Borough of Redcar and Cleveland

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: 16 January 2017 – 9 February 2017

Report published: 7 April 2017

Children's services in the Borough of Redcar and Cleveland area require improvement to be Good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Requires improvement

[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 Inspections 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.

Executive summary

The overall effectiveness of services for children and young people in Redcar and Cleveland requires improvement, although services for children who are looked after and care leavers are good. While there are areas of strong practice, which have ensured that no children were found to be in situations of unassessed or unmanaged risk of significant harm, there are other areas that have not been identified or improved quickly enough.

Since the last inspection in 2012, leaders and elected members have prioritised children's services at a time of austerity. The council's 'Shaping our future programme' and 'Best start in life' (BSIL) review led to a significant service reconfiguration in 2014. This included the development of early help services, an all-age disability service and the implementation of the First Contact service. A focus on continuous improvement has been supported by increased investment in the workforce, including the establishment of two heads of service posts for early help and safeguarding and, most recently, the reinstatement of the director of children's services (DCS) post solely for children's services in September 2016.

Effective strategic planning has led to clear improvements in practice, for example for children looked after, but has not been sufficiently comprehensive to ensure timely progress in all areas. The strategic development of early help services has ensured a wide range of services available to children and families, including some innovative projects. Despite being in place since 2014, there is no detailed or overall evaluation of the effectiveness or impact of these services, the quality of practice is too variable and agencies other than the local authority are not confident to undertake the lead professional role.

The focus on and investment in social workers have resulted in social workers feeling valued and supported in Redcar and Cleveland. Manageable caseloads give social workers greater capacity to work with children, and overall outcomes for children are improving. At the heart of services in Redcar and Cleveland, the experiences of children and young people are well known to social workers and personal advisers (PAs). However, the quality of social work practice is not consistently good. Assessments and plans for children in need of help and protection are not consistently leading to timely interventions that meet the range of needs for all children. There are firm plans to implement a nationally recognised practice framework from February 2017.

While there are strengths in the performance management and quality assurance processes, these do not provide a sufficiently comprehensive overview of all practice areas. This inspection identified practice deficits that were not previously known to senior managers, for example inconsistent management oversight in the First Contact service, a lack of effective monitoring of allegations against people who work with children and a lack of clearly recorded rationale for children living in family arrangements.

When practice deficits have been identified by the local authority, improvements are not consistently implemented in a timely way. Inspectors found that, in a small number of cases, private fostering had not been promptly identified or assessed in line with statutory requirements. A local authority audit in December 2016 had identified shortfalls in private fostering practice, but effective action to bring about improvement had not been taken at the time of the inspection.

When this inspection identified practice or process deficits that had not been known to senior managers, prompt and thorough responses were put in place to address those issues immediately. For example, senior managers commissioned a review of all cases open to the designated officer to assure themselves that appropriate actions had been taken to protect children.

Management oversight, decision-making and the recording of the rationale for decisions is not consistently robust, but supervision is regular and valued by staff.

Effective partnership working underpins timely identification and response to children who are at risk, for example, of child sexual exploitation and to children who may be affected by domestic abuse. Children who are missing education are effectively tracked, although some return interviews for children who have been missing from home or care are not sufficiently analytical to inform future planning. Joint responses between social care and housing to 16- and 17-year olds who present as homeless are well coordinated although, in a very small number of situations, bed and breakfast accommodation has been used.

Outcomes for children looked after are good and improving. Planning for permanence, including adoption, takes place at an early stage, and, for those children who return home, this transition is underpinned by effective assessment, planning and ongoing support. Placement stability is improving for children, and the quality of most placements is good although, despite being aware of a shortage of emergency placements for children who display risk-taking behaviours, the local authority has not made plans to address this.

The experiences and progress of care leavers in Redcar and Cleveland are good. Personal advisers keep in touch with all care leavers, know them well and effectively support them to develop skills for independence. Health, housing and education outcomes for care leavers are good, supported by effective partnership working, although the local authority has not developed opportunities for care leavers to access its apprenticeship scheme.

Contents

The local authority

Information about the local authority area

Previous Ofsted inspections

- The local authority operates no children's homes.
- The previous inspection of the local authority's arrangements for the protection of children was published in July 2012. The local authority was judged to require improvement.
- The previous inspection of the local authority's services for children looked after was published in July 2012. The local authority was judged to be good.

Local leadership

- The DCS has been in post since September 2010.
- Until September 2016, the DCS was also responsible for adult services and public health, as the corporate director of people services. This role incorporated the function of DCS and director of adult social services (DAS), along with all public health and health protection functions.
- The chief executive has been in post since 6 January 2008.
- The chair of the LSCB has been in post since July 2016.

Children living in this area

- Approximately 27,365 children and young people under the age of 18 years live in Redcar and Cleveland. This is 20% of the total population in the area.
- Approximately 25% of the local authority's children aged under 16 years old are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 18% (the national average is 15%)
  - in secondary schools is 17% (the national average is 13%).
- Children and young people from minority ethnic groups account for 3% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian or Asian British.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 1% (the national average is 20%)
  - in secondary schools is 2% (the national average is 16%).

- Redcar and Cleveland is ranked as the 49th most deprived area out of 326 local authority areas; 22% of the lower super output areas within the borough are within the 10% most deprived areas of the country.

Child protection in this area

- At 31 December 2016, 1,185 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,081 at 31 March 2016.
- At 31 December 2016, 191 children and young people were the subject of a child protection plan. This is an increase from 147 children (54 per 10,000 children) at 31 March 2016.
- At 31 December 2016, three children lived in a privately arranged fostering placement. This is an increase from two at 31 March 2015.
- Since the last inspection, nine serious incident notifications have been submitted to Ofsted, and two serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 December 2016, 222 children are being looked after by the local authority (a rate of 81 per 10,000 children). This is an increase from 200 (73 per 10,000 children) at 31 March 2016. Of this number:
  - 116 (or 52%) live outside the local authority area (of whom 81 children live within the Tees Valley boundary)
  - 19 live in residential children's homes, of whom 90% live out of the authority area
  - none lives in residential special schools[2]
  - 172 live with foster families, of whom 54% live out of the authority area (and among these 93 children living outside the local authority, 70 live within the Tees Valley boundary)
  - 21 live with parents, of whom 10% live out of the authority area
  - seven children are unaccompanied asylum-seeking children.
- In the last 12 months to December 2016:
  - five children have been adopted
  - five children became subject of special guardianship orders (SGOs)
  - 90 children ceased to be looked after, of whom 11% subsequently returned to be looked after

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

- five young people ceased to be looked after and moved on to independent living
- four young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure consistently effective management oversight and decision-making of all contacts in the First Contact service, that work progresses appropriately to referral and assessment and that issues of consent are appropriately dealt with.

2. Improve the management and monitoring of allegations against professionals who work with children and of private fostering arrangements.

3. When children move to stay or live with family and friends, ensure that there is a clearly recorded rationale for placing children outside of regulation 24 of the 2010 care planning regulations. Undertake a review of all current arrangements to ensure that these placements are not being brokered by social workers.

4. Ensure that all assessments, including those of early help and private fostering, identify and analyse all risks to and needs of individual children and that they are up to date to inform effective planning. Assessments should include the impact of diversity and the child's experiences in relation to their identity.

