Some of the young people here move on to a supported accommodation service for adults with mental health difficulties.

Key judgement	Judgement grade
The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

There are promising signs of improvement and some positive individual work has been seen. However, serious and widespread failings remain in the local authority and these leave looked after children at risk. There are currently 482 looked after children in Somerset and this figure has remained fairly static, dropping slightly from 515 in December 2013.

Children experience too many changes in their lives. The high turnover of staff at social worker and team manager level means that children are unable to form meaningful and long-term relationships with significant people in their lives. The management of their needs, including high risk issues such as going missing or child sexual exploitation, are weakened as a result of these changes.

Management awareness and the availability of accurate data on children who go missing from care and who are at risk of child sexual exploitation are poor, and lists are not aligned across partnerships. Local information held is not always accurate by area or for individual cases. As a result, these risks are not managed well.

There is no clear, agreed process for permanency planning for children, resulting in drift and delay in the majority of cases. Not all staff feel confident in undertaking complex work and the workforce is insufficiently experienced in permanency planning to secure consistent and timely outcomes for all looked after children.

There is insufficient management oversight in case work and insufficient challenge by the IROs in relation to care planning.

Placement stability data on three moves or more is showing an improving picture, and stability data for children who have been in a continuous placement for over two years has also improved.

Insufficient progress has been made to improve educational outcomes and progress and attendance for children in care fall off sharply as they go into secondary school.

Support to help care leavers into education and employment is not sufficiently robust. The proportion of care leavers in Somerset who are not in education employment or training (NEET) is significantly high.

The quality of assessments, care plans for looked after children, pathway plans and the recording of visits requires improvement. Too many care plans lack sufficient detail, or are unclear about the required outcome and the actions needed to achieve this.

77. At the time of the inspection, the local authority was looking after 482 children. This figure has remained fairly static, dropping slightly from 515 in December 2013. Children's services do not hold readily available and accurate data on looked after children who are, or could be, at risk of child sexual exploitation or of going missing. Systems to ensure oversight of these risks are not in place and management on a case by case basis is not consistently accurate. This seriously compromises the capacity for children's services to understand the scale and prevalence of the issue and to be able to successfully target resources to support children at risk of harm.

78. The high turnover of staff means that many children have not been able to build consistent and enduring relationships with their social workers. Although senior managers have recognised the need to prioritise permanent staff for looked after children, in practice this has not happened due to staff shortages. Frequent changes of social worker were the key concern of the foster carers who met inspectors. They gave examples of children they had cared for having had seven social workers in two years, three social workers in five months and three social workers in ten weeks. Many of the young people who met with inspectors confirmed that they had experienced this level of disruption.

79. The combination of high turnover of staff and a lack of experienced staff has led to a poor social work experience for many children. However, in cases seen where looked after children did have a permanent social worker over a sustained period of time, inspectors saw evidence of good relationships for children, with social workers knowing children well and undertaking more accurate assessments and developing more effective plans for them. Inexperienced or newly qualified social workers are holding too many high risk cases, including missing and child sexual exploitation. In some cases seen, they have managed to undertake this work very well despite frequent changes of line manager and a lack of management oversight.

80. The high turnover of managers has led to a generally poor experience for staff, with oversight and decision making being too variable and some staff reporting feeling unsafe and unsupported. These are issues relating to workloads, pressures and the general working environment for social workers. Not all staff receive consistent, reflective supervision or feel appreciated and supported. Some social workers report having had three team managers since April 2014. In another area, there has been a turnover of 14 different managers over the last two years, which had been unsettling for staff and has further hindered the improvement of practice.

81. Decisions for children to become looked after were the right ones in recent cases seen, and the children were found appropriate placements to meet their needs. This demonstrates a strong understanding of the threshold into care in recent practice, although intervention was not always timely. In a few cases seen, children were left too long before being accommodated or were returned home too quickly to situations where risk remained.

82. Inspectors found evidence of high staff turnover resulting in delays in progressing plans for children and young people. Permanency planning processes are unclear and the quality of work in this area is too variable. Senior managers have recognised this difficulty and put in two new family finding posts and established a Permanence Panel, but, at the time of the inspection, the process for determining a permanence pathway for a looked after child remained unclear. It is uncertain who will call and chair a permanency planning meeting. Given the relatively inexperienced staff group within the looked after children teams, changes of managers, and the lack of a structure for an agreed permanency planning process, risks remain in achieving permanence for some children.

83. Permanency is raised at the majority of the second looked after children reviews, but not always in a purposeful way that identifies what actions are required when and by whom. Assessments to establish whether family members or friends could provide a viable alternative to the child being looked after are discussed at reviews, but these are not always conducted concurrently. The quality of these viability assessments is too variable and they do not always reach a firm conclusion about a placement that could offer permanence. As a result, potential alternatives to care which could enable children to be brought up within their wider family and friends networks are not being explored quickly or thoroughly enough.

84. The local authority has made progress in reducing the average duration of care proceedings, from 56 weeks in 2012–13 to 40 weeks in 2013–14. The timescale for current cases is between 35 and 45 weeks against a target of 26 weeks, so children still face delays in decisions being made about their futures. The Children and Family Court Advisory and Support Service (Cafcass) has raised concerns about the quality of work being submitted to court. However, court work sampled by inspectors is of an adequate quality and is supported and quality assured through close overview and advice from designated solicitors in the local authority. PLO work is generally being undertaken well, with PLO letters written by social workers that are clear and well evidenced. However, some cases seen showed a repeat initiation of the PLO process within a short timescale.

85. Evidence of drift and delay was seen in some cases. Thirty six children have been in their current placements for more than two years without permanence plans being made for them. The lack of drive through the review process to secure permanence for these children has been inadequate and remains a worrying feature. The use of Special Guardianship Orders (SGO) is very low, with 10 children leaving care through SGOs during 2013–14; at 3% of those leaving care, this is well below the national average of 11% and places the local authority in the bottom performing 5% of authorities against this measure. Foster carers spoke of their concern about having to negotiate a package of support individually, although an agreed standard support package is currently being finalised for special guardians.

