Kingston upon Hull

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

Inspection date: 18 November – 10 December 2014

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The overall judgement is that children's services require improvement
The authority is not yet delivering good protection and help and care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.[1]

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

[1] 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 Hull require improvement because:

Performance management and management oversight

- Senior managers do not effectively oversee the progress of children's cases in the access and assessment service and key areas of service operation to ensure that thresholds for service are applied appropriately to prevent the delay and drift being experienced by some children.
- Data are not routinely collected in some key service areas to inform management decisions.

Social work interventions

- Partner agencies do not consistently apply the threshold for access to children's social care. This leads to delays for some children and families receiving the service they need.
- Delay was seen in a few cases: where joint visits were undertaken with the police, before Section 47 (S47) child protection enquiries are instigated; and once children have been seen and an initial assessment commenced, some children experience delay and drift in the access and assessment service.
- Insufficient priority is given to the completion of friends and family care assessments so looked after children experience delay in permanence planning and secure placements.
- Insufficient priority is given to tracking progress in children in need (CiN) cases and cases of children who have a plan for adoption.
- Adoption is not always considered at the earliest possible stage; it takes too long for children to be matched with a family so opportunities for permanence are missed for some children.
- Looked after children wait too long to receive a service from the child and adolescent mental health service (CAMHS).

Quality of planning

- Not all CiN have a clear plan to meet their needs and others do not have their plan reviewed to ensure that their changing needs are addressed.
- Not all children who go missing from home and/or are at risk of sexual exploitation have a robust risk assessment and plan to ensure that their needs are fully met.
- Chronologies are not used consistently, so assessments do not always take account of relevant historical information and others lack sufficient analysis to provide a sound basis for children's plans.

- In a small number of cases children subject to a child protection plan live at home for too long without risk being effectively reduced, others remain on a child protection plan or stay looked after for longer than they need to.

Looked after children and care leavers

- Insufficient priority is given to ensuring that all children are engaged in life story work with their social worker to support effective planning for their future.
- Too many looked after children do not do well enough at school. The quality of their personal education plans (PEPs) is poor and the proportion of looked after children gaining 5 A*-C GCSEs declined in 2014.
- Pathway planning for looked after children starts too late and some young people do not have a pathway plan or they are unaware that one exists, so they are not clear about the plans to support their transition into adulthood.
- Procedure and social work practice does not ensure that service providers are always given the information they need in order to provide effective support to care leavers.

What does the local authority need to improve?

Priority and immediate action

The quality of social work practice

1. Ensure that joint visits and S47 enquiries undertaken by the police and children's social care are undertaken swiftly so that potential risk of harm posed to all children is investigated and responded to quickly.

2. Ensure that all open and subsequent assessments in the access and assessment team are completed in a timescale consistent with the child's needs, leading to clear decisions for families and appropriate plans to meet the needs of children.

The quality of social work plans

3. Ensure that adoption is considered as a viable option for all children at an early stage, that permanence plans are put in place for all children by the second 'looked after' review, and that their implementation is closely monitored.

Outcomes for care leavers

4. Ensure that pathway planning for care leavers starts early in line with statutory guidance, so that all that can be done is done, to support their smooth transition through to independence and their proper preparation for adulthood.

Leadership, management and governance

5. Strengthen the management oversight within the access and assessment service operation to ensure that all child protection investigations cases are

progressed effectively and any delays in joint investigations are reported and/or escalated using the conflict resolution process.

Areas for improvement

The quality of social work practice

6. Ensure that all children who go missing from home and/or are at risk of sexual exploitation have a robust risk assessment and management plan.

7. Ensure that chronologies are in place for all children and that assessments contain sufficient analysis to support decisions and that plans take full account of historical information and patterns.

8. Ensure that case recording is up-to-date so that children's case records consistently reflect the child's situation and progress and that this can be clearly understood from the electronic record.

9. Ensure that all children who would benefit from life story work are effectively engaged with their social worker and have the opportunity of a life story book which provides sufficient detail so children know and understand their life journey to help shape their identity and to make secure attachments to sustain them in the future.

The quality of social work plans

10. Ensure that all children in need services are delivered through the use of a clear plan which is sharply focused on meeting the individual needs of children, and which is reviewed in accordance with the child's timescale.

11. Review all cases where children have been subject to a child protection plan for over 18 months to ensure that effective plans are in place with clear contingency arrangements for children where risk is high or has not been reduced.

12. Ensure in all cases where there is a plan to discharge a care order or revoke a placement order that the matter is progressed and returned to the courts in a timely manner.

Education outcomes for looked after children

13. Improve the quality of personal education plans (PEPs) for looked after children, so needs are specific and the arrangements for providing practical help and support clearly stated at all key stages of their education. Monitor their progress and attainment closely so that they can reach their full potential and achieve good GCSE exam results.

Leadership, management and governance

14. Working through, and reporting to the local safeguarding children board, ensure that partners apply the threshold for access to children's social care

consistently and correctly to prevent social work time being wasted on contacts that could be managed at a lower level so that all children get swift access to the appropriate level of support.

15. Ensure children who go missing from care are interviewed by an independent person when they return.

16. Ensure that data concerning children who go missing from home and/or are at risk of child sexual exploitation (CSE) are systematically collected and analysed, to help influence the shape of services and target interventions.

17. Review and strengthen the collection, reporting and evaluation of performance information so that all key service areas are monitored. This should include effective scrutiny of children in need work, tracking the progress of children subject to a care order placed with parents or subject to an adoption plan and monitoring of the frequency of social work visits made to children in need and looked after children.

18. Ensure that management oversight is sharply focused on the basics of social work practice, providing clear direction about actions required, recording decisions with clear timescales and ensuring that progress and the effectiveness of plans are closely monitored.

19. Strengthen the senior management oversight on the 'reflective' supervision process in social work pods to ensure that all children's cases receive regular scrutiny and that planned actions and timescales are set, recorded and monitored.

20. Hold health commissioners and providers to account for the provision of CAMHS to looked after children so that the emotional and mental health needs of these children are addressed in a timely and effective manner.

The local authority's strengths

21. Families have access to a wide range of good early help support, which has ensured that their needs are met before they require statutory interventions.

22. Services for families who experience domestic abuse are well developed and this has helped to improve the lives of children.

23. Independent child review officers (ICROs) make good use of the 'strengthening families' model to focus discussions and engage all participants so they express their views.

24. Child protection conferences observed by inspectors were well chaired, with good attendance, effective multi-agency information sharing and appropriate decision making.

25. There are many examples of good direct work with children subject to child protection plans. Social work relationships are well developed with children and

families, characterised by social workers and their managers who know the needs of children well.

26. The local authority's Troubled Families (known locally as Priority Families) project has effectively engaged and 'turned around' many of the families it has worked with.

27. Recent assessments are of increasingly good quality with a strong focus on the voice of the child.

28. Families whose first language is not English have good access to interpreter and translation services and issues of disability are appropriately considered in casework.

29. Social workers demonstrate a strong commitment to the 'reclaiming social work' model and have access to a good range of training opportunities including systemic training to support their work.

30. Targeted work delivered through a commissioned project is providing effective support across the city for young people who have experienced, or are at risk of, child sexual exploitation (CSE). Dedicated training is helping to raise the awareness of parents and professionals to the signs of CSE and to direct children and parents to the service they need.

31. Looked after children live in good quality placements close to the communities where they live. Support for foster carers and adopters is good, with carers commenting positively on the good quality, timely support that they receive.

32. The number of children who are adopted is better than the national average

33. The quality of prospective adopter reports and matching reports completed by social workers are good, they contain clear analysis and all the necessary detail to support effective decisions.

34. The corporate parenting panel has taken effective action to ensure that looked after children get the services they need. The views of children and young people and those engaged in the children in care council (CiCC) are helping to influence the shape of services.

35. Care leavers are very positive about the support that they have received and report that the local authority is a good parent.

Progress since the last inspection

36. The last Ofsted inspection of Hull's safeguarding arrangements was undertaken in August 2011. The local authority was judged to be adequate. The last Ofsted inspection of Hull's services for looked after children was in August 2011. The local authority was judged to be adequate. The last inspection of the adoption service was in January 2013 and judged local authority provision as good. The

last inspection of the fostering services was in November 2010 and judged local authority provision as satisfactory.

37. The pace of change leading to improvement since the last inspection has been slow, with some areas identified as needing improvement at the previous inspections yet to be fully addressed. In particular this includes the need to improve partners understanding of thresholds, monitor the quality and timeliness of assessments and reduce waiting times for CAMHS.

38. The local authority has embarked upon an ambitious programme of change, with a clear vision for the delivery of children's services through the 'reclaim social work' practice model. This is beginning to show signs of improving service quality, but impact is not yet consistent.

39. Although there are many examples of good quality direct work with families, the current service is also characterised by the presence of drift and delay in progressing work with children and families.

40. Senior managers have not exercised sufficient oversight of social work decision making to ensure that all cases are progressed effectively. As a result, some children are experiencing delays in the completion of their assessments and drift in the progress made on their plans, so outcomes for children are not improving quickly enough.

41. Senior managers do not have all the performance information they need to give them a complete and accurate picture of the quality of social work practice at the front line. They do, however, have a clear understanding of most current service weaknesses, with work already underway to address these.

42. Improvements have been achieved in the range and delivery of the early help services and for looked after children in key areas such as corporate parenting and health outcomes.

43. The voice of the child is evident in social work assessments and children are supported to express their views, which are helping to shape individual assessments and plans, and services for looked after children.