5. Ensure that all written plans are informed by an up-to-date assessment of needs and that they clearly articulate actions, outcomes to be achieved and ways in which these will be measured, with timescales. When separate plans are utilised, for example in relation to child sexual exploitation, ensure that key risks and actions identified are integrated into the overarching plan for the child.

6. Improve quality assurance processes by ensuring that auditing consistently results in swift and effective action to deal with any identified deficits in practice. A quality assurance function should also be implemented between the adoption panel chair and the agency decision-maker (ADM) to consider the effectiveness of the panel functioning and the quality of work presented.

7. Ensure that all strategic plans are implemented in a timely way and that the impact of the strategies is evaluated, including that of early help.

8. Ensure that the sufficiency strategy identifies and plans for an appropriate supply of emergency placements for young people who display risk-taking behaviours.

9. When children have been missing, ensure that a timely return home interview is offered and undertaken and that risks are analysed to inform future protective actions.

10. Use bed and breakfast accommodation for young people only as a time-limited last resort and only when a multi-agency risk assessment reassures the local authority that the young person is safe.

11. Ensure that the offer of an independent visitor is systematically made to all children looked after who may benefit from the service. Increase the opportunities for care leavers to secure places on the local authority's apprenticeship scheme.

12. Ensure that strategies are in place that improve the attainment of children looked after at key stage 4 and that reduce the number of children looked after who are subject to fixed-term exclusions. Improve the quality and timeliness of personal education plans (PEPs).

13. Ensure that permanence plans for all children looked after are systematically tracked and monitored.

Summary for children and young people

- Children and young people are important to council leaders, managers and social workers in Redcar and Cleveland.
- Senior managers have made sure that social workers have enough time and have good training to get to know children and to work with them and their families. However, social workers' assessment of and planning for what children and families need could be better.
- There are many services for children and families in Redcar and Cleveland that provide good support to ensure that children are safe and that they develop well.
- Senior managers have not yet made sure that all services to children and families are good. There are some things that could be done better, including the recognition of and support for children who live with other family members and the management of situations when allegations are made against people who work with children.
- When children are at serious risk of harm, social workers, police and other professionals work quickly and well together to make sure that children are safe.
- When children become looked after, social workers make sure that they live as soon as possible with families and carers with whom they will stay. There is good support for children's health and development.
- Senior managers need to make sure that there is more support for children looked after to do well in school, particularly at key stage 4, and that fewer children looked after are excluded.
- When young people leave care, personal advisers, social workers and staff from other agencies make sure that they live in places that are safe and right for what they need, and that they receive a lot of help to ensure that they can access education, training or employment. However, there should be more help to support care leavers on the council's own apprenticeship scheme.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Thresholds are consistently applied in Redcar and Cleveland through the First Contact service, which provides an accessible single point of contact for families needing help. However, management oversight and the rationale for decisions are not evident in all cases, including the way in which the need for consent is applied. When children are at risk of significant harm, responses are thorough, timely and well coordinated, and no children were seen to be at risk of immediate harm.

Manageable caseloads allow social workers to develop meaningful relationships with children and young people and to be responsive when risks and needs first emerge or change. Assessments, including early help, are not consistently good, and written plans are too adult focused, lacking clear, timely outcome measures. When there are additional plans to deal with specific areas of risk, these are not consistently integrated into an overarching plan for the child.

Children and their families can access a wide range of services at an early stage, but partners are not confident in undertaking the role of lead professional. Inspectors saw examples of well-targeted projects. However, the local authority does not systematically monitor improved outcomes for children and young people who are receiving early help support.

Effective multi-agency arrangements are in place to support and protect children who are at risk from child sexual exploitation, domestic violence and high-risk adults. However, children who go missing do not always receive a timely return home interview and, when these are completed, these do not effectively inform future planning.

In a small number of cases, when children moved to live with family and friends, managers did not clearly record their rationale for not completing a connected person's assessment. In these cases, it was unclear whether appropriate consideration had been given by managers to children becoming looked after.

Responses to 16- and 17-year-old homeless young people are well coordinated between social care and housing, although bed and breakfast accommodation has been used for a very small number young people.

Children who are privately fostered are not promptly identified as such and do not receive a timely assessment in line with statutory requirements.

The coordination and management of allegations against professionals who work with children is not sufficiently robust or well monitored.

Inspection findings

14. Children and families have access to a wide range of early help provision. Local children's centres act as a central hub to coordinate universal and targeted services. Good partnership working with school nurses and health visitors, who are now part of the council, helps to identify at the earliest opportunity the support needed by families. The local authority has heavily invested in delivering an effective evidence-based parenting model, successfully enabling parents to set boundaries in dealing with problematic behaviour and to build positive relationships with their children.

15. Pathways to secure early help services are clear, and children and families are signposted swiftly to appropriate support services. More complex cases are referred to weekly multi-agency allocation panels, for identification and provision of more targeted services, and are allocated to a key worker to undertake an early help assessment. This role is currently undertaken by the local authority because partners are not confident to take on the role of lead professional or to complete assessments.

16. Inspectors saw some examples of well-targeted interventions, such as Streetz, which gathers intelligence from community safety partnerships identifying areas of high youth anti-social behaviour. Skilled youth workers successfully engage these vulnerable young people, diverting them into more constructive activities. However, the local authority does not systematically monitor the impact of early help or identify patterns and trends of need to inform service development and delivery. (Recommendation)

17. The quality of early help assessments and plans requires improvement, and this is identified through local authority monthly audits. While comprehensive practice standards have been developed and implemented as a result, assessments remain too narrow in focus and consider immediate presenting issues rather than identifying the broader needs of children. A lack of routine reviews makes progress difficult to monitor and hinders the identification of changing needs and risks. (Recommendation)

18. Children who are at risk of significant harm are identified quickly, both during and outside of normal working hours. The response is swift, well coordinated and managed to ensure timely strategy discussions and investigations. Locality teams lead strategy meetings, which involve appropriate partners to inform decision-making and next steps. The local authority has effectively challenged and improved police attendance, enhancing information sharing and planning of investigations. Children are seen quickly, and investigations are timely and focused, leading to action that matches need.

19. First Contact provides a clear and accessible single point of contact for all families needing help and support. This ensures a consistent application of thresholds. The service provides advice and guidance, access to early help and statutory provision and timely signposting to appropriate services. This

ensures that children receive the right help at the right time. While decisions were appropriate and timely in all cases seen, management oversight and the rationale for decisions were not evident in all cases. The local authority takes consent for sharing information seriously, including undertaking home visits to ensure that consent is gained. However, when this happens, further work is being undertaken on cases, including in some instances, the holding of multi-agency meetings. This is effectively an assessment in all but name. While detail of this work is recorded in text boxes as part of the contact record, this practice serves to mask re-referrals and is not being considered as part of the performance monitoring framework. For children, this has the potential for subsequent responses to be less informed, as the detail of this information is not clear or easily accessible on the child's record. No child was seen to be left at risk as a result of this practice, and the local authority quickly responded to these inspection findings. (Recommendation)

20. Engagement of children and young people is a strength. Manageable caseloads enable social workers to spend more time with children and young people and allow workers to be responsive to changing needs. For example, inspectors saw increased visiting by social workers when risks escalated. Social workers know children well and use a range of tools to help children to communicate their views, wishes and feelings to inform assessments and interventions.