86. Placement with parents arrangements are generally managed safely when children return or are placed back at home on a care order. Some work seen by inspectors was reactive, and assessments were not always thorough and did not show clearly where changes have been made to support a return home. Management oversight is not always robust. This is of concern where some teenagers have removed themselves from being accommodated. Inspectors saw some worrying cases where the local authority has been passive in its response to the risks experienced by teenagers, including one young girl returning home and becoming homeless and having to rely on friends.

87. Many of the basic statutory requirements in relation to looked after children are being met, but not to the required level of quality that could deliver an effective service for children. Children are visited regularly, with the proportion of looked after children without a recorded visit in December 2014 being just 1.8%. However, it is not always clear if they are seen alone, and the recording of visits varies too widely. Action required as a result of visits is not always clear. Although inspectors saw some good assessment and care plans, many of those seen were too simplistic and basic, without achievable targets to secure better outcomes for children.

88. Some strong individual practice has been seen, with good direct work with children, including in some high risk cases. Some social work practice shows children's needs are known and responded to, for example, a social worker who ensured that a young person had a night light for their first night in a new placement, and another helping a young person to write out their aims for the next month, six months and year. Some good examples were also seen of supporting issues relating to diversity, including joint work with a traveller liaison officer and the provision of a transgender support group for young people.

89. The proportion of looked after children's reviews which are held on time is high, although there has been a slight downturn in performance, from 98% in December 2013 to 95.6% in December 2014. IROs cite high caseloads in excess of 80 as being a contributory factor in this decline. The quality of reviews is too variable, though some good examples were observed, and many children experience more stable relationships with the IRO service than with their social workers. Greater challenge needs to be evident on the progress of care plans during the review process. However, IROs report that the practice culture is one that does not support open challenge as it is seen as criticism by some social workers. In a small number of cases, young people have chaired their own reviews, and they feel this has worked well.

90. Placement stability data on three moves or more are showing an improving picture, from 15% of children at 31 March 2013, to 12% at 31 March 2014 and 11.3% at 31 December 2014. Stability for children who have been in a continuous placement for over two years has also improved, from 53% of children at 31 March 2013 to 61% at 31 March 2014. However, this latter figure is still well below the England average of 67% of children and, on its average performance over the last three years, the local authority is within the worst 10% of performing local authorities on this measure. There has been a slight improvement in the last year, but this is early improvement which needs to be accelerated and embedded.

91. Support to meet the educational needs of looked after children is not sufficient to ensure that all children make their expected progress and achieve their potential in education, or progress to employment by the time they leave care. The virtual school has been slow in developing a rigorous and robust approach to the educational needs of looked after children. With the appointment of a new headteacher in September 2014, some improvements have been made, although looked after children continue to experience too many school moves when changing care placements. Data is not robust enough to ensure that children's attainment and attendance are consistently monitored and supported.

92. Results for looked after children at the end of Key Stage 2 are weak, with only 33% of eligible Somerset children achieving the national benchmark of a level 4+ in reading, writing and maths in 2014. While this was an improvement from the very low figure of 19% for 2013, it was still well below national and regional averages of 48% and 43% respectively. Key Stage 4 results improved in 2014 from poor results in 2013, although the achievement gap between children in care and other young people in the county by the time they leave school is not closing quickly enough. According to the local authority's own data, the gap is above the national average, at 41% compared to 31% nationally for those achieving five good GCSEs including English and maths.

93. Looked after children make good progress from the end of Key Stage 1 to the end of Key Stage 2 in primary school, but progress and attendance for looked after children all off sharply as they go into secondary school. Not enough support is in place to make sure that looked after children do not miss out on their education. Absence rates for looked after children are high in comparison to other local authorities, with 6.2% of children looked after children identified as persistent absentees in 2013, compared to statistical neighbours at 5.9% and the national average of 5%. Improving these rates is a key objective of the virtual school's development plan for 2014-2017.

94. A Corporate Parenting education sub-group now scrutinises the progress and plans of looked after children including absences from school, with a determination to improve outcomes. Too many looked after children (15%) are missing education through not having full-time provision in place; some have been on part-time timetables for two years or more, and the virtual school is looking into this for each individual. While there have been no permanent exclusions of looked after children since 2010, 14% had at least one fixed term exclusion in 2013/14, which is considerably worse than the national average of 4.1%.

95. Personal educational plans (PEPs) are not being completed on time for one in five children, their quality remains too variable and some do not drive children's achievement well enough. Examples seen did not show what had made a difference to the child or young person's achievements. The process does not ask children and young people about their interests and ambitions in enough depth to make a difference for each individual. PEPs are not systematically quality assured and do not yet provide a secure system to monitor and evaluate the effectiveness of Pupil Premium funding.

96. There is an active children in care council that meets regularly. This group can easily identify where they have made a difference. Some of the young people who spoke to inspectors did not feel that their social workers made good decisions on their behalf, expressing concern about distant placements and unreliable transport making it harder for them to see their brothers and sisters. They knew how to make a complaint, and a number had done so. The children in care council has made changes to the complaint leaflet to make it more user friendly for children and young people. It is delivered in the quarterly mailing of the Who Cares magazine to all looked after children and care leavers, including two young people who are in youth offending institutions.

97. The annual complaints report presented to the Corporate Parenting Board shows that children made 32 complaints in 2013–2014; 10 of these children were supported by an advocate. Complaints show that children are unhappy at the number of placement moves they have experienced, a view confirmed by inspectors' findings that children are experiencing too many moves. Complaints are not always responded to in a timely manner.

98. Advocacy and independent visiting services are provided to looked after children. In the last year, 331 young people were referred, and currently 50 looked after young people have an advocate mentor allocated to them. The local authority plans to increase this number.

99. The sufficiency statement for looked after children and care leavers provides a model for ensuring that children's services have enough suitable placements to meet demand, but sufficiency plans are not yet specific enough and do not include targets or timescales. The local authority is beginning to improve the sufficiency and choice of foster placements. The quality of materials used to recruit foster carers is high; these include a new website and leaflets that provide case studies on the target groups of young people where greater capacity is required.