44. Leaders and senior managers give vulnerable children the highest priority. Although the reclaim social work model is not yet fully embedded across all services, change has been generally well managed, morale is high and senior managers have won the support of the work force, which provides a sound basis for further improvement.

Summary for children and young people

- Inspectors found that many services for children in Hull need to improve to be good although some are really helping children and young people.
- Managers do not have sufficient grip of the access and assessment service so children do not always receive the service they need quickly enough.
- Not enough children have good assessments and plans, but social workers are getting better at listening to children and young people. The quality of direct work with children and families is generally good.
- There is a wide range of good early help support for families, including for those children and families who have experienced domestic violence, so their needs are met well.
- Some children in need do not have a plan for professionals to support them so it is not clear how their needs will be met, other children do not have their plan reviewed to make sure that their changing needs are met and some children are not visited often enough.
- Arrangements to support children missing education are good and children who go missing from home and care get help from services which are helping them to keep safe.
- Too many looked after children do not do well enough at school and the quality of the personal education plans to support them are of poor quality.
- Looked after children live in good quality homes where they are well cared for, with most children living close to Hull.
- Plans for looked after children to support their move into adulthood starts too late and some care leavers feel they have to leave care before they are ready.
- The number of care leavers who are in employment, education and training has got better recently so their life chances are improved.
- Care leavers are very positive about the support they receive and report that the local authority is a good parent.

Information about this local authority area[2]

Children living in this area

- Approximately 62 100 children and young people under the age of 18 years live in Hull. This is 25% of the total population in the area.
- Approximately 34% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 31% (the national average is 17%)
  - in secondary schools is 26% (the national average is 15%).
- Children and young people from minority ethnic groups account for 14.6% of all children living in the area, compared with 22.5% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is White Eastern European (predominantly Polish).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 13% (the national average is 18%).
  - in secondary schools is 10% (the national average is 14%).
- Hull is the eleventh most deprived local authority area in England and over half of its geographical area featured in the 20% most deprived areas in England based on the index of multiple deprivation. The proportion of children who speak English as an additional language is growing and the city is becoming more ethnically diverse.

Child protection in this area

- At 18 November 2014, 3698 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 3,190 at 31 March 2014.
- At 18 November 2014, 267 children and young people were the subject of a child protection plan. This is an increase from 248 at 31 March 2014.
- At 18 November 2014, three children lived in a privately arranged fostering placement. This is a reduction from six at 31 March 2014.

[2] 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 18 November 2014, 678 children are being looked after by the local authority (a rate of 123.7 per 10,000 children). This is an increase from 640 (117 per 10,000 children) at 31 March 2014. Of this number:
  - 230 (or 33%) live outside the local authority area
  - 52 live in residential children's homes, of whom 42% live out of the authority area
  - two live in residential special schools[3], of whom 100% live out of the authority area
  - 499 live with foster families, of whom 35.7% live out of the authority area
  - 70 live with parents, of whom 8.6% live out of the authority area
  - four children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 45 adoptions
  - 22 children became subject of special guardianship orders
  - 177 children ceased to be looked after, of whom 1.7% subsequently returned to be looked after
  - 16 children and young people ceased to be looked after and moved on to independent living
  - three 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 seven children's homes. Four were judged to be good or outstanding in their most recent Ofsted inspection.

Other information about this area

- The Director of Children's Services has been in post since March 2014.
- The chair of the LSCB has been in post since July 2010.

[3] 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	Requires improvement

Summary

Families have access to a wide range of early help support which is underpinned by a clear 'early help and intervention framework'. Services for families who experience domestic abuse are well developed. However, step-down arrangements from children's social care are not consistently used effectively, so there are some examples when families receive a social work service for longer than necessary.

Partner agencies do not consistently apply the threshold for access to children's social care so social workers are routinely assessing a high number of contacts which leads to delays for some children and families in receiving the service they need.

Ineffective management oversight and performance management in the access and assessment service leads to delays in assessments being completed, decisions made and plans put in place for a high proportion of children and families.

A lack of robust monitoring of CiN cases leads to some children not having a plan or their circumstances not being reviewed in a timely way; assessments are not always up-to-date and there is a significant gap in visits made to see some children.

Once child protection concerns are identified, swift action is taken in the vast majority of cases to ensure that children are safe. Decision making in the majority of strategy discussions seen is appropriate. Most S47 enquiries are carried out effectively but a lack of consistent decision making leads to delays in a small number of cases.

Child protection conferences seen by inspectors were well chaired, parents were engaged well, with good attendance and information sharing by professionals leading to appropriate decision making. Good direct social work intervention was seen in a significant number of child protection cases. Social workers and their managers know the families that they work with well. However, some children subject to a child protection plan live at home for too long without risk being effectively reduced.

Systems for protecting children at risk of CSE and for children who go missing from home are underdeveloped. Despite this, provision is made and effective direct work is undertaken with this group of vulnerable children helping to reduce risks for young people.

Effective arrangements are in place to track children missing education. Good systems are in place to monitor and support children who are educated at home and to ensure that children and young people have good access to alternative education.

45. The local authority has recognised that early help processes are insufficiently developed and an Early Help and Intervention Framework has recently been introduced (January 2014). Professionals use different formats for their early help assessments, which does not support consistency. Step-down processes are underdeveloped, which adversely affects the capacity of children's social care as social workers continue to work with some families longer than necessary.

46. However, families have access to a wide range of good early help services and there are clear signs that they are accessing these services more quickly. This is supported by the location of an early help social worker within the access and assessment team, so the referral process leads to swift and accurate assessments of cases, which are appropriate for early help support from partners working within localities. Locality based 'early help action' meetings are held every three weeks and allow a comprehensive range of partners, including health, the police, alcohol and drugs misuse, family support and schools' staff, to consider appropriate support for families.

47. Partner agencies do not consistently apply the threshold for access to the children's social care service. There are examples of inappropriate contacts being made, leading to a high demand for service. Within the social care system management oversight has not ensured that cases are progressed in a timely way, and some children experience delay whilst further information is gathered. In a few cases contacts did not progress to a referral when they should have done.

48. There is a high prevalence of child neglect in Hull. The total number of referrals recorded between 1 December 2013 and 30 November 2014 was 4558; of these, 2683 (59%) involved abuse, risk and neglect issues and 31% of children subject to a child protection plan (at 30 November 2014) relate to serious concerns about neglect.

49. Targeted work delivered through the 'priority families' project is embedded within the early help strategy. The latest figure (October 2014) shows that the scheme had 'turned around' over 1000 families, out of a target of 1080 which is good.

50. Management oversight of referral decision making in child protection work is consistent. The majority of decisions are prompt though this is hampered by the variable quality of referral information which is not consistently well recorded. In some cases there is a lack of clarity about risk and it is not evident from the case record that all relevant historical information has been considered.

51. Where immediate risk of harm is identified, a timely response is provided through co-location with the police which enables prompt strategy discussions. The majority of strategy discussions are undertaken between the police and children's social care, but firm plans are in place to involve health professionals

more effectively in order to improve information sharing and decision making. Decision making in the majority of strategy discussions seen was appropriate. However, recording of strategy meetings is too limited in some cases, so the rationale for the S47 enquiries is not always clear.

52. The lack of clarity with regard to undertaking S47 enquiries combined with insufficient evidence of management oversight, leads to drift in a small minority of cases and to decisions being made without full information. Prompt initial visits as part of the S47 enquiries were seen in the vast majority of cases, however delay was seen in a few cases where joint visits were undertaken with the police. Examples were seen in a small number of cases of delays in instigating the child protection processes for example convening initial child protection conferences.

53. The reclaiming social work model has not been effectively implemented within the access and assessment service and there is insufficient focus on the assessment and intervention within the child's timescale. Social work caseloads in the access and assessment team are too high with some social workers experiencing caseloads of up to 35 children. This, combined with ineffective management oversight and performance monitoring, leads to a high proportion of children and their families experiencing significant delay before assessments are completed, decisions made and appropriate plans put in place. The intensity of work varies significantly with these families, some receive an appropriate level of support with services provided, whilst others experience significant gaps in being visited and the assessment being progressed. In all cases seen, children had initial visits to assess risk. However, in a small minority of cases children were not seen alone, and the rationale for this was not clearly recorded. An increase in the number of referrals has also impacted on the capacity of this part of the service. The local authority has responded by creating additional social work capacity but it is too early to measure the impact.

54. Once children have been through the access and assessment service a significant proportion of families experience good direct social work intervention which are sensitive to their individual needs, so they receive appropriate support. Social work teams are organised in to 'pods', which include family practitioners and clinicians. Children's situations are thoroughly discussed by professionals in the pods so on-going assessments benefit from a multi-disciplinary approach to meet the needs of families. Workers have a good understanding of the needs and wants of children through reflective discussions and clinical supervision. Evidence was seen in a significant number of cases of effective direct work with children and their families; including the use of a variety of tools such as the 'three houses'. This work is helping children to express their views leading to good quality assessments and plans. However work is not yet consistent and there is insufficient focus on the historical information in assessments hampered by the lack of chronologies.

55. A lack of robust monitoring of CiN cases leads to high proportion of children not having a clear plan which is regularly reviewed. Work has begun to address

this, so the number of CiN is beginning to reduce. The recent appointment of an independent chair for higher risk CiN cases is helping to ensure services are more responsive to children's changing needs.

56. Families have good access to a translation service and issues of disability are appropriately considered in casework.