21. The quality of social work assessments is not consistently good. In assessments that require improvement, chronologies are not used effectively to identify the cumulative impact of harm suffered. Some are not sufficiently individual and do not give a clear picture of the child's experience. This includes consideration of the impact of diversity and identity. (Recommendation)

22. Assessments are regularly updated to reflect current needs. In good assessments, children's histories are used well to understand the full extent of harm, and inspectors saw examples of child protection procedures being invoked appropriately during the assessment period. Assessments include information from partners and wider family members, and issues of identity and diversity are recognised and understood. Assessments for children who have disabilities are particularly strong and well written and have the child at their centre. The impact of disability on the child and their family is recognised and understood but does not dominate, and this ensures a holistic meeting of needs.

23. Child protection conferences are chaired well. Strong multi-agency commitment and information sharing ensures that risk and protective factors are identified appropriately. The local authority uses a single report for conference with information collated from partners, which eases the burden on families during this very stressful time. However, these reports are not always shared with parents in advance of meetings. This limits their ability to engage fully and to prepare for meetings. The local authority is aware of and

has taken steps to improve this, although the impact of this was not seen at the time of inspection.

24. Planning for most children is well coordinated and driven by passionate and tenacious social workers. Impactful partnership working is promoted through regular core groups and multi-agency meetings that provide a range of services to support and protect children. However, records and written plans do not reflect the richness of work being completed. Safety plans developed to manage specific risks, such as child sexual exploitation, run in parallel to, rather than being integrated into a single plan. This can be confusing for professionals and families and increases the risk of issues being missed or not fully considered. Plans are too adult focused, not sufficiently realistic and without clear timescales for outcomes to be achieved. This does not effectively support the timely progress of work. (Recommendation)

25. For a small number of children in need, interventions lack focus and pace because assessments and plans are outdated and cases have not been reviewed when they should have been. More recently, children in need receive thorough assessments and this is leading to clearer planning and more timely multi-agency interventions.

26. Management oversight in the vast majority of cases is regular. However, some decisions lack a clear rationale. Tasks are subsequently not routinely reviewed to ensure completion, which leads to drift for some children. For more complex cases, which are not progressing, a multi-agency complex case meeting has been introduced in response to lessons learned from a serious case review. This has increased accountability and provides more effective senior management oversight, which is addressing drift in those cases.

27. When children move to live with family and friends, the local authority is appropriately focused on balancing issues of consent, minimum legal action and the best interests of children. However, in a small number of cases, managers did not clearly record their rationale for not completing a connected person's assessment. In these cases, it was unclear whether appropriate consideration had been given by managers to children becoming looked after, although ongoing social work support was evident.

28. There are effective partnerships with health, housing and the police in relation to children missing from education (CME) and strong links with other local authorities across the region. A dedicated officer tracks and monitors all CME. Cases of missing children are routinely cross-referenced through the vulnerable, exploited, missing and trafficked (VEMT) meeting, to identify potential risks of child sexual exploitation.

29. The local authority has robust systems in place to support children who are home educated and to monitor the quality of provision. Names of home-

educated children and their families are cross-referenced with data held by the VEMT group on a monthly basis, which enhances a robust response.

30. Children and young people who are at risk of child sexual exploitation receive an assertive response to keep them safe. The vulnerable persons group (VPG) is facilitating regular and timely identification of individual young people, enhancing multi-agency interventions and ensuring timely reviews of risk. This results in a comprehensive and well-orchestrated support package, including a focus on disruption activity. However, not all children who go missing receive a timely return home interview. Interviews seen by inspectors are poor in quality and do not consider why children go missing or identify how further episodes can be reduced. (Recommendation)

31. The multi-agency risk assessment conference (MARAC) and multi-agency public protection arrangements (MAPPA) effectively consider risks to children from domestic abuse and from high-risk adults. Agencies work well together to identify children at potential risk and effectively coordinate a multi-agency response. Operation Encompass alerts schools and nurseries when children are exposed to domestic abuse and is enabling services to provide more timely support and to be alert to potential concerns. Children and families benefit from a broad range of services to provide help and support where there is domestic abuse, including programmes for victims and perpetrators, substance misuse programmes and parental mental health support that includes specific therapeutic counselling for children.

32. When 16- and 17-year-old young people are homeless, joint responses between social care and housing ensure that they are promptly assessed and informed of their right to become looked after. Mediation and support to reunify young people back with their families are effective. Although emergency and supported accommodation is available, the local authority has used bed and breakfast accommodation for two young people within the last six months, when previous accommodation had broken down. Although the young people were seen regularly and supported, the use of this accommodation increases their vulnerability. (Recommendation)

33. Children who are privately fostered do not receive a timely assessment to identify their needs, and appropriate checks are not swiftly completed, which potentially increases vulnerability. While social work visits are undertaken and children are seen, the local authority cannot assure itself that the risks to and needs of those children are appropriately identified and managed in a timely way. This was identified by a local authority audit in December 2016, but had not been effectively addressed at the time of the inspection. (Recommendation)

34. The management of allegations against professionals working with children is not robust. The tracking and monitoring of investigations are poor. Records are incomplete and lack detail in terms of dates of enquiries, analysis of information, rationale for decisions and timescales to hold professionals to

account. The local authority responded promptly and thoroughly to these inspection findings, ensuring that no children were left unsafe, by increasing the capacity of the designated officer and putting in place an action plan to improve the practice and processes underpinning the work. (Recommendation)

The experiences and progress of children looked after and achieving permanence	**Good**

The outcomes for the vast majority of children who are looked after are good, and the identification of and response to their health needs, including their emotional well-being, are particularly impressive.

Thresholds for children entering care are appropriate and, in the vast majority of cases seen, timely. No children were seen in the inspection who were looked after unnecessarily.

The local authority has a clear focus on securing permanence for all children, and timeliness of care proceedings is good. Placement matching is thorough and timely, supporting the majority of children and young people to live in homes that meet their needs, although there are insufficient emergency placements to meet the needs of children who have complex needs and display risk-taking behaviours.

Children's and young people's views are consistently sought and considered, although only a small number of children benefit from an independent visitor. Children have meaningful relationships with their social workers and independent reviewing officers (IROs) who know them well, and this promotes good outcomes. This supports placement stability, which is improving.

The local authority demonstrates a commitment to pursuing adoption when this is appropriate, including for those for whom it is hard to find an adoptive placement.

There are effective arrangements to track children missing from care and education. Risk of child sexual exploitation is well considered, and timely action and intervention are helping to reduce risk, although information from return home interviews is not used effectively to inform future planning.

The attainment and progress of children looked after are in line with those of their peers in the borough, but the gap in attainment between children looked after and their peers at key stage 4 in the borough remains too wide. The quality of PEPs is inconsistent, and too many children looked after are subject to fixed-term exclusions. There is not a clear plan in place to address this.

A well-resourced and committed leaving care service is in touch with all current care leavers, which is impressive. The service has developed a powerful set of partnerships with a range of agencies that, between them, improve health, housing and education outcomes for care leavers. The use of council apprenticeships for care leavers, however, is not routinely embedded.

Inspection findings

35. Children and young people become looked after only when it is in their best interests. Decisions for children entering care are appropriate, generally timely and taken at an appropriately senior level. Inspectors saw no cases in which children were looked after unnecessarily. Pre-birth assessments are of a good quality and inform early permanence planning well. Viability assessments are timely and thorough, with clear analysis of risks, strengths and the capacity to meet needs and to protect children.