100. The Fostering service is strong with skilled, committed carers. A good end-of-year recruitment campaign resulted in the service exceeding its recruitment target by two carers, up overall from 45 in 2013 to 62 in 2014. Every foster carer spoken to said that they would recommend fostering for Somerset. They value both the training they receive. One carer told inspectors that they have 'every opportunity to do any amount of training'. Another said 'I've been praised and I've been questioned. I found this useful. It helps me reflect and become better'. Foster carer assessments and annual reviews are generally of a good quality.

101. A range of specialised fostering schemes are able to demonstrate positive outcomes, including placing children with attachment difficulties. The local authority has demonstrated strong performance in foster to adopt work, resulting in some very young babies being placed quickly in placements that could become their long-term adoptive homes, minimising placement moves for these children. There has been a reduction in the use of residential placements for looked after children, from 65 young people in residential provision in December 2013 to 46 young people in December 2014.

102. Measurable improvements have been made in addressing the health needs for looked after children since the last inspection, although the recording of health information needs to be improved. Nationally published data as at 31 March 2014 show that the take-up of dental checks by looked after children is higher in Somerset at 86% of children than the England average of 84%. As of January 2015, 91.6% of initial and review health assessments combined were up to date. Use of the Strengths and Difficulty Questionnaires (SDQ) to monitor children's emotional wellbeing has increased steadily, rising from a very low 3.4% in December 2013, to 16% at 31 March 2014 and, according to unvalidated local authority figures, to 58% in December 2014. The outcomes from these SDQs are now helping to inform a more targeted approach to children's wellbeing. The local authority has also introduced an interactive sexual health app that can be used directly with young people, and is in the process of finalising a health passport.

103. There is no dedicated child and adolescent mental health service (CAMHS) for looked after children. The specialist CAMHS team, education support teams and social workers work together to support children's mental health and wellbeing, seeking to ensure timely access to an appropriate level of service. Social workers and foster carers report that it can be difficult to access appointments speedily. In 2014, 162 looked after children were referred for specialist services. Urgent assessments are carried out where children and young people are showing significant symptoms of depression, suicidal thoughts, and symptoms of Anorexia Nervosa or deterioration in their emotional well-being. CAMHS social workers attend the monthly looked after tracking panels to support better identification and responses to children needing a CAMHS service.

104. Children who live out of the authority area do not always receive regular support and contact from their social workers. Children say that when they do have contact, it is good. They say that they have access to education and health services and to opportunities to attend leisure activities. Contact with family and friends is arranged through the home where they are living, and one young person was pleased that her new placement was closer to where her mother lived, so keeping in contact was made easier for her.

105. In October 2014, the local authority audited 42 cases of children and young people placed some distance from Somerset, to assure themselves that children were being visited regularly and to assess the quality of social work practice children were receiving. The audit showed that social workers were visiting children placed at a distance regularly. However, this was not always the view of children living away from home. The audit found improvements in the recording of why the placements are made. Challenges remain in ensuring that carers have sufficient information about the children in their care to enable them to understand and fully support their needs.

The graded judgement for adoption performance is that it requires improvement

106. The local authority has increased the number of children adopted in the last year, bringing its performance close to comparable authorities. Figures for 2013–14 show that, out of 56 cases where children had ceased to be looked after due to an adoption order being made, 31% were aged five years and over and in one case, siblings aged three and six years were matched with adopters within six months of their Placement Orders being granted. The overall percentage of looked after children adopted during the year increased from 6% in 2012–13 to 16% of children in 2013–14, although this level of performance was below the England average of 17%.

107. The local authority's performance measured against the DfE adoption scorecard (December 2014) is good. It shows that across all three indicators Somerset is performing as well as or better than the England average. The three-year average time between a child entering care and moving in with its adoptive family (for children adopted) is shorter in Somerset at 560 days than the England average of 628 days. Figures show this is a year on year improving picture for Somerset.

108. Despite these improvements, children's and adopters' experience of adoption is adversely affected by an inconsistent quality of practice. There is an absence of robust family finding arrangements, and this has caused delay in some cases. There are no formal family finding meetings to evidence the progress made, the interest being generated or what strategies need to be employed to secure an adoption placement. In a few cases seen, there is a lack of urgency in adoption work, with sequential rather than parallel planning taking place. Social workers have commented on the low number of Prospective Adopter Reports (PARs) sent to them to consider and the lack of placement choice.

109. The quality of PARs and Child Permanence Reports (CPRs) is variable. A good exploration of diversity was seen in one PAR of a prospective adopter from a traveller background, but most assessments lacked sufficient analysis of the information presented. Language and terminology were not always appropriate for a formal report and potential vulnerabilities were insufficiently considered. Permanency options were well set out in CPRs, but diversity was not adequately considered. Some CPRs lacked information on siblings who were also looked after by the local authority. Descriptions of children were often reported to come from foster carers, suggesting that social workers do not know their children well.

110. The variability in the quality of PARs and CPRs and the inexperience of some workers affect the suitability and timeliness of matches. One adopter talked about the lack of experience of both the child's social worker and adoption social worker, and the need for them to continually seek guidance from their managers.

111. Three children's adoption placements disrupted during the last year. Disruption minutes from one case reflect a lack of experience and understanding in adoption work and poor social work support. For example, the minutes noted periods without an allocated social worker, social workers not knowing the child well enough, differing perceptions of agencies' responsibilities and foster carers taking the lead.

112. A tracking system is now used to log all requests for an adoption decision, and from that point managers monitor children's progress along the adoption journey. The adoption team manager attends tracking panels to consider children who may need an adoption placement, so that links with family finders can be made at an early stage.

113. Most Somerset children are placed within the county, but for wider searches the agency refers children to the Adoption Register and the South West Adoption Consortium and it advertises in publications such as 'Be My Parent'. The local authority was involved in two Adoption Activity days last year, but adopters and workers involved did not regard them as helpful in securing links. Adopters have access to children's profiles via a secure electronic link.

114. The local authority has had success in recruiting five foster to adopt households. Foster to Adopt is being explored with adopters during their assessments and, in some cases seen by the inspection team, the issue had been given careful consideration. Inspectors saw good pieces of work, enabling babies to be placed with their permanent carers at an early stage, and in one case a baby was placed with an older sibling.