57. The ICROs make good use of the 'strengthening families' model to focus discussions and engage all participants so they express their views. Child protection conferences observed by inspectors were well chaired, with good information sharing and appropriate decision making.

58. Although the quality of reports produced by social workers are generally good reports to initial child protection conferences and reviews are not always shared with parents in a timely manner. This means that some parents are not sufficiently prepared to participate effectively in the conference. A limited number of children participate in conferences. Attendance at conferences by other agencies is good, except for GPs. Police attend initial conferences but have recently stopped attending review conferences, so they are not contributing fully to the on-going assessment of risks posed to children and to the plans to reduce these risks.

59. Child protection plans do not consistently contain clear outcomes to measure children's progress. Consequently, plans do not always enable parents to understand what needs to be achieved by when and how progress will be measured. Core groups are regular and well attended by other agencies. Arrangements to monitor the frequency of child protection visits have recently been strengthened; this has led to improvement so that all but two children are visited in accordance with the timescale set out in their child protection plan.

60. In a small number of cases ICRO's have not provided robust challenge and inspectors identified children subject to child protection plans for a long period where insufficient progress had been made. In these cases plans have drifted with agreed actions not being sufficiently followed through because workers have an over optimistic view of parents' ability to change.

61. The local authority has recognised that the electronic case recording system does not effectively support social work practice and there are firm plans in place to address this. The quality of social work recording is variable with some records not consistently up-to-date. Cases viewed on the electronic record system do not always enable sufficient understanding of the child's journey or their current situation.

62. Social workers demonstrate a strong commitment to the 'reclaiming social work' model and have access to a good range of training opportunities including systemic training. Social workers use a variety of intervention tools including the 'risk direction scale', which assists social workers to consider risks posed to individual children and whether these have changed. Genograms are used regularly, which is good.

63. In most of the cases seen, the local authority and partners provide a timely and effective response to cases where domestic abuse is identified as a risk factor. For example, in one case seen, effective direct work led to the child disclosing that her parents were still in a relationship so further action was taken to ensure the child was effectively safeguarded. The Independent Domestic Violence Advisors (IDVAs) visit families within two days of reported instances in 86% of cases. However, social workers do not receive Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessments in a timely manner following a referral from the police, leading to delays in accessing services for some children.

64. There is a wide range of partners represented at Multi-Agency Risk Assessment Conferences (MARAC), and arrangements are in place so that schools are effectively engaged to ensure that children living in households where there is reported domestic abuse receive appropriate support. The prevalence of domestic violence in Hull is high. A good and effective range of support is available to families experiencing domestic abuse. For example, the Domestic Abuse Project (DAP) which works with victims of domestic abuse which received 2,272 referrals last year, from which 1,808 victims effectively engaged with the service.

65. The Targeted Youth Support Service is providing mentoring, mediation and practical support to young people who are homeless or at risk of homelessness. Through this service young people can access an advocate. However when young people first present as homeless they are not consistently offered a social care assessment. This means that their eligibility for Section 20 accommodation is not always explored by a social worker. There is a range of supported accommodation available to young people in Hull and bed and breakfast accommodation is rarely used. There were no 16 or 17 year-olds in bed and breakfast accommodation at the time of this inspection.

66. The local authority has clear and comprehensive tracking systems for children missing from education with links to health, housing and social care. Current data shows that so far in 2014-15 there have been 78 children and young people referred as missing education, of whom only two are still being investigated. There are effective systems to monitor pupils' attendance at schools, both in local authority maintained schools and academies. A range of measures have led to attendance in Hull's schools improving over the last four years with 2014 figures above comparable national figures for both primary and secondary schools.

67. The education welfare service also monitors pupils who are permanently excluded to ensure that they attend full-time alternative provision to help safeguard this potentially vulnerable group. The local authority maintains and commissions alternative education provision through pupil referral units and is closely monitoring provision for pupils who have been, or are in danger of, being excluded from school. This enables a thorough review of all placements, to ensure that pupils have 25 hours of appropriate education each week.

68. The local authority has an effective system for investigating, recording and supporting children who are educated at home. Currently there are 42 primary and 83 secondary children educated in their homes. Monitoring shows that the reports produced following visits are sharply focused on both safeguarding and the quality of the curriculum provided.

69. The local authority does not routinely collate data on CSE or missing children to identify trends, to assist strategic planning and monitor performance. There is no multi-agency tracking of individual cases. This does not enable a comprehensive overview of risks posed to children in the area. There are a lack of tools and processes in place to support practitioners, and not all children at risk of going missing from home have clear safety plans. Good provision is made to target children who at risk of CSE across the city through a specific project which undertakes effective direct work with children and young people. This work is effectively supported by arrangements to raise awareness of CSE through dedicated training on CSE for social workers which is then cascaded to parents. This has raised professional's awareness of signs and symptoms of CSE and is helping parents to become better informed of signs and symptoms and how to access services. This has improved the identification of this type of risk. A multi-agency strategy is being implemented which has a much more robust approach to CSE, but it is too early yet to measure impact.

70. The Local Authority Designated Office (LADO) is also the manager of the ICROs, which adversely affects the capacity of the LADO. Despite this, in cases seen by inspectors, allegations were investigated effectively. Agencies are making referrals and appropriate follow-up action is taken. The LADO has engaged well with the local authority fostering team manager to assist in the management of allegations against foster carers and this has contributed to a number of foster carer de-registrations in 2013-14.

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

Summary

The number of children and young people in care is high and rising, and some young people remain in care for longer than necessary. Children live in safe and secure placements, and nearly all children are settled and well cared for. The vast majority of children live with families close to their home communities.

Social work relationships with children and families are well developed. Social workers and their managers know the needs of children well and provide good quality direct work. The voice of young people is increasingly evident in work seen and is helping to shape assessments and plans. Support for foster carers and adopters is strong, with carers commenting positively on the good quality, timely support that they receive. Although children who go missing from care are well supported, return interviews do not take place with an independent person.

Although the quality of the most recent assessments show improvement, practice is not consistent; some assessments do not contain sufficient analysis to support decisions. Care plans are not always clear about what needs to happen and they are not always progressed effectively between reviews.

The quality of PEPs is too variable. Looked after children in Hull at Key Stages 1 and 2 perform better than the national average for this peer group in reading, writing and, particularly, mathematics. However, the proportion of looked after children in Hull gaining 5 A*-Cs GCSEs including English and mathematics is below the national average.

Performance in relation to health checks for young people has improved considerably but care leavers do not have a health passport to support their progression to independence. Looked after children do not have timely access to CAMHS support.

Performance on the rate of children being adopted is significantly above the national average. However, for some children adoption takes too long. Plans for permanence are not always progressed with sufficient rigour, adoption is not always considered at the earliest possible stage, and it take too long for some children to be matched with a family. Life story work with children is not sufficiently prioritised.

Pathway planning takes place too late and the quality of most pathway plans is poor so young people do not experience a smooth well planned transition into adulthood. Although most care leavers live in suitable accommodation provision, performance remains below statistical neighbours. Care leavers are well informed about entitlements and benefits and young people were very positive about the support they receive. The rate of care leavers in EET has recently improved significantly.

Corporate parenting is a strong feature. The CiCC are helping to shape services well.

71. The looked after children population is high and is continuing to rise from 640 (at 31 March 2014) to 678 at the time of the inspection. The current rate is

123.7 per 10,000 children, above the statistical neighbour average rate of 102 per 10,000 (31 March 2014) and double the England average of 60 per 10,000. Although no children were seen who should not have entered care, the rising numbers of children in care is compounded by delays in the discharge of care orders and a lack of management oversight of 'placements of children with parents' on care orders, with a back-log of 42 children waiting for their order to be rescinded. This means that some children remain in care for longer than necessary. The local authority is successfully placing a high proportion of children at home with parents. The most recent local authority data shows that 7.3% of these children return to care in the 12 month period after their return home.

72. The quality of social work assessments is not consistently good. Although inspectors saw some good examples others were poor quality and they do not contain sufficient analysis and plans do not always progress sufficiently between reviews. In some cases seen insufficient attention was given to ethnic and cultural considerations in assessments and planning. Performance on friends and family care assessment timescales is poor with few examples of assessments seen, completed within the required 16 week timescale. Fourteen out of the 33 cases currently being assessed have exceeded this timescale, with the worst example taking nine months to complete. As a result, sometimes children experience delay in permanence and secure placements.

73. Permanence planning is not effectively overseen or driven by managers. There is no process in place to enable senior managers to assure themselves that actions and decisions are being followed in the right timescale for the child. A lack of purposeful decision making in some case supervision means that plans are not always progressed with sufficient rigour.

74. Social workers do not consistently demonstrate in their case work that they are clear about permanence plans for individual children. Care proceedings are not always started early enough and adoption is not always considered at an early stage for all children. As a result, early opportunities to create permanent plans for some children are missed.

75. Although there are many examples of good quality, timely action taken to ensure that permanence is achieved for children, social work practice does not always ensure parallel and concurrent planning is considered early enough. In some cases this has resulted in sequential planning, leading to delays in achieving good outcomes for children. Despite some success in achieving a rise in the use of Special Guardianship Orders (SGO) from 15 (2012-13) to 21 (2013-14) foster carers, including friends and family carers told inspectors that they were deterred from applying for an SGO because of the reduced financial support they would receive.

76. Some care plans seen do not articulate clearly how the needs of children will be met. Although inspectors saw some good effective plans for children, others were poor quality lacking essential details, and not always including actions

required to achieve improved outcomes or a timescale to measure progress. In some cases this has led to delays for children.