36. The Public Law Outline is used effectively to work with the vast majority of families. Pre-proceedings letters appropriately outline to parents what they need to do to achieve positive and sustained change, and the course of action that will be taken to safeguard and protect children if the required change is not achieved. Legal planning meetings are used well to ensure that decisions to start proceedings are carefully considered. However, in a small number of cases, particularly when parents disengage, pre-proceedings reviews were not timely and the rationale for not taking more authoritative action sooner was not clearly evident.

37. When children return home, appropriate assessment and careful planning inform this. Good support packages and regular monitoring ensure that children's needs are met, risks are reduced and children continue to be safeguarded and protected.

38. Children's needs for legal permanence are mostly supported in a timely way. Assessments completed for the courts are of good quality, and care plans are accepted by the courts, in the majority of cases, without the need for independent or expert assessments. Care proceedings are concluded within an average of 22.3 weeks, as reported by the judiciary, which is below the national threshold of 26 weeks.

39. Children are seen alone and regularly by their social workers. Their views and experiences are well recorded and inform care planning. Social workers are able to provide a good account of the child's circumstances and assessed needs. Children are supported to engage and contribute to reviews of their care, which are well facilitated, for example by the use of a specific tool. Social workers and IROs have meaningful relationships with children and know them well, which contributes to the achievement of positive outcomes. Reviews are timely and effective, and children are supported to maintain positive contact with their families and friends. This quality of support is equally evident for children who are placed out of borough and is further enhanced by elected members who also visit this group of children. Similarly, the overall quality of support is evident for disabled children who are looked after and for whom transition planning is good and effectively supported by the all-age disability service.

40. Health outcomes for children looked after are outstanding and are supported by a dedicated health looked after team. Performance in relation to initial and annual health assessments and reviews is excellent, with full-year completion in 2015–16 at 96% and reported by the local authority to be 100% at the time of inspection. An effective quality assurance framework enables senior managers to monitor the timeliness of health provision and the quality of health plans and to review assessments for children looked after. This is making a difference to children's and young people's well-being.

41. The identification of and response to children's emotional well-being and mental health are also outstanding. Strengths and difficulties questionnaires are routinely completed and used to inform health assessments. Access to mental health services is exceptionally good. The co-location of a dedicated child and adolescent mental health services (CAMHS) practitioner within the children looked after team and the support of a psychologist and assistant psychologist result in timely face-to-face case consultations with social workers. This enhances understanding of children's emotional needs and helps to identify and support the direct work to be undertaken with children, particularly those who have complex emotional difficulties. Inspectors saw effective interventions for children who have a range of needs, which support placement stability for those children.

42. When children looked after go missing or are at risk of sexual exploitation, concerns are swiftly identified, risk assessments are completed and direct work is undertaken to support them as part of risk reduction strategies. There is effective joint working with the youth offending service for children looked after who offend. Not all return home interviews focus appropriately on reducing risk to children. In some cases, completion of these is cursory, for example containing children's verbatim accounts for the reasons for going missing as opposed to making an evaluation of circumstances and of how these could be prevented in future. (Recommendation)

43. The quality of assessments and plans, when they are not prepared for court, ranges from good to requiring improvement. However, the work undertaken with children by social workers evidenced a full understanding of children's needs and ways in which they are well involved in supporting and improving their lives. Assessments that are good consider historical concerns well, and there is an informed analysis of risks and placement needs of children. These have been updated in a timely way in response to changed circumstances or increased need, and this is facilitating a responsive service for children looked after. In the weaker assessments, direction lacks focus when plans are not informed by up-to-date assessments. The impact of diversity in relation to the children's lived experience is not sufficiently explored and, in particular, there is very limited consideration of how the experiences of separation and loss impact on the identity of children looked after. Life story work for children who are looked after but not being adopted is not always timely.

44. The head of the virtual school has good links with other local authority virtual school heads in the region, and there is comprehensive monitoring of the attendance and progress of individual children, supporting timely intervention if attendance or standards of behaviour decline. As a result, the attendance of children looked after over the past two years has been high, at 97%. Two-thirds of children looked after are being educated in schools rated good or better. The virtual school head gives careful consideration to moving children looked after out of schools when standards decline, providing additional support to children to remain if that aligns with their current placement and plan.

45. The attainment and progress of children looked after at key stage 2 are in line with the stronger performance of their peers in the borough, compared to regional and national comparators. Across all areas of assessment, for reading, writing, mathematics, grammar, spelling and punctuation, children looked after in Redcar and Cleveland do well. However, the gap between their attainment and that of their peers in the local authority remains. The education outcomes after key stage 2 for children looked after are less good. The progress of children looked after between key stage 2 and key stage 4, and attainment at key stage 4, reflect the performance of the borough's secondary school pupils that is below regional and national figures, overall. Compared to their counterparts in other regions of the country, children looked after do not make as much progress from their initial starting points. The gap in attainment between children looked after and their peers at key stage 4 in the borough remains too wide. (Recommendation)

46. The quality and timeliness of PEPs are not good, and only 80% are completed within the agreed timescales. Targets set in plans are not specific enough to provide clear actions to support progress. They do not measure the impact of the pupil premium sufficiently. The local authority recognises the need to improve PEPs and is introducing a new electronic PEP, which has the potential to improve the quality of target setting and the ability of the virtual head to monitor progress. Too many children looked after are subject to fixed-term exclusions. In 2015–16, 18% of children received a fixed-term exclusion. (Recommendation)

47. There is a strong focus on achieving permanence for all children looked after, through options that meet the needs of individual children. Permanence is considered at an early stage and for all children. An overall plan for permanence is evident at the time of the second review, including plans to return home. Special guardianship orders (SGOs) and child arrangement orders (CAOs) are used appropriately, as well as long-term fostering. Plans for permanence are monitored through the children looked after monitoring group, chaired by a senior manager, but the local authority does not fully understand the effectiveness of this, as permanence tracking is not sufficiently comprehensive. (Recommendation)

48. For a small number of children and young people, the lack of availability of specialist placements to work with challenging and risk-taking behaviours, both in an emergency and in the longer term, has resulted in placements breaking down, despite good levels of support and intervention. (Recommendation)

49. The fostering service is managed well to meet the needs of children and young people. The quality of the assessments of foster carers and of the matching reports is good, and this effectively supports best matches for children. Brothers and sisters are consistently placed together unless their plans identify that it would not be in their best interests.

50. Foster carers are well supported by experienced workers and receive effective supervision to ensure that good-quality care is maintained. Training opportunities for all foster carers are good. This helps them to provide good care for children and young people, and there are examples of foster carers being provided with bespoke training to meet the needs of children for whom they care.

51. Inspectors saw some good individual examples of the effective use of advocacy to support and engage children, although only a small number of children benefit from having an independent visitor. (Recommendation)

52. An articulate and well-supported looked after children's council (LACC) has been instrumental in developing the five promises: listen, achieve, communicate, engage and support (LACES) and 'My Guide' for children looked after, along with associated branding in the form of artwork, hoodies and wristbands. This provides children with good information about their rights. The LACC has organised and run the achievement awards evening and has effective links with the corporate parenting board and senior managers.

The graded judgement for adoption performance is that it is good.