115. Twenty six children are currently waiting to be adopted. Twenty-one children have a potential match with adopters. The local authority is actively seeking prospective families for the remaining five children waiting. Some children are currently being fostered with Multi-Treatment Foster Carers and receiving intensive support intended to bring about greater emotional stability and a reduction in problem behaviours, with a view to them being able to move successfully into adoption placements in a timely manner.

116. Somerset has 10 adopters waiting for a match and six of these are being considered for links. This leaves only four in-house adopters available to be considered for a match until numbers increase.

117. The 2011–2014 average time between the local authority receiving court authority to place a child and deciding on a match to an adoptive family was shorter at 156 days than the England average of 217 days.

118. Performance information for completing the two-stage assessment process within the required six month timescale is not good. Not all prospective adopters go through the assessment and approval process in a timely manner. Figures show that since the introduction of the process, of families who had completed both stages, only 24% had completed stage one within the two month timescale and 89% within the four month timescale at stage two. Adopters spoken to have had mixed experiences. For example, one adopter described a "clunky and elongated" process where she had had three social workers prior to panel. Another adopter had progressed through both stages swiftly, but said she was aware of other prospective adopters from stage one who were still waiting for an assessment social worker to be allocated to undertake their assessment. All adopters spoken to valued the preparation course and had a good experience at the adoption panel.

119. Consideration of adoption panel minutes and discussion with the panel chair show clear and careful consideration of the issues relating to approval and matching. The panel has a range of members on the central list, including adopters and adoptees. It was noted that the medical adviser had only attended one out of seven recent panels, and one adopter spoken to talked of a delay in matching due to lack of clarity regarding a medical issue.

120. The panel minutes set out clearly the areas of discussion and recommendations, which are considered by the agency decision maker (ADM) within timescales. The panel chair and agency decision maker work closely together to discuss any emerging practice issues.

121. Post-adoption support is considered at the time of matching, although provision is limited. One adopter talked of the lack of support, purchasing therapy herself for her adopted child, and a lack of training provided for adopters. She felt that the post-adoption support helpline was impersonal and did not encourage adopters to seek help at times of crisis. Adoption figures for 2013–14 show that 36 adult adoptees were in receipt of post-adoption support. However, the agency has not been able to supply current figures for the number of requests for assessment of post-adoption support and how many have been declined. This lack of management information makes it more difficult for the authority to evaluate and plan services.

122. The local authority has 432 letter-box arrangements and is working with approximately 350 of these. This leaves a high percentage of families at risk of not receiving any level of service to support contact with birth children. Fifteen families are receiving support in supervised direct contact, and birth parents are offered counselling and support through a commissioned service following the making of an adoption order.

The graded judgement about the experience and progress of care leavers is that it is inadequate

123. Not all care leavers have a pathway plan and, as a consequence, they are unclear what plans are in place for their futures, including suitable accommodation and employment opportunities. The proportion of pathway plans completed for care leavers aged 18 years and over has increased, to 91% of care leavers from 85.1% (November 2014). The proportion of completed plans for young people aged 16 to 18 years remains much lower, at 65%. Most care leavers spoken to said that they had been involved in compiling their plan, but this does not always happen and the level of young people's involvement is not clear from the paperwork. In one case, the team manager reported that the young person had been "the least involved" in his plan, but it read as though he had participated fully.

124. The quality of pathway plans is variable. Young people's histories and needs are described well, but actions and timescales to drive plans forward are not specific enough. Pathway plans are not independently reviewed, which means that decisions lack scrutiny and challenge. The date of the last review of the plan is not recorded. These weaknesses make it difficult to see if reviews are happening, if they are happening on time and if progress is being made against the targets agreed for young people.

125. The choice of accommodation for care leavers is too limited, with accommodation vacancies, rather than the assessed needs of young people, determining the options available. There are significant gaps in provision. For example, 75 care leavers are parents, caring for 83 children, but only one dedicated mother and baby flat is provided in one of the local authority units. Not all care leavers are suited to large hostel provision, and one care leaver spoke of feeling unsafe and antagonised by other residents. Four providers are contracted to provide housing support and services for 16 to 25 year-olds. Leaving care workers concurred with the service Annual Report, which noted that there is a need for a better geographical spread of accommodation, and that support staff need more training to assist young people regarding abuse, mental health, sexual exploitation and domestic abuse. Inspectors agreed with the service's own assessment and saw examples of care leavers repeatedly losing accommodation as a result of poor support from providers or issues such as drug use or criminal behaviours not being addressed.

126. Most care leavers spoken to said that they feel safe where they live. However, local authority data for January 2015 show that 44 (9.7%) out of the 454 care leavers are not in suitable accommodation. The authority knows this is too many and is working with housing providers to improve the range and geographical spread of accommodation for care leavers. At the time of the inspection, two young people were in custody, four in bed and breakfast, 17 (3.7%) of no fixed abode/sofa surfing and 12 (2.6%) were not in touch with the local authority. Sixteen (3.5%) young people were reported to be living in houses of multiple occupation which are deemed as suitable by the local authority. Those care leavers in bed and breakfast accommodation are visited daily by professionals to ensure that they are receiving sufficient support.

127. There are 11 young people in Staying Put arrangements. These arrangements are working well and, through the work of a newly appointed county lead for Staying Put, a possible 30 more young people have been identified who could benefit from these arrangements during the next year. A comprehensive information pack for carers and young people has been developed. The worker has started to visit foster carers to ensure that they understand the arrangement and can give full consideration to the young person's future stability.

128. Support to help care leavers into education and employment is not sufficiently robust. The proportion of care leavers in who are not in education, employment or training was slightly higher, at 47% at 31 March 2014, than the national average of 45%. The local authority's own data shows a continual decline in the number of care leavers not in education, employment and training throughout 2014. Too many young people are leaving care without reaching their potential in education or training, and plans to secure their future economic stability are insufficiently detailed, coordinated and monitored to support their ambitions. Although care leavers are given encouragement to be ambitious, services are insufficiently focused to help them overcome the barriers that have built up through poor guidance in the past. The pathway plans seen by inspectors do not track or take account of young people's achievements, nor do they always make clear what financial and practical support is available to sustain their education or training.