77. The local authority is working effectively with children on the edge of care. Decisions for children entering the care system are effectively overseen by a 'resource panel' chaired by a senior manager, and 55 children, young people and their families are being supported by the Marlborough Children's Home service, which combines home-based support with outreach to children on the edge of care. The intensive and flexible support provided to families is helping them to repair and sustain their relationships. Admissions to care in these families is rare.

78. Some young people who have a plan for adoption or long-term fostering do not have a life story book. Some adopters stated that they had 'stepped in' to create a life story book for their adopted child because one had not been provided. Examples of good life story preparation was seen for some children, and foster carers report more recent improvements in social workers completing these.

79. The quality of case recording is too variable. Good recording includes detailed information relevant to the child's overall plan, whilst poor quality records do not demonstrate purposeful work with children, so it is not always clear what progress is being made. There has been a big improvement in the recording of the voice of the child, which is helping to influence the shape of their assessments and plans.

80. Children are routinely seen and seen alone to ensure that social workers know and understand the needs of children. Young children spoken to (six aged between eight and 11) knew their social worker well and were aware of why they were in care and whether they were going to stay in their current placement.

81. Young people who go missing from care do not receive a return interview with an appropriately independent person, so opportunities are missed to explore their circumstances objectively. Whilst evidence was seen of young people being spoken to about episodes of missing, this was usually by their social worker or in some cases, the residential worker. Social workers take robust action to support children who have gone missing and this has reduced risk for children who go missing persistently. For example, in two cases seen by inspectors, support for young people living in 'out of city' residential placements with a history of going missing has been tackled with young people responding well to their care plan, with no overnight absences, good school attendance and increased placement stability.

82. Physical health performance is strong overall: 94.9% of all looked after children had a health check in 2013-14; 93.2% had up-to-date immunisations, which is much improved from the previous year (up from 31.5% 2012-13 and better than the national average); and 100% of all children under five had an up-to-date development check in 2013-14. The local authority has only recently

started to gather data on dental health checks, which was a previous area of poor performance. Where required, joint visits to young people in care are undertaken with sexual health nurses. The health needs of children are consistently considered in looked after reviews which is helping to ensure that individual needs are met.

83. Looked after children are insufficiently prioritised for mental health services, with relatively few (11) receiving direct support from the CAMHS. Although this service has recently been re-commissioned CAMHS is not delivering the agreed 'targeted and dedicated specialist service' for children in care. Some young people wait too long to access the service, so their needs go unmet. Not all children living outside the local authority have access to the mental health service they need in the local authority area where they live.

84. The local authority has recognised the need for consistent and readily available psychological support. In the absence of targeted health commissioned service the local authority has employed two psychologists which, has enabled a focus on attachment issues for young people and provided support to social work teams working with individual young people in care. This has enabled a greater understanding of behavioural issues and is helping to support the needs of looked after children. Examples have been seen where the local authority has also bought packages of support for young people with specific complex needs, which is helping to improve outcomes for those children. This is all helping to prevent unplanned placement moves for children. Placement stability is in line with the national average with the percentage of children who had three or more placements in the last 12 months at 7.6% and the percentage of children who have been in placement for two or more years (31 March 14) at 65%.

85. The proportion of good and better schools attended by looked after children is 57%, consistent with the current profile of good and better schools within the local authority. However, this means that 43% of looked after children are not attending good schools and this includes 26 young people attending inadequate schools. The local authority has identified this as an area for development.

86. Progress measures between Key Stages 1 and 2 in 2014 show Hull looked after children to be performing better than the national averages for looked after pupils in reading, writing and particularly mathematics. When compared with the progress measures for all pupils nationally, there has been some significant narrowing of the results gap in mathematics between Hull looked after children and all pupils nationally but weaker progress in reading and writing. At Key Stage 2 the latest results show a similar profile of outcomes in reading, writing and mathematics to national figures for looked after children. Improved outcomes for reading have closed the gap with national averages for looked after children and for all pupils.

87. Progress measures for Key Stages 2 to 4 show looked after children in Hull in 2014 performing below comparable national looked after children figures in English and mathematics and well below the outcomes for all pupils nationally. In 2014 some 22% of Hull looked after children made expected progress in

English compared with 36% for all looked after children nationally in 2013, the latest comparable year. For all pupils nationally in 2013, the figure was 69%. In mathematics, the proportion of Hull looked after children making expected progress in 2014 was 22%, compared the national figure of 32% for all looked after children in 2013; the proportion for all children was 70% in 2013. Looked after children in Hull are not doing as well as they could do in these subject areas.

88. There is also a weaker profile of attainment for secondary looked after children. In 2014 there was a fall in the proportion gaining 5 A*-C GCSEs including English and mathematics. In 2012 19% of Hull looked after children achieved this measure, but in the last two years it has declined and in 2014 the proportion was 10%. This was below the latest national looked after children comparative data for 2013, which was 16% achieving this measure. Over the last three years the gap in attainment for this measure between Hull looked after children and all pupils nationally has been variable, with the latest data showing that this has widened. The local authority has identified this as an area for further action and this is a priority area for the virtual head teacher.

89. The looked after children service transferred to electronic personal education plans (ePEPs) in 2012, but this has not been a coherent process. The ePEPs sampled showed that there was inconsistency in their completion with important aspects missing, such as attainment and attendance information and targets for the individual child. Some do not have a clear record of the responses from the child as part of the PEP procedure. A recent audit by virtual school staff has highlighted the issues around consistency, quality and effective monitoring procedures and there are plans for further work to improve the overall quality of the ePEPs.

90. The virtual school is able to provide a comprehensive analysis of outcome data. There is a tracking system for all looked after children, both in the local authority and outside, noting outcomes for their attainment and progress and the Ofsted judgement for the school attended. Fixed term exclusions show an improving picture, and are below current national looked after children comparative data. The tracking data from the virtual school showed that 36 Hull looked after children were given fixed term exclusions during 2013-14. In terms of the national comparison, the proportion of Hull looked after children with at least one fixed term exclusion has declined from 11.7% in 2011 to 7.2% in 2014. This latest figure for 2014 is below the latest available national figure for looked after children, 2012, which was 11.36%.' There have been no permanent exclusions of looked after children since 2011.

91. The Independent Visitors Project currently has 74 independent visitors matched with 74 children and young people from Hull with 22 of these placed outside the Hull boundary. A further 137 children and young people are using advocacy services. Two advocacy workers are employed through the targeted youth support service to provide support to looked after children, and the KIDs service provides advocacy for disabled children so that their wishes and feelings

can be known and understood. This is a good and extensive range of services which is providing appropriate independent support for looked after children.

92. Despite high caseloads (90-113) in the ICRO service performance on the timely completion of reviews is good with mid-year performance (September 2014) at 95.4% this is much improved from 90.2% at 31 March 2014. There are delays in ensuring that minutes of reviews are circulated quickly with independent chairs reporting a backlog from October 2014. However, recommendations are circulated quickly (within the week) and examples were seen of these being provided the same day. Not all children's cases are tracked between reviews by the ICRO, opportunities are missed to unblock some issues so children do not always make good progress.

93. The service is making increasing use of the formal dispute resolution process (31 instances this year) and is able to demonstrate some progress with issues as a result; for example, recent improvements in life story book work. However, there is no log of 'disputes' or their resolution which limits the services ability to provide a full picture of deficits to senior management.

94. Most reviews are comprehensive, with clear and purposeful actions. Parents' views are considered well but ICROs gave examples of social workers providing reports for reviews late, some leading to the adjournment of the child's review to give parents/carers more time to consider the report. Contact is explored with clear recommendations regarding important issues for children such as contact arrangements. The effect of contact on children is discussed, and advice is sought from psychologists when social workers feel that contact plans should be changed. However, opportunities are missed for children and young people to be actively involved in decisions about their life plan as although the rate of children expressing their view through the review process is very high at 99%, with 54% of children supported by an advocate, only 45% of children attend their review, which is low.

95. In three out of four cases seen by inspectors the Public Law Outline (PLO) had been followed swiftly and effectively leading to appropriate outcomes for young people. However, the local authority has only just started to pilot legal gateway meetings to ensure that there is more effective tracking of the process. Parenting assessments and a range of support services, including drug and alcohol interventions are used to inform planning and effect change; these include substance and alcohol misuse services provided for a small number of young people in care.

96. Performance on the completion of care proceedings is improving: in 2013-14 the average time taken was 34 weeks, and in the first quarter of 2014 this had improved to 28 weeks with the local authority reporting performance in line with the national average of 22 weeks at the end of the second quarter. The Child and Family Court Advisory Support Service (CAFCASS) report no issues concerning the local authority.

97. Children live in safe and secure placements, and in the majority of cases seen by inspectors children are settled and being cared for well. There is a sufficiency of foster placements and the local authority use relatively few independent provider placements and residential units. At the time of this inspection there were only 26 children living in private children's homes. Arrangements for commissioning these placements are robust. Children are only placed in good or better homes, and where inspections highlight concerns or judgements are downgraded the ongoing suitability and safety of the match is actively considered. Only two young people are currently living in provision graded adequate and none are living in inadequate provision. There is a strong focus on placing children near to their home, with 86% of children in care living within 20 miles of Hull and more than 60% within the city.