53. Adoption is considered at an early stage for all children who may benefit from this as a permanence option, and a comprehensive pre-adoption planning meeting ensures that all actions are identified and progressed without delay. This supports early family finding.

54. While the numbers of children adopted are low, the local authority demonstrates a commitment to pursuing adoption for children, including those who, it is considered, have more challenging needs in family finding. Inspectors found no evidence that the length of time taken in these cases has had a negative impact on the children involved, and careful support and planning are evident.

55. The timeliness for children entering care, moving in with their adoptive family and being adopted is improving and is better than the national average. The time from when the court makes the order enabling the local authority to place a child with adopters until the child is placed is also improving, but remains above the national average. However, the in-year figure for 2016 is vastly improving and is better than the government threshold, ensuring that the needs of these vulnerable children are met well.

56. Children's permanence reports (CPRs) are good, and the majority are comprehensive and explain the child's world and their identified needs well. The reports are updated in a timely way when new information is identified, which means that prospective adopters have the most up-to-date information available about children to inform decision-making. The quality of the prospective adopter reports (PARs) is very good, and there is clear analysis of applicants' strengths and vulnerabilities and exploration of sensitive issues, helping to underpin matching processes effectively.

57. The recruitment and assessment of adoption applicants are undertaken in line with national regulations. Adopters seen by inspectors were extremely positive about all aspects of the service that they receive from Redcar and Cleveland adoption agency. Creative practice is evident as the authority extends training to the adopter's extended family, effectively developing the whole family's understanding of adoption and the child's lived experience. This helps to build resilience to the child's new home and family.

58. There is proactive work with, and weekly consideration of, approved adopters who are waiting to be matched. Adopters who are waiting are linked to the national adoption register and other regional and national processes and they are supported in identifying potential adoptive placements.

59. There has been one decision to reverse an adoption plan in the last year, when extensive family finding was put on hold while therapeutic work could be undertaken. The plan was subsequently and appropriately changed, and permanence has now been achieved.

60. Careful matching with prospective adopters at matching meetings ensures that risk of disruption is minimised. The local authority has had no adoption disruptions in the last few years. When fostering for adoption has been utilised, it has been effective and appropriate and it is routinely considered in relevant cases, in addition to all adoption applicants being asked to consider this route to permanence.

61. The permanence panel functions as an adoption panel. The chair of the panel is independent and experienced. There is a sufficiently wide range of panel members who are knowledgeable about adoption and permanence, including adopted adults and adopters. There is effective quality assurance of the CPRs and PARs, ensuring that the panel has all relevant information to

focus on key issues. The record of panel decision-making and challenge is not sufficiently detailed to ensure that the ADM is assured of the robustness of the panel process. In response to this finding, managers immediately implemented a process to ensure that quality assurance matters are recorded separately.

62. Quality assurance and service improvement opportunities are not maximised, as there is no mechanism for reporting to the agency, nor does the agency require it. The ADM makes clear and timely decisions on individual cases, based on a suite of reports and agency advice, but there have been no meetings between the ADM and the chair of the panel at the time of the inspection. This means that there is no accountability for or challenge to the quality of the business of the panel or any challenge to the agency on the quality of its work. (Recommendation)

63. Adopters are well supported by their supervising social worker when children first move to their care, and careful consideration is given to the transition arrangements. Foster carers are an integral part of these arrangements and help to prepare children well for the move to their new family. Examples of good practice, involving birth parents meeting adoptive parents and effective engagement with the wider birth family, to contribute to life story work were seen by inspectors. The vast majority of life story books are good and are individualised to the child. This promotes a clear understanding of their history. Later life letters contain a good level of detail and appropriate language and tone to help children to understand the plans that have been made for them.

64. Matching processes are further enhanced by effective use of child appreciation days, which are routinely used for those children who have had significant contact with a number of agencies and professionals. This assists adopters to understand the child's story from the perspective of those that know them.

65. Effective and wide-ranging adoption support is provided to all those who need it, including services for birth parents and adopted adults, as well as children and their adopters. Adoption support plans are thorough and include appropriate financial support in line with identified need. Requests for post-adoption support receive a prompt and consistent response, ensuring that children's support needs are dealt with without delay. One adopter commented that the level of support that they had been provided with, following their child becoming part of their family and at a time of some behavioural deterioration, had 'transformed' their lives.

66. A dedicated worker in the team ensures effective support for children's contact with their birth families. Additional post-adoption support services are appropriately commissioned through a voluntary agency. The authority effectively utilises the adoption support fund for creative therapeutic work, and services commissioned are carefully monitored for their effectiveness.

Adoptive families are invited to attend organised events throughout the year, enabling them to share experiences and access informal support from the adoption team and from other adopters.

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

67. Excellent practice is evident in the leaving care team that keeps in contact with all of the 106 current care leavers and knows them well. An experienced team of managers and PAs, who have many years of service in the same team, provides continuity and stability for care leavers. Between them, the managers and PAs have a comprehensive knowledge of the local and regional support resources that can be coordinated to support the development of care leavers.

68. Effective partnership working with a range of strategic partners, including health, education and housing, results in well-planned services for care leavers in the local authority and across the wider region. Agreements with social landlords to provide priority housing for care leavers stretch across local authority boundaries, while protocols to support care leavers' enrolment and continuing education attendance include all the main further education colleges in the Tees Valley.

69. All care leavers are in suitable accommodation. There is a good range of accommodation in place, ranging from emergency accommodation, through supported lodgings, to independent one-bedroom flats with social landlords, who give priority to care leavers in their lettings policies. There are currently 14 care leavers living with foster carers as part of the planned growth in staying-put arrangements. One group of unaccompanied asylum seekers is housed in suitably vetted multiple occupancy housing that meets their needs. No care leavers have been placed in bed and breakfast accommodation over the past few years. Care leavers stated that they feel safe and fully supported in the areas where they find accommodation.

70. Care leavers have very good access to health services. All care leavers receive a health passport, containing all their relevant health information. The great majority are registered with doctors and dentists and attend appointments when arranged. Access to mental health services is exceptionally good, with a CAMHS nurse, co-located with the children looked after team, who regularly signposts care leavers to a range of other services that support them to develop their emotional resilience. The current target for the time between a referral to CAMHS and an appointment is four weeks, a target that is consistently met. PAs educate care leavers in how to achieve healthier lifestyles and how to avoid risky behaviours. Care leavers who are

at risk of sexual exploitation or drug and alcohol abuse are identified quickly, and appropriate interventions are speedily put in place.

71. PAs develop the independent living skills of care leavers well. They prepare care leavers for their transition into independent tenancies through one-to-one sessions and group work, for example, on how to plan a budget and understand their entitlements. PAs run well-attended shop and cook sessions, in which care leavers learn how to shop for healthy ingredients and turn them into nutritious meals.

72. Social workers in the children looked after team work closely with PAs to ensure that the transition of 16- and 17-year olds into the leaving care service is planned smoothly and effectively. PAs are attached to eligible care leavers as soon as they turn 16, so that they receive a continuity of support and advice when they turn 18. The recent transfer of social workers from the leaving care service back into the children looked after team means that they have a very good understanding of the range of resources that the leaving care service can access and good working relationships with PAs.