129. Work placements and other opportunities to support care leavers into employment, such as apprenticeships, are limited, with only seven care leavers in local authority apprenticeships at the time of the inspection. Some small-scale initiatives provided by targeted youth support services and partners include care leavers among vulnerable young people, but they do not tailor their services specifically for care leavers. The Jobs, Education and Training (JET) scheme and the Re-Engage initiative, to re-engage all young people who gained one GCSE, have had some success with a very limited number of care leavers, encouraging eight back into education in 2014. Ten care leavers are in higher education, which is a very low number compared with other similar authorities, although 13 more are likely to go to university in 2015.

130. Case records demonstrate that leaving care workers assist young people to ensure that their health needs are met. Details of GPs, dentists and opticians are regularly recorded. In some cases, care leavers have had adult mental health assessments which have led to direct support and signposting to other relevant services. Case recordings show that some young people benefit from focused pieces of work with the CAMHS service, such as the Emerging Personality Disorder team. Leaving care workers report that not all care leavers are able to access adult mental health services due to different thresholds being employed; this may result in care leavers' needs not always being met.

131. The Care Leavers Learning Review commissioned by the LSCB and SAB focused on early deaths among vulnerable young adults and has prompted the local authority to reflect on its practice. At the time of the inspection, the report remained unpublished. However, its findings are informing the local authority planning on how best to respond to vulnerable young people more effectively. A protocol for transitions is being devised alongside a panel to consider adult safeguarding cases. The learning from this local review will be published to support national learning.

132. In cases seen where care leavers who have learning difficulties and physical disabilities were transferred to adult social care teams, there was evidence of social workers co-ordinating services well. A commissioned service also provides mentors who work with care leavers to support their social development and encourage attendance at social groups for care leavers, such as the Women's Activity Group.

133. Care leavers confirmed that they have their National Insurance numbers, birth certificates and passports. Case records show that if the young person does not have these documents then there is action in place to obtain them or ascertain their whereabouts. Care leavers do not have a letter detailing their health history. This is an important omission for those seeking medical treatment. The local authority is aware of this concern and is currently piloting a health passport for care leavers.

134. Most care leavers know who their leaving care worker is and have access to their phone numbers and those of managers when they need help or support. The local authority reports that they are in touch with all but 12 (2.6%) of their care leavers.

135. Leaving care workers receive regular training on safeguarding, child protection, drug and alcohol misuse, mental health, self-harming, benefits and entitlements. This suite of training courses assists them to offer guidance and good support to care leavers. Workers are trained in the use of screening tools to gain an understanding of care leavers' knowledge and ability regarding their needs relating to health, education, training, employment, and identity and independence skills. Scores from these tools are used to assess risk and indicate when to refer to specialist support.

136. A number of groups help develop care leavers' independence skills, including drop ins, job clubs and social groups. However, the provision is patchy with young people in some areas, such as Shepton Mallet and Frome, having little or no provision. Some commissioned providers offer group work support for care leavers to develop independence skills, and leaving care workers tailor individual packages of support.

137. A number of care leavers participate in the Somerset Leaving Care Council, to consider changes and improvements needed to leaving care services. They meet with managers and attend the Corporate Parenting Board to present their views. They know they are beginning to have an influence and make a difference. For example, they are helping to raise awareness about the need to improve accommodation for care leavers including a better geographical spread of housing options across Somerset. They are confident in raising issues. Achievements are celebrated at an annual event along with looked after children.

138. The local authority has a range of detailed information for care leavers, including 'A Guide To Leaving Care in Somerset'. The local authority website also contains useful documents on rights and benefits, finances, support in education and training, emergency accommodation, accessing files, the corporate parenting pledge and Get Set (early help and support). Care leavers spoken to are aware of how to make a complaint, and had used this process.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

The scale and depth of the weaknesses identified in the local authority's children's services are significant.

Ofsted inspections, which identified services as being adequate in 2012 and inadequate in 2013, a multi-remit inspection in 2014 which confirmed services were not at the required level, a DfE Improvement Notice in 2013 and numerous actions plans, have ensured that leaders are aware of the significant failings in children's services. However, despite knowing of these failings, progress to improve outcomes for children over a period of time has been slow and laboured.

A legacy of continual changes within the senior leadership team over the past ten years, a pattern of instability across the workforce, an over-reliance on the use of agency staff and an absence of effective partnership working have led to a service that has struggled to draw together a cohesive and strategic approach to improve services for children. Throughout this time, poor management oversight throughout all levels of the organisation, weak practice, stagnation in early help and a culture that managers and social workers say has inhibited change have been allowed to permeate into children's services. These are seriously affecting the lives of children and families.

Oversight, scrutiny and challenge from corporate leaders have not been sufficiently robust and embedded in the governance arrangements for children's services. Consequently, chronic instability at all levels of the organisation, poor practice and a culture of mistrust have been allowed to become embedded.

Appointments of a new Chief Executive in May 2014, a new interim Director of Children Services in November 2014 and a new Improvement Board chair in September 2014 have led to some very early but promising signs of recovery. Whilst the scale and challenge for children's services remain far-reaching, there is a sharper focus on reducing organisational churn, stemming the flow of movement, performance management and championing the needs of children.

A detailed assessment, which has just been completed, of what it is like for children in families who are experiencing significant drug and alcohol problems, will inform the development of targeted services for children and families living in highly vulnerable situations. The Health and Wellbeing strategy 2013–2018, which sets out the partnership's shared vision, has the potential to add weight to the need for a better coordinated approach to service provision for children and families.

139. The difficulty in securing a stable senior leadership team over the last ten years, and in particular since the last inspection, has disrupted any prospect of improving services for children. As a consequence, there has been a lack of sustained improvement in most areas of children services. Children are experiencing too many changes in their lives. Until recently, social workers have not been confident to raise issues within the organisation, which has seen a high number of whistle-blowing concerns raised with Ofsted. Children have complained to inspectors, and were seen to be still carrying their frustrations at the decisions made about their care. Families have been angry at the lack of consideration given to their views and have said so to inspectors. Partner agencies have felt excluded and describe a culture that has put barriers in the way of progress.