98. The fostering panel functions well, particularly considering the volume of work has tripled in past two years due to the high number of family and friends carers. The panel is always quorate and members are appropriately experienced and trained. The chair rigorously checks that all appropriate documentation is included and escalates this if something is missing. The number of fostering households has remained stable at 330. Social workers support foster carers well; they develop strong relationship with fostered children, carers, and the natural children of carers. Carers say social workers are knowledgeable, accessible and help them to persist in caring for children through very challenging times. One carer described the support provided as 'phenomenal'. Where there is a risk of breakdown, 'maintenance meetings' are convened early and are helping carers to continue to look after children where this is in their best interests.

99. The process for dual approval of foster carers as 'lodging providers' under 'staying put' arrangements through the fostering panel is a strength. All 13 young people in foster care who turned 18 years old during 2013-14 remained living with their foster carer under staying put arrangements. In addition, there were nine young people who turned 19 years old, 11 who turned 20 years old and one who turned 21 years old who remained living with their foster carer.

100. There is a large number of friends and family placements (145) and these provide strong and stable placements. The assessments of friends and family foster carers providing care for children specifically known or related to them take too long to be completed and approved by the fostering panel, with many cases exceeding the statutory timeframe. This results in delay in securing permanence and security for these children.

101. The CiCC is actively engaged with the corporate parenting panel. Children's views and suggestions are listened to and create change for other looked after children. For example, looked after children have said that they would like contact with their brothers and sisters to be arranged in a more child-focused way, so this is being considered by the group and by the corporate parenting panel. They have been active in updating the pledge and have been successful in changing pocket money amounts for young people in local children's homes. Young people are engaged in key tasks such as the recruitment of foster carers

and managers and training of social workers, such as helping influence practice in 'how to listen to young people'.

The graded judgment for adoption performance is that it requires improvement

102. When it is decided that children need a permanent home, adoption is not always considered at the earliest possible stage in the care planning process. The adoption service is not consistently aware of children for whom adoption may be the plan. There is a helpful process of adoption consultation available prior to the second looked after review but this is not consistently used.

103. The local authority's performance, measured against the 2010 to 2013 adoption scorecard, is poor and shows a worsening picture in respect of timeliness from 675 days 2011-13 to 704 day 2012-14. The average number of days between a child entering care and being placed with their adoptive family is 675. This is 28 days slower than the England average and 99 days slower than the authority's statistical neighbours. Once the court has agreed that a child can be placed for adoption, a family is found in an average of 306 days, which is 96 days slower than the national average and 116 days slower than the authority's statistical neighbours.

104. There are indications of a recent improvement in timeliness. The most recent Department for Education published data shows that the average time between a child entering care and moving in with its adoptive family, for children who have been adopted (three year average) by Hull improved from 675 days (31 March 2013) to 530 days (31 March 2014). This is now within the 608 day target and quicker than the England average figure of 628 days. Performance on the average time between receiving court authority to place a child and the local authority deciding on a match to an adoptive family (three year average) in Hull has improved from 306 days (31 March 2013) to 150 days (31 March 2014). This was now within the 182 day target and quicker than the England average figure of 217 days.

105. Performance on numbers of children adopted in Hull overall is good. From 2010 to 2013 the percentage of children looked after being adopted in Hull is 25% (145 children), which is significantly better than the England three year average of 13%. This included 7% (10 children) from a Black minority ethnic background and 21% (30 children) over the age of five. The percentage of children being adopted in Hull is increasing year-on-year with the figure rising to 28% (60 children) in 2013–2014. Current data provided by the local authority indicates a continued strong performance and states that 35 matches were made in 2013–14 including six groups of brothers and sisters. Twenty-two adoption orders have been secured since April 2014.

106. The local authority does not give sufficient priority to the effectiveness of permanence decisions for children, nor does it monitor the progress made by

children with a plan for adoption. The authority's performance, measured against the 2010 to 2013 adoption scorecard, shows a high percentage (17%) where plans have changed away from adoption compared to the England three-year average (9%). At the time of the inspection 81 children had a plan for adoption but, for 46 children adoption was no longer being pursued because the permanence decision had been or needed to be changed away from adoption.

107. At the time of the inspection the adoption team were family finding for five children with a further seven linked or matched. The local authority currently has 15 approved adopters waiting and 14 under assessment. Children with active family finding in the adoption team can be quickly matched and placed within the current resource. The adoption service makes extensive efforts in family finding activity for children using a wide range of methods. This includes working closely with the Yorkshire consortium, use of the national adoption register, national on line family finding services and adoption activity days. It participates in consortium recruitment activity and Hull specific activity through a media and marketing officer and regular promotion through recruitment sessions. The service will use inter agency placements when they are unable to place children within their own adopters, but have only needed to make one such placement so far this year.

108. The adoption panel is chaired well by a suitably qualified and experienced person, panel minutes and recommendations are clear and appropriate. The quality of child permanence reports received by the panel is too variable some do not include all risk issues, history is not recorded well and the reason why action was not taken to intervene earlier is not always clearly stated. The Agency Decision Maker (ADM) oversees a clear quality assurance process which is underpinned by the helpful use of the adoption panel business meetings. This enables the progress made by individual children through the adoption process to by monitored closely.

109. The adoption team is well managed and has made good use of the adoption reform grant to secure three additional posts and provide theraplay training for the team. The quality of prospective adopter reports and matching reports seen is good and they contain clear analysis and detail. Adopters report being happy with the recruitment and assessment process, stating that the reports accurately reflected their potential. All of the adopters spoken to reported that a suitable match was made.

110. Adoption disruption rates are low, particularly given the high number of adoption placements made, with only two adoption disruptions post placement in the last two years, one of which was an inter-agency placement. The disruption review for the Hull child was independently conducted and well managed with thorough analysis, and did not show that this was an inappropriate match.

111. Post adoption support is a strength in the local authority and 42 children and families are currently receiving it, along with 450 indirect letterbox

arrangements. Adopters spoke positively about adoption support and were aware how to access this now and in the future. Independent support, advice and counselling is available for birth family members. The adoption 'statement of purpose' was last reviewed in October 2014 and clearly outlines the adoption support available.

112. Life story materials are of variable quality. Insufficient priority is given to this area of work. Some life story books do not include all important parts of a child's life to create a complete and lasting record, and some later life letters are not sensitively written to meet the later needs of the adopted young person. This was an area for development identified at the previous adoption inspection.

The graded judgment about the experience and progress of care leavers is that it requires improvement

113. Progress in improving pathway planning for looked after children since the last inspection is poor. Pathway planning for children often takes place too late and the quality of most pathway plans is poor. Up to a third (37) of looked after young people who are eligible for a pathway plan do not have one.

114. The leaving care team is a skilled and experienced team but a recent restructure of the leaving care service and later referral at the age of 17½ has resulted in work with care leavers starting too late and the expertise of the leaving care team being applied too late. This means that there is only a short time to engage and equip young people for independence. There is a current increase in workloads in the leaving care team which is further affecting the ability of workers to meet the presenting needs of care leavers.

115. Information for young people about their health histories is not available and there is no health passport scheme. The local authority is aware of this and is in the process of implementing improvements.

116. Care leavers are not specifically included in the newly commissioned CAMHS and few access the mainstream service. There is a counselling service available and some young people who spoke with inspectors had accessed counselling support which they said was helpful.

117. Young people report that they know where to access support and advice relating to drug and alcohol issues, and the recently enhanced specialised services within the local authority (Refresh and Renew) are able to offer bespoke packages of support to care leavers. Pregnant teenagers report having been well supported in antenatal care.

118. There is a growing range of accommodation type and the percentage of care leavers in suitable accommodation has risen from 80% (2013–14) to 83% at the mid-year point (September 2014) but remains below statistical neighbours and the national average. Recent commissioning work within the local authority

has resulted in the provision of new accommodation, including a one to one 24-hour facility for young people with the most complex needs. The work to increase the range and choice of suitable accommodation has led to improvements in the range of provision enabling needs to be met in the majority of cases. At the time of the inspection there were no young people currently in bed and breakfast accommodation. The arrangements for sharing information do not ensure that all service providers have all the necessary information about young people's histories so that they can provide the best possible service. All young people who spoke with inspectors said that they were happy and felt safe where they lived.

119. The percentage of care leavers not in education, employment or training (NEET) is declining. The local authority has improved the support provided to looked after children at this crucial transition point and targeted support is provided for looked after young people who become pregnant to help them to remain in education. The current local authority data shows the rate of young people NEET aged 19 to 21 is 21% (November 2014) which is a significant improvement from the figure of 53% for 2012-13, the latest comparable figure. Young people in EET aged 19 to 21 is 65% (November 2014) which is again much improved from the 2012-13 figure of 44%, and slightly above the statistical neighbour and national figures for that year. The vast majority of young people who spoke with inspectors were in EET; seven care leavers are in apprenticeships, three with Hull City Council.

120. The number of care leavers in higher education has increased from eight in 2010-11 to 13 in 2013-14. The proportions of care levers in higher education has been above the national average in each of the last three years. They are well supported financially by a dedicated lead in the leaving care team.

121. In 2012–13 the local authority was in contact with all but one of the 45 care leavers who were over the age of 19. Young people who spoke with inspectors are very positive about the support they receive from the leaving care team and their contact with other workers. They all reported feeling that the local authority had acted like a good parent to them.

122. Young people are well informed about entitlements and benefits and the leaving care service links into national organisations to ensure that advice, literature and up to date information is available. The local authority has signed up to the national 'Charter for Care Leavers' and this is part of the corporate parenting strategy. However, only one of the care leavers spoken to was aware of the Charter and the local authority does not have a, Hull specific, version of it.