73. The proportion of care leavers who are in education, training or employment is above both regional and national comparators. At the time of inspection, 67% of care leavers were in some form of education, training or employment. Of those, the great majority were on a further education course at one of the local colleges or sixth forms, and the remainder were in employment. Eight care leavers are at university. The leaving care service has protocols in place with all the main further education providers in the area that clearly delineate their respective roles and responsibilities for supporting care leavers while they are at college. The recently introduced personal education and employment plans (PEETs) are used effectively to review care leavers' progress and to plan their next steps in further or higher education and in seeking employment.

74. The leaving care service effectively supports those care leavers who are not in education, training or employment (NEET), resulting in the good performance identified for those care leavers in employment, education or training. All NEET care leavers are assigned to a dedicated 'routes to employment' worker, whose role is to support them to find further training or employment. She meets every six weeks with the PAs to monitor the progress of all care leavers and to agree actions if they have become NEET. Specific projects have been identified to engage with those care leavers who are furthest away from the job market, in which they develop their employability skills through practical horticultural tasks and work on their English and mathematics.

75. Care leavers engage actively in representative and consultative forums, and have good opportunities to help to shape services**,** both in the local authority and across the wider region. Care leavers were centrally involved in reformulating the council's pledge and promises for all children looked after

and care leavers, and a number of care leavers attended a regional conference to advocate their aspirations to the Children's Commissioner. Care leavers understand what their entitlements are, and make good use of them, particularly when they move into independent accommodation and when they progress to higher education. The updating of the children looked after/care leaver website has not been prioritised, so care leavers do not find it helpful.

76. Written pathway plans are not effective tools for planning actions and interventions for care leavers. In a sample of 15 pathway plans, the targets were not specific enough, and their timescales were too open ended. Too often, accountabilities for actions are not clearly assigned. As a result, many care leavers do not refer to or recognise these plans as useful tools to aid their development. (Recommendation)

77. Overall, the local authority has acquitted itself well as a corporate parent, particularly through its commitment to maintaining a well-resourced leaving care team at a time of financial retrenchment. However, there are some areas in which the council does not fulfil the role effectively enough. For example, care leavers do not have a standard pass to use leisure services in the local authority, and the local authority misses opportunities to fast track care leavers in its own apprenticeship scheme. (Recommendation)

Leadership, management and governance	Requires improvement

Summary

There are many strengths in the leadership and governance of Redcar and Cleveland, which have supported clear improvements in outcomes for children. However, some aspects of strategic planning, management oversight and performance monitoring are not sufficiently comprehensive or effective to ensure that outcomes for children are good in all service areas.

Leaders and elected members have ensured the prioritisation of children's services at a time of austerity. Service reconfiguration and strengthened capacity at senior management level, including the reinstatement of the DCS post solely for children's services in September 2016, are effectively supporting service improvements. Significant investment in the workforce has resulted in manageable caseloads, giving social workers improved capacity to work directly with children, and overall outcomes for children are improving. Social workers feel valued and supported.

Where there has been more effective strategic planning and oversight, this has underpinned clear practice improvements, for example for children looked after. However, there are areas where the pace of progress and improvement has been too slow, for example the early help strategy. A detailed joint strategic needs analysis (JSNA) and a sufficiency strategy work well for most children looked after, but they have not adequately planned for and have not delivered an appropriate supply of emergency placements for a small cohort of young people who have complex needs and display risk-taking behaviours.

The performance and quality framework is not sufficiently comprehensive to identify and improve some practice shortfalls quickly. The auditing programme is wide ranging, but has not identified all areas for improvement identified during the inspection. An over-emphasis on good practice means that the auditing process lacks rigour and does not result in swift improvement in social work practice where this is necessary. Records of practice management are not strong enough to ensure that social workers are held to account for their practice and that performance monitoring is consistently effective. Senior managers did not have a full awareness of key service shortfalls identified, but responded promptly to inspection findings, putting in place action plans to address deficits.

Strong relationships among senior leaders, including the DCS, the chief executive and the lead member for children, lead to effective communication. Governance by elected members is strong, and constructive strategic partnerships support a range of successful multi-agency projects that have improved children's lives.

Inspection findings

78. Redcar and Cleveland Borough Council has made a major commitment to and investment in children's services at a time of reduced resources overall. The introduction of the Shaping our Future and Best Start in Life programmes in 2014 and the reinstatement of a dedicated DCS post in September 2016 have been key to an increased focus on improving the quality of social work practice and children's and families' experiences. Following a restructure of services in 2014 and the subsequent creation of two heads of service posts to strengthen the delivery of early help and safeguarding, a strengthened workforce strategy was introduced, which incentivises social workers, ensures manageable caseloads and offers high levels of training. Appropriately focused recruitment, support and training for foster carers are leading to increased placement stability. This has resulted in a stable and committed workforce that knows children and families well.

79. Where there has been effective strategic planning and oversight, this has underpinned clear practice improvements, for example for children looked after. However, there are areas where the pace of progress and improvement has been too slow, for example the early help strategy. (Recommendation)

80. The early help strategy has delivered a wide range of services, including the development of some creative projects, but the lack of impact evaluation means that its effectiveness is not understood. Partners are not fully engaged or confident in undertaking the lead professional role. Where there has been more effective strategic planning and oversight, practice improvements are more clearly evident, for example in relation to health outcomes and placement stability for children looked after. However, some areas for improvement have not been sufficiently planned for or effectively addressed, particularly in relation to educational attainment, addressing fixed-term exclusions, improving service response to and management oversight of those children in private fostering arrangements and allegations against professionals.

81. Planning for and the procurement of placements for children who become looked after in an emergency are not sufficiently strong. The department's appropriate focus on vulnerable children remaining in families, strengthened by additional support, results in family breakdown in the teenage years for a small number of young people who have complex needs and/or display risky behaviours. This has resulted in a small cohort of troubled young people coming in to care who have multiple placement moves before the right one is found. Inspectors saw inappropriate use of hotel accommodation for one looked after child as a temporary option, due to the lack of emergency placements. The placements market overall is well understood by the council and is underpinned by a strong and well-linked JSNA and sufficiency strategy. (Recommendation)

82. Services to meet the needs of the child population of Redcar and Cleveland are mostly supported by strong commissioning and assurance processes. Casework seen on inspection undertaken by the emergency duty and youth offending teams was of good quality and well coordinated. However, the commissioning of advocacy and independent visitor services, which is undertaken regionally, is not supported by an evaluation of the quality, effectiveness or reach of those services for Redcar and Cleveland. A regional meeting of commissioners is planned to review the services.

83. Performance monitoring is not sufficiently comprehensive to ensure the identification of all practice deficits. Issues identified by inspectors, such as triage work being recorded on the contact format in the First Contact team, and the management of allegations against professionals, were not being monitored effectively. There is no established quality assurance mechanism in place between the agency decision maker (ADM) and the adoption panel chair. This limits the effectiveness of senior management oversight of adoption practice and the adoption panel. Bespoke performance reports drawn from live data, represent a useful facility, which is used by senior managers to understand and deal with identified performance variance.