140. Professionals and partner agencies have confidence in the new interim leadership team, and say that progress against the improvement plan over the last four months is starting to take shape and that change is now tangible. Staff report that morale is improving, the culture is more open and that they feel less threatened. Partner agencies say that communication and practice is better and more focused.

141. Through a number of inspections and action plans and a DfE Improvement Notice, children's services are starting to know and understand what has to be done to ensure that children receive a better and more consistent approach to their needs. The improvement plan has recently become sharper, more focused on specific and measurable targets and is being used well to pick up pace. It is still early days and, as a consequence, any change achieved remains fragile, but staff report hopeful signs.

142. Oversight, scrutiny and challenge from corporate leaders including the Somerset's Children's Trust and Scrutiny panel have not been sufficiently robust. As a consequence, chronic instability at all levels of the organisation, poor practice and a culture of mistrust have been allowed to persist.

143. Over a number of years the early help offer has stagnated. As a result, too many children have to wait until their circumstances become worse before they receive help, and in many cases are subject to repeat referrals, which at 29% were higher than the England average level of 25% at 31 March 2014.

144. A range of early help services is available to support families, but the understanding across the partnership of how and where to access them is limited. Early help hubs across the four localities and the recent appointment of a CAF coordinator are helping to drive this work forward. The use of the CAF has increased significantly since September 2014 and the number of lead professionals from different agencies is also showing an improving picture, ensuring a better understanding of a shared responsibility across the partnership to the early needs of children and families.

145. Partnership working is severely under-developed and, in some cases seen, there is a lack of collaborative practice across the partnership to safeguard children. Some partners are absent from critical case and planning meetings. As a consequence, managers and social workers feel the responsibility to safeguard and protect children at risk of exploitation remains solely theirs. Multi-agency approaches to the planning and delivery of services is beginning to develop, for example, through the child sexual exploitation sub group, but this is at an early stage and has yet to demonstrate sustained involvement from all partners to improve outcomes for children. Thresholds are not consistently understood or applied by all partner agencies, including the police and health partners, and more work needs to be done to improve this.

146. The local authority has a commissioning programme in place and recognises that it requires a more integrated approach from across the partnership, to provide effective services and improve outcomes for children and families,. A legacy of poor partnership working over a number of years has restricted the development of such an approach. The voluntary sector confirms a different attitude is now evident in more recent practice and is beginning to regard themselves as part of a more cohesive approach to supporting families. Contracts are now evidence based with commissioned services reporting on how interventions and support are improving outcomes for children and families. There is a range of county wide services to support children under 18 living with substance misusing parents, children living with domestic violence, support groups for young carers and advice and support for care leavers. Some tensions exist between the local authority, health partners and the voluntary sector in ensuring there is sufficient mental health support for children and families. There is some confusion about the current referral pathways in place to access mental health services and a view that thresholds for mental health services are too high.

147. The number of temporary posts and agency workers at middle manager level and, crucially, at team manager level means that social workers do not benefit from good supervision or the opportunity to develop trusting relationships with their managers. There are few opportunities for coaching and modelling good practice by managers, which is important for social workers if they are to develop positive practice. Decision making and the oversight of social work practice by team managers is not consistent. This means that practice standards have not been established and the quality of social work remains too variable.

148. The lack of consistent management oversight and the constant churn of social workers mean that there has been a delay in applying the PLO process in a number of cases. Difficulties in getting cases listed at court, assessments not always completed on time, change of professional midway through the process, and change of case direction have all added to delay and drift in court proceedings. Decisions about children's future plans take too long. Cafcass and legal services report inconsistencies in the quality of paperwork submitted by the local authority and are concerned by the number of changes in social workers on some cases.

149. The IRO service is stretched, caseloads are high and, although there is evidence of increased capacity within the team, there remains a heavy reliance on the use of agency staff to plug the gaps. Children are not always seen before reviews and actions are not always progressed between reviews. The challenge that the IRO service brings to case work and social work practice is not always seen as a positive contribution to the improvement of social work practice. Developing and strengthening the role to enable IROs to progress plans in a purposeful way for children and to improve practice is critical to supporting the improvement agenda.

150. Some of the structural changes that have been implemented are having a positive impact on practice. For example, the replacement of the pod structure with assessment, safeguarding and looked after teams has improved how work flows through the system. The Signs of Safety model has been adopted and is now starting to be embedded well across the service. It has given social workers a strong framework on which to develop their practice, to challenge their thinking and better consider risks.

151. The Joint Strategic Needs Assessment (JSNA) prioritises the needs of children and young people and has involved them in setting priorities through surveys in schools and colleges. The JSNA is used to highlight issues to which commissioners respond, for example, a road safety campaign to reduce the number of traffic accidents involving 11 to 17 year-olds. Supporting the JSNA report, a Hidden Harm assessment shows that 18% of the 465 children with a child protection plan in place are living in families where drugs, alcohol, mental health and domestic abuse present as significant factors in their lives. The assessment shows that it is estimated that 6,300 children are living in households were domestic abuse is a regular occurrence, and 800 of these households are considered high risk. Targeting resources and progressing the early help agenda now requires a swifter response to ensure that vulnerable families are better supported.

152. The Health and Wellbeing strategy 2013–2018 sets out the partnership's shared vision for improving the health and wellbeing of children and families living in Somerset. It sits alongside other key documents to support the improvement of services across the partnership. It recognises that a more integrated way of working is required between children's services and health partners to reduce the need for numerous assessments and achieve a better coordinated approach to service provision for families, but there is little evidence of these ideals being implemented.

153. The sufficiency statement for looked after children and care leavers provides a model for ensuring that children's services have enough suitable placements to meet demand, but sufficiency plans are not yet specific enough, and do not include targets or timescales.

154. A new workforce development strategy is beginning to bear fruit, and there has been a reduction in the use of locum staff over the last four months. Whilst the overall staff turnover rate stands at 18%, the highest turnover is amongst frontline staff. A number of initiatives are in place to secure better retention of staff and reduce the continual churn within the workforce. A number of experienced staff have been supported to gain social work degrees through the Open University, and social workers from a USA international social work programme have helped to build capacity in the workforce. The support package offered to newly qualified social workers has attracted a number of new staff into the organisation. They are benefiting from smaller case loads, reflective practice sessions and a programme of training and development. One social worker described her training as 'inspirational'.