Key judgement	Judgement grade
Leadership, management and governance	Requires improvement

Summary

The pace of change leading to improvement since the last inspection has been slow. Senior managers know that the quality of service received by the majority of children and family's needs to improve and they are committed to continual improvement but this has not always led to decisive action to improve service weaknesses. Some areas identified as needing improvement at the previous inspection have not yet been fully addressed. This includes issues about partners' understanding of thresholds, the timeliness of work moving through the child protection system, ensuring all eligible young people have pathway plans, and access by looked after children to CAMHS.

The local authority has embarked upon an ambitious programme of change, with a clear vision for the delivery of children's services through the 'reclaiming social work' practice model; this is beginning to show signs of improvement, but progress is not yet consistent. This is particularly the case in the access and assessment service, where a lack of throughput of work is contributing to social workers' high caseloads and delays for children in receiving the service that they need.

Senior managers do not have all the performance information they need to give them a complete and accurate picture of the quality of social work practice. As a result, many examples were seen by inspectors of cases where there had been drift and delay.

The electronic case recording system is not fit for purpose. It does not function effectively as a working system to support social workers to plan and record their work and it is difficult to track progress on cases.

Senior managers have achieved widespread understanding of, and enthusiastic support for, the 'reclaim social work' practice model for delivering social work services. This includes support from the chief executive, elected members and crucially, is underpinned by the support and commitment of the social care workforce. Although this new approach to service delivery is not yet embedded, the service is well placed to consolidate successes and improve further.

Most social workers are permanent employees, and the turnover in the workforce is very low. Workers show enthusiasm for, and commitment to, working for the local authority, and are well-supported through training.

The lead member and the senior leadership of the local authority champion the needs of vulnerable and looked after children. This is supported by strong, commitment across the political spectrum and from council departments beyond children's services. Corporate parenting has significantly improved and is now a strong feature of the service. The voices of young people are clearly heard by the

corporate parenting board, and their views result in changes in practice.

123. The pace of change since the last inspection has been too slow. In its ambitious re-design of services the local authority clearly articulates a desire to ensure that the changes it is making are 'right first time'. However, this has been at the expense of moving forward some areas of work which should have been addressed sooner, and which in some cases are not yet resolved. For example, there are still issues about partners' understanding of thresholds, the timeliness of work moving through the child protection system, ensuring that all eligible young people have pathway plans, and access by looked after children to CAMHS.

124. Performance information is not yet sufficiently developed to provide a clear picture of practice and to identify where action needs to be taken to address shortfalls. Some key data, such as information about statutory visits to CiN, or the progress of cases through the PLO process, are not routinely captured and considered by senior managers. During the inspection the local authority had to undertake urgent work to look at the circumstances of a large number of long-term CiN to assure itself that these children had been visited and were safe.

125. The electronic case recording system is not fit for purpose. It does not function effectively as a working system to support social workers to plan and record their work and it is difficult to track progress on cases. This deficiency has been recognised by the local authority and it has committed substantial funding to secure a replacement system which is subject to the required tendering process.

126. There is senior management oversight of key decisions in cases through the weekly resource allocation panel. The panel is making effective plans on issues such as whether cases should enter the PLO process, whether children should be looked after, and the appropriateness of, and funding for, external placements. However, the quality of scrutiny is not always sufficiently robust and actions are not expressed in a specific, measurable, attainable, realistic and timely (SMART) way, and progress is not systematically monitored. The local authority has recognised the need to review the work of the allocation panel to sharpen its focus and increase its effectiveness. In particular, plans have now been made to introduce a separate permanence panel to oversee and drive the timely progress of permanence plans for children.

127. Managers do not have a strong enough grip on the progress of work through the child protection system. At the centre of the 'reclaiming social work' practice model is 'reflective discussion', designed to provide peer review and challenge and thus ensure that cases move forward in children's timescales. However, not every child's case is the subject of a frequent enough reflective discussion. The quality of the discussions is not always sufficiently evaluative, with some lacking clarity around the analysis of the information presented, the desired outcomes and the actions to achieve these. As a result, examples were seen by inspectors of children experiencing drift and delay. This is particularly the case in the

access and assessment service, where the practice model is not ensuring a timely throughput of work. This is contributing to high caseloads in this part of the service. Although social work practice ensures that children are safe, many children and families experience drift and delay in the services they receive.

128. The changes made in the social work practice model of service delivery are widely understood and supported by elected members, the chief executive and most partners. Most importantly, staff on the front line are clear about the model and what it is designed to achieve, and enthusiastic about this approach to provide effective social work. They feel well-supported by the model which moves away from social workers organised in teams to groups of professional from different disciplines working together in 'pods' so that service responses are holistic with social workers describing feeling less isolated as a result.

129. Although the local authority is faced with difficult financial constraints there is clear commitment to children's services from the chief executive and elected members. Meetings take place every six weeks between the leader of the council, the portfolio holder, the chief executive and directors from across the authority which act as problem-solving forums and help to move plans forward. These meetings have considered issues such as budgets, how the changes in the social work delivery model are working, the high and rising number of looked after children, and the local authority's work with children at risk of CSE.

130. The local authority has recognised many of the areas for development identified by inspectors and work is in progress to address these, although in some cases this could have been put in place more quickly. The authority has responded swiftly to some deficiencies identified during this inspection, for example recognising the need for additional decision-making capacity in the access and assessment service. The local authority has an accurate view of the quality of social work practice, with its view of the quality of the 85% of cases tracked during the inspection being in line with that of inspectors.

131. Links between local partnerships such as the local safeguarding children's board (LSCB) and the health and wellbeing board (HWB) have been established, but it is too early for the impact of these links to be seen. The Director of Children's service attends these meetings to ensure that issues are effectively linked to drive progress. The chair of the HWB considers that there are strong connections between the board, the LSCB and the Children's Trust, and that these ensure a sustained focus on safeguarding across the city. However, there is little evidence to demonstrate that safeguarding is a key priority for the HWB and although the LSCB annual report was recently presented to the HWB there is no evidence of the HWB taking action in response to this report.

132. The local authority has developed a clear service improvement framework to allow it to understand the quality of practice. This incorporates information from reflective discussions, case audits, observation of practice and feedback from families. However, the framework has been implemented only recently and it is too early for it to have had an impact.

133. The local authority has undertaken a range of audit work since October 2013 which has identified gaps in service and resulted in recommendations for improvements. However, senior and middle managers have not always taken robust or timely action to ensure that these recommendations are effectively addressed. Insufficient priority has been given to ensuring that action plans are regularly monitored. For example, an audit of contacts to the access and assessment service undertaken in April 2014 on work from late 2013 and Feb 2014 identified issues in respect of cases drifting which were similar to those observed by inspectors during the inspection.

134. The overview of children going missing or at risk of CSE is underdeveloped, with the local authority not yet able to identify trends or hotspots to assist strategic planning and monitor performance. Suitable plans are in place to improve assessment and tracking in this area, and a new risk assessment tool is being introduced to shape multi-agency practice.

135. The lead member demonstrates a proactive approach to championing the needs of looked after children. Corporate parenting is driven by a committed group of elected members and senior managers from across the local authority. Members of the CiCC attend each meeting of the corporate parenting board. Practice is directly influenced by the views that young people put forward. For example, young people said that they did not want to be taken out of lessons to attend meetings and this practice has now stopped.

136. The local authority demonstrates a strong commitment to the early resolution of complaints, with complainants being satisfied with the outcome of their complaints in 82% of cases overall. Local authority data shows that all 14 of the young people who have made complaints in the last six months have been satisfied with the outcome. There are many examples of working groups taking forward the key issues identified through complaints to help improve services.

137. Commissioning of external placements is a strong feature of the local authority performance. A needs analysis undertaken on behalf of the local authority gives a sophisticated overview of the use of external placements, thus ensuring that the needs of children and young people requiring external placements are understood. The sufficiency strategy, currently in final draft form, is comprehensive, and draws on both the needs analysis and information from the Joint Strategic Needs Assessment to ensure that services are sharply focused on meeting local needs.

138. Most social workers (93%) are permanent employees, and there is a very low turnover within the workforce. Workers are motivated and enthusiastic about working for the local authority. The local authority has positive relationships with local universities; a number of authority employees are undertaking an employment-based social work qualification, and students who are offered placements with the authority often then go on to apply for jobs there once they have qualified. The workforce development plan is detailed and supports the 'reclaiming social work' practice model. A first cohort of workers is completing detailed training on systemic practice; there is anecdotal evidence

from social workers and their managers that this is beginning to have a positive effect on practice, though the full impact has yet to be evaluated.

139. Strong visible senior management leadership has helped to promote the 'reclaim social work' practice model across the work force, but this has not transferred into the effective drive needed to ensure that children always get the service they need early enough. Insufficient priority is given to holding social workers and front line managers to account for delays in service. The quality of one-to-one supervision for social workers is too variable, with gaps in supervision frequency noted in some cases and limited evidence seen of annual appraisals. No evidence was seen of audits of the quality or frequency of supervision. Infrequent supervision limits opportunities to formally support staff and promote their continued professional development, to challenge or commend performance or to complete staff appraisals to promote effective social work practice.

140. The local authority has notified Ofsted of eight serious incidents since August 2012. Of these, four have resulted in serious case reviews, with two completed and the reports published. Notifications have been timely, as have the decisions about whether to proceed to a serious case review. One incident is awaiting a decision as to whether a serious case review will be undertaken. In the three cases where a serious case review was not undertaken this decision was appropriate. There are no patterns or themes shared by the serious incidents which would suggest repeated or systemic failures on the part of the local authority and/or its partners.