84. An intensive auditing programme, conducted on a cyclical basis, focuses on capturing good social work practice. The over-emphasis on good practice reduces rigour with which practice deficits are identified. Inspectors also found the audit produced by managers on the cases tracked during this inspection to be over optimistic and lacking in analysis of impact for children. Where some shortfalls have been identified, steps have not been taken or have not been effective in making improvements, for example in the quality of plans and the deficits in private fostering. The DCS accepts that some practice deficits arose when improvements in standards lost momentum during a period when services were configured differently. (Recommendation)

85. Management oversight and challenge of social work practice are not consistently clear and recorded in case files and key meetings. Examples include the decisions taken in the First Contact team not to immediately progress to referral, and decisions at care panel about whether to issue care proceedings. This reduces accountability and line of sight and does not facilitate a shared understanding of individual cases. This is further evidenced in relation to the lack of systematic tracking of permanence plans for children. (Recommendation)

86. The workforce strategy is comprehensive, and the local authority has invested in the learning and development of staff, resulting in a permanent and stable workforce. The DCS has suitably retained a middle management structure of specialist posts to effectively support career development and progression, such as the workforce development manager. These dedicated roles add considerable value to the delivery of services, for example,

supporting the current extensive plan to roll out a nationally recognised model of social work practice.

87. A leadership culture, based strongly on interpersonal relationships, means that senior leaders across the council, including elected members, can demonstrate a good commitment to and prioritisation of children's services. The council operates in an ethos of integrity and respect, and this is modelled by its senior leaders, including the DCS and chief executive, and is perceptible throughout the organisation. Its success is evident in strong and effective partnerships, and this impact is seen operationally in good levels of multi-agency support offered to children and families, such as the community safety partnership's use of Streetz to reduce anti-social behaviour on the beach area of Redcar, and the integration with CAMHS to support the emotional well-being of children looked after. Both are strong examples of effective collaboration across agencies to deliver identified services. Constructive working relationships between the judiciary, the Child and Family Court Advisory and Support Service (Cafcass) and the local authority have led to a reduction in the time of cases in proceedings, currently at 22.3 weeks.

88. Governance of children's services by elected members and other senior leaders is strong, and the DCS is widely recognised as the pivotal figure in the improvement of children's services. The chief executive meets regularly with the independent chair of the LSCB and clearly holds the LSCB to account. The leader of the council chairs the Health and Wellbeing Board and is focused on children's issues, as is the committed and knowledgeable lead member for children's services.

89. The corporate parenting panel suitably includes a number of elected members and it mostly provides effective scrutiny and challenge, although not all areas of practice have been effectively addressed, for example the high number of fixed-term exclusions for children looked after. The LACC is well respected, and children are listened to and their voice is heard. Children and young people provide an update report for each panel meeting and they have attended panel meetings. They have helped to develop the five promises, LACES, and an information guide for children looked after.

90. The council in general and the children's services department in particular are a learning organisation and committed to using feedback constructively to improve services to children, although not all opportunities for learning are maximised. The role of principal social worker has been instrumental to service development, by capturing the themes and trends from a wide range of sources, such as peer reviews, and ensuring that feedback is used as a stimulus for improvement. For example, the introduction of the complex cases meeting was drawn from learning from an SCR. However, there is limited systematic evaluation and dissemination of wider learning from complaints. During the inspection, senior managers were highly responsive to feedback from inspectors. Their willingness to listen to and act on

inspectors' feedback on identified deficits evidenced prompt and effective learning and action to support improvement.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement.

Executive summary

While there is good oversight of and activity in some areas, there are other areas in which the Redcar and Cleveland Safeguarding Children Board (RCSCB) requires improvement to ensure full and effective oversight and monitoring of all safeguarding activities.

Since September 2016, the new chair and members of the Board have reviewed and identified those key areas requiring improvement in an appropriately focused self-assessment action plan. Work is well under way to improve the current business plan, and all partners are committed to the Board's priorities, safeguarding children and the work of the sub groups. The Board is well resourced and has sufficient capacity to support the planned improvements.

The RCSCB has not facilitated an audit under section 11 duties since 2013–14, and an analysis of training needs has not been updated for almost five years. This is identified as an action in the RCSCB improvement plan.

The RCSCB reviews performance data and, through this process, has identified and driven improvement in some areas, but there is more to do to improve the systematic analysis of the data, identify trends and patterns and measure these in the short, medium and longer term, to assess children's experiences and outcomes. The methodology and quality of auditing activity are not robust.

The Board is not sufficiently sighted on the experiences and quality of services for children who have disabilities, the management of allegations against professionals, those privately fostered, young carers and children living in this area from other areas.

Children who are vulnerable to child sexual exploitation are a shared priority, and there is a strong strategic and operational commitment from all partners to respond to and reduce risks for children.

Arrangements for initiating and undertaking SCRs and child death reviews are effective. Lessons are promptly disseminated, and partners are clearly committed to addressing all improvements, collectively and within their individual organisations.

RCSCB's most recent annual report, 2015–16, does not give a comprehensive assessment and analysis of the effectiveness of all safeguarding activities in Redcar and Cleveland.

Recommendations

91. Undertake as a priority a section 11 audit, to assure that organisations are discharging their duties to safeguard and promote children's welfare.

92. Ensure that the Board both receives and tests information to satisfy itself on the quality of experiences and services for all vulnerable groups of children. This includes children who have disabilities, children who are privately fostered, young carers, children who are living in the area from other areas and oversight and challenge of the management of allegations against professionals.

93. Ensure that the Board has effectively contributed to maximising operational partnership contributions to early help, in particular the undertaking of the role of lead professional.

94. Undertake an analysis of multi-agency training needs, to ensure that the training programme meets identified needs, and evaluate the impact of training on frontline practice after the events. This should include reviewing the effectiveness of training and awareness raising in relation to private fostering.

95. Improve the quality and methodology of multi-agency auditing activity to robustly test key areas of frontline practice and measure the quality of children's experiences and outcomes.

96. Ensure that performance data is used to systematically understand children's outcomes and experiences and to identify patterns and trends to form a robust assessment of the quality and effectiveness of services.

97. Engage and consult with a wider range of children and families in the delivery of RCSCB business priorities and planning.

98. Improve the quality of the annual report to demonstrate that the RCSCB has undertaken a rigorous assessment of the performance and effectiveness of local services, and that it identifies weaknesses and necessary actions.

Inspection findings – the Local Safeguarding Children Board

99. The RCSCB requires improvement to be fully effective in overseeing and monitoring all safeguarding activity and to ensure that it effectively discharges all its statutory responsibilities.

100. The current RCSCB chair is independent, started in post in July 2016 and chaired the first board meeting in September 2016. From this point, there has been some purposeful activity to review and refresh the business

priorities. The chair has led a development day to review the governance, business plan and priorities of the Board. The current business plan is not robust and does not give the clear direction and measurable objectives needed to drive forward the priorities. The long-standing arrangements with strategic boards have lost some focus and, therefore, the influence of the RCSCB on services for children and families is unclear. The chair has reviewed these arrangements and is in the process of formalising refreshed agreements.

101. The RCSCB has an operational development plan to improve broadly the key areas identified at this inspection, for example the quality of the annual report, the focus and robustness of the business plan and better analysis of multi-agency data and performance. The chair is fully aware that an analysis of training needs and section 11 audits are priorities to complete in early 2017 and that this forms part of the development plan. The focus and priorities of the sub groups have been refreshed to align with the improvements needed. (Recommendation)

102. There are formal and informal arrangements to meet with the chief executive, DCS and lead member. The DCS chairs the executive group of key partners, which maintains oversight of the progress of priorities and the effectiveness of the Board, including the areas for improvements.