155. The Chief Executive takes an active interest in children's social care and is seen as a stable presence in the authority. He knows that progress to improve services and outcomes for children has been too slow and that the authority has been too inward-looking. Since his permanent appointment, he has sought support from outside the organisation and has shown, and led, willingness for the organisation to learn best practice from other local authority children's services, including how to recruit and retain staff and what a good quality assurance model looks like. He is eager to help staff to know what good looks like, and knows that the organisation has to be more outward looking if services are to move forward much more effectively than they have in the past.

156. The Lead Member is actively involved in the improvement work for children's services. She knows that progress to improve services in the past has been too slow and that a rapid response is now required by the partnership to secure better outcomes for children and families. Elected members have knowledge about the role of the Corporate Parenting Board and understand the responsibilities involved, but need to strengthen this through more focused scrutiny and action.

157. A quality assurance framework has recently been introduced and has the potential to provide a robust case auditing and management oversight model for the department. However, it is not yet delivering a much needed level of scrutiny to performance management.

158. Young people spoken to at the Children in Care and Leaving Care Councils said that they felt listened to. They meet regularly with members of the Corporate Parenting Board and are involved in changing and improving services. They gave examples of influencing changes to the clothing allowances for children in care, increasing apprenticeships in the authority and assisting in the leaflets developed for young people. They expressed frustration at the number of changes in their lives and the number of moves they are expected to tolerate.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children is inadequate
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate.

Summary of findings

The LSCB is inadequate because:

Scrutiny and assurance

- The LSCB has failed to successfully challenge the lack of a collaborative partnership approach to Somerset's safeguarding agenda.
- The LSCB has not assured itself that the Children Missing and Child Sexual Exploitation strategy has been effectively implemented in a timely and robust way. The Board does not know the scale and prevalence of these issues and the impact on children and young people living in Somerset.
- Whilst the Board's performance management and quality assurance activity is making improvements in some areas, its challenge and scrutiny are not yet having sufficient impact on the persistent shortfalls inspectors have found in frontline safeguarding services.
- The Board's failure to successfully challenge poor police attendance at child protection strategy meetings is inadequate, and has led to delays in decision making and investigations into potential risk to some children.
- Thresholds for intervention in Somerset have not been effectively explained and are not consistently applied across the partnership.
- The early help strategy has not been effectively implemented or well-coordinated and the Board has not ensured that pathways to early help services are well understood or promoted.

Learning

- Frontline workers in Somerset were not able to identify learning from serious case reviews and audit activity. While learning has been disseminated, the Board has not effectively evaluated the impact of these lessons on practice.
- The Board has not routinely used the views of children and families to inform its work or measure improvement or impact. Professionals are not able to fully articulate how the LSCB has influenced their practice.
- The Board has not, until recently, evaluated the impact of training and assured itself that training leads to improvements in service delivery and outcomes for children and young people.

What does the LSCB need to improve?

Priority and immediate action

159. Ensure that partner agencies are consistently held to account in relation to their statutory responsibilities to safeguard children.

160. Ensure that there are comprehensive arrangements in place across the partnership in relation to children missing and children at risk of sexual exploitation. The Board needs to drives this agenda more purposefully and that identification and prevention are well coordinated.

161. Ensure that the early help strategy is driven more effectively and that it is well understood and applied across the partnership and results in a well-coordinated early help offer to children and their families.

162. Ensure that the police consistently and effectively contribute to child protection strategy meetings and investigations.

Areas for Improvement

Data and performance management

163. Ensure that sufficiently comprehensive performance information from partners is received and that this is used to effectively scrutinise safeguarding performance across the partnership.

164. Ensure that the scrutiny and challenge function results in sustained improvements in outcomes for children and young people in Somerset.

165. Ensure that all partners regularly attend and that they are purposefully engaged in the work of the Board.

Quality of Practice

166. Ensure that the partnership understands and applies the thresholds for intervention consistently when professionals are referring children and their families to children's social care services.

167. Ensure that lessons learned from audit activity and serious case reviews lead to improvements in safeguarding practice.

168. Ensure that mechanisms to gather the experiences and views of children and young people in Somerset are further developed and that these are used to inform the work of the Board.

Inspection judgement about the LSCB

169. Governance arrangements have not been sufficiently robust to ensure that the Board is effective. While the chair regularly meets with the Director of Children's Services and the Chief Executive, the Board has not successfully challenged the widespread and serious failings that inspectors identified in help, protection and care for children and young people.

170. There are effective links between the LSCB and the Health and Wellbeing Board (HWB) and the Children's Trust. The Chair of the LSCB is a participating observer of the Children's Trust as well as a member of the Children's Improvement Board. This ensures that key strategies for improvement and implementation processes are effectively communicated to the wider Board in a timely manner.

171. The revised Business plan and key strategic documents such as the Learning and Improvement Framework, Quality Assurance Framework and Training Strategy have provided a clear foundation for the Board to support the improvement agenda. A revision of the LSCB constitution and action by the Chair has led to improved attendance from most members at the board. However, ensuring the consistent attendance by all partners still remains a challenge.

172. The annual report presents a rigorous and transparent analysis of how partner agencies discharge their child protection and safeguarding functions. The report identifies areas of poor performance through evaluation of social care and partners' data and the results of audit and quality assurance activity. The report is user friendly, clear and comprehensive and incorporates both the private fostering annual report and the LADO annual report. While the Board has identified key priorities, such as the need to strengthen the early help offer and improve police support for child protection, progress being achieved in these critical areas is too slow and this is having a serious impact on children's safety and wellbeing.

173. Whilst the child sexual exploitation strategy has been implemented, the work of the LSCB sub-group to drive this strategy forward and implement the action plan has been far too slow. The scale and prevalence of the issue is not fully known and understood across the partnership. The profile of alleged perpetrators, and how well victims are identified, safeguarded and supported require urgent attention to ensure that the LSCB has a greater influence in driving a more strategic approach to the work of the partnership going forward. Arrangements by the LSCB to oversee effective information sharing to help build a greater understanding of the problem and drive forward a robust multi-agency action plan are underdeveloped. The LSCB has completed a multi-agency audit; however, work has not been effectively targeted, coordinated or evaluated until very recently. The impact of this closer focus on child sexual exploitation has yet to be reflected in consistent practice across the partnership. The LSCB has, however, ensured that a significant level of awareness raising regarding child sexual exploitation has taken place across Somerset through training, and this is resulting in a shared and better understanding of the issues of child sexual exploitation.