What the local authority inspection judgements mean

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.

Information about the local authority inspection

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

At the same time, HMIC, the CQC and HMI Probation conducted pilot inspections of the police force and health and probation services respectively. All the inspectorates used this opportunity to share their findings and better understand the contribution of these services and the local authority to the help, protection and care of children and young people. Each inspectorate conducted their activity under their own statutory powers. As the inspections by HMIC, the CQC and HMI Probation were pilot inspections to test new frameworks and methodologies, they will not result in published reports.

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This 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 team

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

Lead inspector: Gary Lamb

Deputy lead inspector Mike Ferguson

Team inspectors: Paul D'Inverno, Peter McEntee, Louse Hocking, Stephanie Murray, Robert Pyner and Ty Yousaf (Seconded Inspector)

Quality assurance manager: Nicholas McMullen

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Kingston upon Hull Safeguarding Children Board

Inspection of the effectiveness of the local safeguarding children board

Inspection date: 18 November – 10 December 2014

Report published: 10 February 2015

The Local Safeguarding Children Board requires improvement
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 *require improvement*.[1]

Contents

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

Summary of findings

The HSCB requires improvement because:

Scrutiny and assurance

- The LSCB has not, until recently, provided regular detailed monitoring and evaluation of the effectiveness of practice in all front line services. While it has a long track record of scrutinising work by children's social care services, police and health agencies have not had the same level of oversight or challenge. The LSCB has recognised this and these agencies are now routinely providing data for a multi-agency performance scorecard. However, this is a recent development and its impact is only now becoming evident.
- The LSCB has been slow to develop and coordinate the implementation of its Children Missing and Child Sexual Exploitation strategy. This is now happening and the Board has a clearer view of the nature and extent of risks to children in Hull, but this is not yet comprehensive.
- Board members and constituent agencies have not consistently challenged partners about poor performance or escalated concerns to the Board. This has limited the Board's activity in the execution of its scrutiny function. While the annual report provided by the Board establishes clear priorities and presents an accurate self-assessment, it does not provide a detailed analysis of the impact of its work or the performance of partner agencies.

Learning

- Some frontline workers in partner agencies including children's social care and health could not demonstrate an awareness of 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.
- While recent engagement with children and young people and their families has improved, the Board has not routinely used their views to inform its work or measure improvement or impact.

What does the LSCB need to improve?

Areas for improvement

Data and performance management

- Ensure that sufficient comprehensive, accurate and timely performance information continue to be provided to the LSCB by all partner agencies and is used to effectively scrutinise performance and assess quality of practice.
- Ensure that the LSCB provides sustained and proactive challenge to partner agencies over safeguarding performance and this leads to improved outcomes for children and young people.
- Ensure that the LSCB annual report provides a rigorous assessment of the performance and effectiveness of safeguarding services and the impact of help and protection on children and young people and their families.
- Ensure that pathways for agencies to escalate concerns to the LSCB are supported by clear evaluation and reporting arrangements.

Practice and policy

- Ensure that arrangements in relation to children missing and children at risk of sexual exploitation are well understood by the LSCB. Ensure that the Board effectively drives this agenda and that action is well coordinated through a clear strategy and action plan and this is reviewed regularly by the Board.
- Ensure that learning from audit activity and serious case reviews is effectively disseminated, learning is evaluated and this work leads to sustained improvements in safeguarding practice.

Quality of practice

- Ensure that the experiences and views of children and young people and their families are identified and used to inform the work of the Board and lead to improvements in safeguarding services.

Summary for children and young people

- Inspectors found that the Local Safeguarding Children Board (LSCB) in Hull needs to improve, although some of its work is helping children and young people.
- The LSCB has not made sure that sufficient people who work with children in Hull know how to identify and help those children and young people who are at risk of sexual exploitation.
- The LSCB does not get enough regular and detailed information from partner agencies about their work. This means that it cannot tell how well they are helping and protecting children, and so cannot identify where improvements need to be made.
- The LSCB has not sufficiently used the opinions of children and their families to help it in carrying out its work.
- The Chair of the LSCB is now making sure that safeguarding improvements for children and young people across Hull are maintained.
- The LSCB provides a lot of training for staff and this has helped to improve services.
- The different agencies of the LSCB work well together and share information and know what services are available to children and families in Hull.

Inspection judgement about the LSCB

1. Governance arrangements between the LSCB and the local authority are effective. The LSCB chair regularly meets with the Director of Children's Services and Chief Executive Officer to ensure that the local authority is fulfilling its safeguarding responsibilities. The Chief Executive holds the chair of the LSCB to account and completes an annual appraisal process.

2. There are clear links between the LSCB and the Health and Wellbeing Board (HWB). The participation of the DCS in both bodies ensures that issues are effectively linked. However, there is little evidence that safeguarding is a key priority for the HWB other than a focus on wider public health concerns such as child obesity and the impact of child poverty.

3. Hull LSCB is chaired by an independent chair, who was appointed in 2010. The Board meets all statutory requirements set out in Working Together 2013. The LSCB receives ongoing commitment and support from local political leaders who retain a clear focus on safeguarding service delivery across the partnership.

4. A revision of the LSCB constitution and assertive action by the Chair has led to improved attendance from more senior key managers and to the appointment of executive leads of sub-committees. The LSCB has clearly identified priorities in the current business plan to improve safeguarding practice. The Board regularly reviews progress and takes any necessary action to meet objectives.

5. In its recently published annual report, the LSCB shows an accurate overview of some of its own strengths and areas for development. For example, it recognises that it does not know enough about the quality of service provision and the difference this makes to the lives of children, young people and families in Hull. It also highlights the need to improve quality assurance and scrutiny of performance information. These shortcomings mean that the LSCB does not have sufficient understanding of the strengths and weaknesses of individual partner agencies. As a result, the annual report does not present a rigorous and transparent analysis of how effectively partner agencies discharge their child protection and safeguarding responsibilities.

6. The LSCB ensures multi-agency policies and procedures are fit for purpose, reviewed effectively and are updated appropriately to incorporate statutory responsibilities and changes to practice. For example, the LSCB has helped to drive forward the implementation of the early help strategy. This has resulted in improved awareness across the partnership of available preventative services.

7. The independent chair is now establishing a culture of scrutiny and challenge across the Board and its constituent agencies. 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

challenge has resulted in some marked improvements, for example, in relation to understanding about how to manage allegations and the role of the LADO. In response to information about a doubling of CAMHS referral rates in 12 months and significant delays for young people in accessing support and intervention, the LSCB took action that supported the recommissioning of the CAMHS contract. Overall though, it is too soon to know how well these improvements in the LSCB's functioning will be sustained.

8. The lack of performance information available to the Board adversely affects its ability to present a systematic assessment of the quality and effectiveness of safeguarding practice across the partnership. While the LSCB has a clear view of how partnerships operate through audit activity, the Board has not received a consistent flow of performance information in order to identify trends and patterns within individual agencies. Key partners, including health and police have not routinely contributed to a multi agency balanced scorecard. The LSCB has held these agencies to account and is now receiving the data it needs. As a result the LSCB is able to provide a more rigorous examination of the contribution of these agencies. There is early evidence of impact and improvements to practice in some areas as a result of this work. For example, the number of children subject to a child protection plan for a second time has reduced following well targeted intervention. Additionally, the timeliness of child protection visits to children and young people has improved following sustained challenge by the LSCB.

9. In light of the reorganisation of frontline children's social care and the introduction of the "pods", Children's Social Care and the LSCB jointly commissioned a 'strengths-based learning review' to assess whether children continue to receive a responsive and timely service. This identified areas for closer evaluation, such as the timeliness of assessments, quality of planning and high caseloads in social care. The LSCB challenged the local authority about these concerns and as a result senior managers now present regular reports to the Board on these issues. Consultant Social Workers have attended the Board and provided a direct frontline narrative on performance and the challenges they experience. This has been supplemented by a 'walking the floor' visit by Board members to talk directly to frontline social workers

10. Despite a long term strategic and operational joint focus on CSE and missing children, Hull has only recently produced a single multi-agency strategy. The strategy is comprehensive, robust and clear. While the LSCB has completed a multi-agency audit and a self assessment, until recently, work has not been well targeted, coordinated or evaluated effectively. The LSCB identified this shortfall and is now effectively prioritising the CSE agenda and providing sustained drive and focus. As a result, the partnership now has a fuller understanding of the nature and extent of CSE across Hull. While these developments are recent, there are examples of early improvement as a result and it is clear that the Board has strengthened arrangements to monitor risks to children. For

example, recent focus has resulted in the introduction of the MACE risk assessment tool and a review of the definitions of risk document. Additionally, the LSCB has ensured that a significant amount of awareness raising regarding CSE has taken place across the partnership through training and publicity events and this has resulted in a better understanding of the issues of CSE.

11. Partnership work is mostly effective and all key partners are well engaged and make an active contribution to improve the delivery of services for children and young people. Most services are well coordinated and targeted. For example, the LSCB has worked closely with partners to ensure that the Strengthening Families child protection conference model was successfully implemented and secured key agencies' understanding of the model. However, some partners have not effectively escalated concerns appropriately to the LSCB. For example, social workers report delays in gleaning information from the police following child protection concerns. This lack of escalation or challenge on the part of partners reduces the impact of the Board to effectively monitor frontline practice.