103. The Board has sufficient finances to progress priorities and the commitment of partners to engage fully in the improvements identified. The Board is well attended and the chairing of sub groups is shared within the partnership. The partners report confidence in the chairing arrangements for the RCSCB and an open and transparent culture, which enables appropriately challenging debate. There have been some changes in the chairing of some sub groups and some issues with achieving consistent membership, due to changes of posts in partner organisations. The executive group and the Board regularly monitor and address these issues successfully.

104. The RCSCB, through the monitoring and evaluation sub group, reviews the quarterly multi-agency performance report of key indicators. The group requests further supporting analysis to explain the data and to identify where there needs to be further testing of areas, for example poor police attendance at strategy meetings and the arrangements for initial health assessments for children looked after who are living out of the area. As a result, the Board has influenced marked improvements in these areas. There is more to do to improve the systematic analysis of the data, identify trends and patterns and measure these in the short, medium and longer term to form an assessment of the quality of experiences and outcomes for children. (Recommendation)

105. The Board has started to request information for children who have disabilities and has received annual reports in relation to private fostering, but this is not yet sufficiently effective to test the experiences of these

children meaningfully. The Board is not sighted on the experiences and quality of services for young carers and children living in this area from other areas. Therefore, the Board cannot be assured of how effective responses are for these children. The Board has not been sufficiently robust in its oversight of the management of allegations against professionals who work with children. There are collaborative developments well under way to launch a Teeswide performance framework, intended to improve and streamline data to enable better local, regional and national comparisons. (Recommendation)

106. The RCSCB commits resources to auditing activity, and some steps have been taken to improve the quality of audits, but there is more to do to ensure that themes and patterns are identified. The methodology for undertaking audits is not sufficiently robust and relies on survey-type self-reporting from practitioners. This is not objective professional scrutiny of children's experiences and the quality of practice that they receive. This limits the effectiveness of findings and the impact of learning. Overall auditing activity does not test a sufficient sample, is not sufficiently focused on or measuring the outcomes and experiences of children and is overly focused on systems and processes. The RCSCB has missed the opportunity to focus on and test thresholds through auditing activity. (Recommendation)

107. The RCSCB is part of well-established Teeswide arrangements to review, update and maintain consistent policies and procedures. These arrangements work well and ensure that there are timely reviews and updates to procedures in response to national and local changes and incorporating learning from activities. This includes local and national SCRs and recommendations from the child death overview panel (CDOP).

108. The RCSCB has a clear learning and improvement framework, which sets out the ways in which reviews will be conducted and the learning disseminated. SCRs are initiated in line with the criteria and, when situations are complex, the Board promptly seeks advice from the national panel. There are clear collaborating and decision-making arrangements where this is needed, for example for domestic homicides, and agreements to share learning.

109. SCRs are published appropriately, and any delays are for valid reasons and do not delay action planning, sharing and disseminating learning through the website, informative e-bulletins, team meetings and learning events. Practitioners are well informed of the lessons from SCRs, although the impact on their practice is less clear. Learning is promptly incorporated or strengthened into multi-agency training events. The complex cases panel, which has contributed to timelier decision-making in serious cases, was set up in response to the findings of an SCR. Inspection also found that social work practice is increasingly identifying and addressing disguised compliance. The Board maintains regular oversight of reviews in progress and ongoing action plans. When the criteria are not met for a review, the

benefits of learning through other means are fully considered. Currently, a learning review is due to be undertaken.

110. The RCSCB coordinates a wide-ranging training programme, which offers varied training opportunities, including the statutory core safeguarding training, throughout the year. There is strong commitment from partners to provide facilitators to support the delivery of the training so that participants fully benefit from specialisms. Social workers are positive about their training experiences, and this is supported by the evaluations on the day. However, training is not evaluated at a later stage to consider its impact and effectiveness on frontline practice. The training needs analysis is significantly overdue. Therefore, the Board cannot be assured that it is fully meeting all multi-agency training needs While there has been training and awareness raising activity in relation to private fostering, this has not been effective in increasing the identification of the numbers of children privately fostered and in ensuring adherence to private fostering regulations. (Recommendation)

111. The reviews of child deaths are collaborative Teeswide arrangements, and the RCSCB hosts the panel and provides business support. The panel has made improvements during 2016, and the rapid response procedure is now timely and operating well. The numbers of deaths for Redcar and Cleveland have remained consistent since 2012. Since 1 April 2016, the panel has reviewed 34 deaths across Tees, of which five related to children in Redcar and Cleveland. The learning and dissemination of learning are well coordinated regionally through campaigns. For example, Safe Sleeping is a regular campaign. There are close links and joint membership with the suicide prevention group and the sub group reviewing SCRs, which enables close working across shared responsibilities.

112. The Board maintains regular oversight of the effectiveness of early help services through reports, updates on developments and regular single-agency audits from the early help service. The Board has only recently started to include children receiving early help services in its multi-agency auditing programme. This has been a missed opportunity to independently test the experiences of children receiving early help services and to be influential in galvanising partners in the early help offer, in particular undertaking the role of lead professional. (Recommendation)

113. The RCSCB has very recently refreshed the neglect strategy and is in the process of defining the action plan to support the strategy for a re-launch in May 2017. The RCSCB fully recognises the continued challenge of responding to children who are experiencing neglect. Therefore, investing in strengthening families, skilling early help workers and consistently using recognised practice tools are key priorities going forward.

114. Children who are vulnerable to child sexual exploitation are a shared priority, and it is a strategic and operational commitment from all partners to respond to and reduce risks for children who are vulnerable to child sexual

exploitation, going missing or being trafficked. The strategy is agreed Teeswide, and operational delivery in each area is reviewed under the respective LSCB. The RCSCB closely monitors the progress of developments and the effectiveness of responses for these vulnerable children, and progress is clearly measurable over the last year.

115. The RCSCB, has an agreed strategy for female genital mutilation under the northeast partnership. This is supported by clear procedures and guidance for practitioners. A specialist agency leads the multi-agency arrangements to raise awareness, review procedures and provide support to females at risk. There are no reported cases or previous figures for Redcar and Cleveland, which is consistent with the profile of the area. There have been reported referrals in other areas of the regional partnership, which evidences that shared procedures are in operation.

116. The RCSCB has a shared regional strategy to meet the 'Prevent' duty with a single referral point and dedicated police channel officer in Cleveland. The RCSCB has a local profile, which identifies the nature and level of risk, and a local action plan is in place to measure progress. A range of agencies have progressed referrals, which demonstrates that the duty is broadly understood. Progress is well under way and training for all education representatives is complete. A pool of trainers are equipped to deliver the required training. The wider workforce has received training, and activities are ongoing to raise awareness through community networks.

117. The RCSCB benefits from the contributions of the Safe4us group of children and young people, but more needs to be done to consider how the views of a wider group of children and families can influence and contribute to the work of the Board. (Recommendation)

118. The RCSCB's most recent annual report, 2015–16, is not of sufficient quality and does not reflect a rigorous assessment, supported by sufficient data and analysis. The report sufficiently informs readers on the effectiveness of practice and children's experiences in all key areas of safeguarding. The shortfalls in systematically analysing patterns and trends in performance data and the weaknesses in the auditing activity have limited the overall assessment and reporting in the RCSCB annual report. (Recommendation)

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 that 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 whom 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 six of Her Majesty's Inspectors (HMI) from Ofsted and two Ofsted Inspectors (OI).

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