174. Private fostering arrangements are under-identified, and this is reported in the annual LSCB report. Despite some awareness raising across the county, notifications remain lower than might be expected given the size of the county, the number of boarding schools in the local authority area and the number of students attending language courses. The LSCB remains concerned at the low levels of reporting and continues to raise this as an issue across the partnership. However, there is no evidence that holding the partnership to account and raising these concerns is having any impact on improving the number of notifications and therefore outcomes for children.

175. The LSCB ensures that multi-agency policies and procedures are fit for purpose, reviewed effectively and are updated appropriately to incorporate statutory responsibilities and changes to practice. However, despite the LSCB promoting the newly-revised thresholds document, front line workers across the partnership do not consistently apply these thresholds effectively.

176. A comprehensive multi-agency quality assurance framework has now been introduced by the LSCB through the work of the Quality and Performance sub-group. Whilst the Board is now providing a sharper scrutiny function and evaluation of practice, this is a recent improvement and it is not yet making sufficient impact on poor performance within social care services, the police and health partners. Persistent weaknesses in key areas continue. For example, repeat referrals in Somerset continue to rise, and the quality of assessments and plans remains inconsistent despite ongoing challenge by the LSCB.

177. The impact of the Board's evaluation has been further adversely affected by the significant number of changes to the senior leadership team within the local authority, as well as the high number of agency social workers. However, progress has been made in some areas, for example, establishing a multi-agency dataset and themed assurance reports to ensure that the Board has a better oversight of performance across safeguarding services.

178. The level of challenge across the LSCB has improved in the last year. The LSCB now challenges partner agencies' performance through a range of activities, including Section 11 audits, case reviews and action plans arising from Serious Case Reviews. This focus has resulted in some improvements, for example, the police, youth offending service and children's social care have been challenged over young people being held in police custody overnight. This practice has now stopped. Additionally, the LSCB has identified shortfalls in safeguarding practice across maintained schools. However, critical weaknesses remain and the Board's influence has not been sufficient to successfully challenge poor police attendance at strategy meetings and their routine involvement in child protection investigations continues to be inadequate. A recent audit of 12 strategy discussions show that records of five of them failed to identify who took part in the discussion. Thresholds for services are not widely understood by some partners and timely contacts and referrals are not always made. For example, where a large number (36) of cases of concern were referred together in one batch from the Royal United Hospital Bath to Somerset Direct.

179. Partnership work does not consistently result in timely, well targeted improvements to safeguarding practice. Partners have not worked collaboratively in a sustained way to ensure that improvements are implemented across key areas of safeguarding. There are, however, examples of well-coordinated and targeted work by the LSCB. For example, the LSCB has worked closely with partners to ensure that the Signs of Safety model has been successfully implemented; although not fully embedded in practice, it is providing a framework to support practice development.

180. Partners make appropriate financial contributions to support the business of the Board. The LSCB has successfully engaged a wide range of voluntary sector representatives as well as three lay members.

181. Whilst some processes are in place to gather the views of children and young people, these are not systematically collected or evaluated and do not sufficiently inform the work of the LSCB. The Board has identified this as an area for development and is in the process of developing a programme of events to better engage children and young people.

182. In the last three years, the LSCB has initiated one serious case review and notified Ofsted of two other serious incidents which did not meet the serious case review criteria. Decision making is both timely and robust. Whilst learning is becoming established and lessons identified are disseminated by the LSCB through the 'Salutary Tales' briefing, social workers were unable to readily articulate to inspectors how this has helped to influence service improvement or their practice. Monitoring of whether lessons learnt lead to improvements in practice is not robust.

183. A Learning Review was jointly commissioned by the LSCB and the Safeguarding Adults Board in light of a number of unexpected early deaths of vulnerable young adults aged over 18. The review found that care leavers were disproportionately represented. The review focused on the effectiveness of service coordination and delivery and resulted in a number of well targeted recommendations. For example, the need for better communication with young people, improved preparation for independence as well as ensuring that they people know their rights and options. Learning from this review has not been published to date and whilst there is no comparative data nationally, it is hoped the publication will inform a greater debate and national learning.

184. The LSCB now undertakes a programme of multi-agency audit activity, including themed audits on areas such as the children's workforce and children looked after as well as early help and safeguarding. However, the quality and impact of audit activity has been insufficient to ensure meaningful change at the front line. For example, an early help audit has identified that fundamental weaknesses persist, through contacts continuing to rise as well as the number of early help assessments completed remaining low and partner engagement being poor, despite these issues having been clearly highlighted in previous inspections. Whilst there are clear mechanisms in place to disseminate key messages and learning from audit activity, this is not consistently influencing frontline performance nor leading to sustained improvements in practice.

185. There is evidence of some learning and improvement through case reviews, case audits, and research and quality assurance. The Learning and Improvement Framework supports agencies to identify and address the safeguarding training needs of their workforce on a single and inter-agency basis.

186. The LSCB is committed to commissioning and funding multi-agency safeguarding training and undertakes an annual training needs analysis that results in comprehensive and robust pathways to training. However, evaluation of the impact of this training is underdeveloped. The LSCB has recognised this shortfall and the framework now has a developing emphasis on evaluating the impact of learning on practice. This is a recent improvement, the impact of which is not yet evident.

187. Effective arrangements for the review of child deaths are in place. The panel is comprised of appropriate professionals and is well attended and has clear terms of reference for work undertaken. Regular reports are made to the LSCB as well as contributions from the annual Child Death Overview Panel being presented to the Board. Reports identify issues of concern and themes, for example, obesity, the prevalence of parental mental and emotional health as well as the risks associated with co-sleeping with infants. These reports have resulted in well targeted preventative strategies as well as promoting public awareness across Somerset.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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