12. Partnership working has been further strengthened through the implementation of "Walking the Floor" activities where Board members spend time with frontline practitioners in different settings. For example, Board members from children's social care and youth justice recently met with school nurses, health visitors and nursery nurses. This has facilitated a deeper understanding of services available as well as challenges and strengths within safeguarding services across the partnership.

13. Health, youth justice services and the probation service are fully engaged in the work of the Board at both operational and strategic levels. For example probation challenged health agencies about the availability of services to victims of sexual abuse and as a result a unit at the hospital was maintained to provide support services. The vice chair of the Board is the Head of the National Probation Service (Humberside) and this ensures there is a clear message that safeguarding is seen as everyone's business.

14. The police representative on the Board is a Divisional Commander. This seniority provides an effective high level contribution and swift decision-making and action in response to LSCB findings and challenge. The Chairs of the four Humberside LSCBs meet regularly with the Chief Constable and annually with the Police and Crime Commissioner to ensure most key priorities and challenges are shared and effectively targeted. For example, the LSCB has challenged the police about attendance at review child protection conferences. Additionally the LSCB is currently addressing the fact that Hull does not currently have ready access to secure or secure welfare beds for young people. This has resulted in some young people being held inappropriately in custody overnight. The Board has ensured that representatives from both the voluntary sector and housing providers are actively involved in the Board activity. This effective

communication has resulted in clearer expectations and commitment to safeguarding responsibilities across the partnership. For example, the Council's housing department ensures that their repair and maintenance contractors receive safeguarding training and guidance. Additionally, the LSCB influenced the Children, Young People and Families Board to commission a voluntary and community sector safeguarding support service, which, for example, has established a safeguarding forum and helps ensure that VCS providers receive safeguarding training and know how to make a referral to children's social care.

15. Partnership working between the youth offending service and childrens social care has been strengthened following well targeted work and challenge by the LSCB. Communication and information sharing processes are now well defined and result in effective arrangements to safeguard children and young people. A number of LSCB members now sit on the youth offending management board and this has further strengthened partnership arrangements as well as raised the profile of the youth offending service within the LSCB.

16. Partners make appropriate financial contributions to support the business of the Board. The Board benefits from the membership of one lay member and is actively seeking to appoint a further lay member.

17. While some processes are in place to glean 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 have identified this as an area for development and in response to this has recently developed a comprehensive programme of events and mechanisms to better engage service users.

18. Since 2012, the LSCB has initiated serious case reviews (SCRs) in response to four serious incidents. In three further cases it decided not to undertake SCRs. The decision in each case was appropriate. Learning is well established and includes lessons from both local and national issues and relevant research. The LSCB disseminates learning across the partnership through training, bulletins and emails. While most practitioners are aware of lessons learnt, a small minority were not. For example, some social workers found it difficult to articulate to inspectors how learning has helped to influence service improvement. Monitoring of whether lessons learnt lead to improvements in practice is not robust.

19. The LSCB undertakes a programme of multi agency audit activity including themed audits on areas such as child sexual exploitation and child protection conference arrangements. This has effectively engaged frontline practitioners their managers, and children and families, so they are directly involved in this learning activity. The quality and impact of audit activity has been variable, but more recent activity has resulted in some well targeted improvements across safeguarding services. While there are clear mechanisms to disseminate key

messages and learning from audit activity, this is not consistently influencing frontline performance or leading to sustained improvements. For example audit activity has identified that detailed risk assessments are not carried out for women with complex social and emotional factors when they first present as pregnant. As a result, potential vulnerabilities are not identified at an early stage. Additionally, health professionals have reported that referrals made by health to social care regarding unborn babies do not always receive a timely response from children's social care services. These shortfalls have been identified and raised by the LSCB but it is too early to see whether significant improvement has ensued.

20. The training strategy supports agencies to identify and address the safeguarding training needs of their workforce on a single and inter-agency basis. The LSCB is committed to commissioning and funding multi- agency safeguarding training and undertakes an annual training needs analysis that informs the delivery of the training programme. This results in clear learning pathways and a comprehensive training programme. Training is well delivered, well received and highly rated by professionals. However, the LSCB has recognised that arrangements to evaluate the impact of training is an area for development and is now taking action accordingly. The training strategy now has a much stronger emphasis on evaluating the impact of learning on practice.

21. Highly effective arrangements for the review of child deaths are in place. The child death overview panel (CDOP) comprises appropriate professionals, is well attended and has clear terms of reference. It reports regularly to the LSCB which also considers the annual CDOP report. Reports identify issues of concern and identified themes, for example, teenage suicides and the risks associated with co-sleeping with infants. Both these issues have resulted in well targeted preventative strategies as well as promoting public awareness across Hull.

Information about the LSCB inspection

This inspection of Hull Safeguarding Children Board was carried out as a joint pilot inspection by Ofsted, the CQC, HMIC, and HMI Probation under section 20 of the Children Act 2004. This inspection replaces the review of the LSCB that would otherwise have been conducted by Ofsted alone under section 15A of the Children Act 2004. Consent to conduct this pilot inspection and publish this joint report was given by the LSCB chair and the statutory Board partners that are members of Hull Safeguarding Children Board.

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This 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 LSCB knows about how well it is performing, how well services in the area are doing and what difference they make for the people they are trying to help, protect and look after.

What the LSCB inspection judgements mean

The grade criteria used for the pilot inspection of the LSCB are listed below. These criteria will be reviewed and may change based on feedback from the participants in this pilot inspection and responses to a consultation on these criteria, run by the inspectorates from June to September 2014.

The LSCB is likely to be judged to be good if the following apply:

- The governance arrangements enable LSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people. The LSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated into a delivery plan to improve outcomes. The LSCB monitors how well partners take forward issues in each agency.
- The DCS works closely with the LSCB Chair and the local authority chief executive holds the LSCB Chair to account for the effectiveness of the LSCB

- Regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children[2] identify where improvement is required in the quality of practice and services that children, young people and families receive. This includes monitoring the effectiveness of early help.
- The views and experiences of children and young people and their families inform the work of the LSCB. The experiences of children and young people are used as a measure of improvement.
- The LSCB identifies where safeguarding is insufficiently prioritised and takes robust action to challenge and support partners. Partners hold each other to account for their contribution to the safety and protection of children and young people (including children and young people living in the area away from their home authority), facilitated by the chair.
- Safeguarding is a priority for all of the statutory LSCB members and this is demonstrable, such as through effective section 11 audits and section 157 and 175 Education Act Audits. All LSCB partners make a proportionate financial and resource contribution to all LSCB functions, including the audit and scrutiny activity of any sub-groups. The LSCB is sufficiently resourced to meet its statutory functions.
- The LSCB has a local learning and improvement framework with statutory partners. Opportunities for learning are effective and properly engage all partners. Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved. They result in shared action plans with clearly defined recommendations for improvement. Serious case reviews are published. The LSCB also uses wider learning from other serious case reviews to improve practice locally.
- The LSCB ensures that high-quality policies and procedures are in place (as required by 'Working together to safeguard children')[3] and that these policies and procedures are monitored and evaluated for their effectiveness and impact and revised where improvements can be made. The LSCB monitors and understands the application of thresholds locally and facilitates a shared understanding across all partners of local thresholds.
- Effective partnership working with other LSCBs within the geographical area ensures a consistency of approach and avoids duplication and/or gaps in policy, systems and processes, where appropriate. Particular attention is given to wider partnerships where board partners relate to more than one LSCB.

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[2] This applies to all children and includes having an understanding of the local safeguarding response to deaf and disabled children in all aspects of the LSCB functioning.
[3] Working together to safeguard children, Department for Education, 2013; www.gov.uk/government/publications/working-together-to-safeguard-children

- The LSCB understands the nature and extent of the local issues in relation to children missing and children at risk of sexual exploitation and oversees effective information sharing and a local strategy and action plan.
- The LSCB uses case file audits including joint case audits to identify priorities that will improve multi-agency professional practice with children and families. The chair raises challenges and works with LSCB partners where there are concerns that the improvements are not effective. Practitioners and managers working with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. The LSCB is an active and influential participant in informing the planning of services for children, young people and families in the area and draws on its assessments of the effectiveness of multi-agency practice. It uses its scrutiny role and statutory powers to influence priority setting across other strategic partnerships such as the Health and Well-being Board.
- The LSCB ensures that sufficient, high-quality multi-agency training is available and evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people, families and carers. All LSCB members support access to the training opportunities in their agencies.
- The LSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and, where necessary, challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.
- The LSCB effectively scrutinises the performance of custodial and detention facilities within the local authority area.

The LSCB is likely to be outstanding if the following applies:

- In addition to meeting the requirements for a good judgement, it provides evidence of being a highly influential strategic arrangement that directly influences and improves performance in the care and protection of children. That improvement is sustained and extends across multi-disciplinary practice with children, young people and families. Analysis and evaluation of performance is exceptional and helps partners to properly understand the impact of services, the quality of practice and the areas for improvement. There is a comprehensive range of training for managers and practitioners that is directly related to multi-agency improvement priorities. The LSCB creates and fosters an effective learning culture locally that extends to front-line practitioners. The LSCB listens to and understands the views of children and families.

The LSCB is likely to be judged as requires improvement if the following applies:

- It is not yet demonstrating the characteristics of good[4].

The LSCB is likely to be inadequate if the following applies:

- It is not demonstrating that it has effective arrangements in place and the required skills to discharge its statutory functions set out in Working together to safeguard children, the Children Act 2004 and the LSCB regulations 2006. The LSCB does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

[4] Failure to achieve a single criterion will not in itself automatically lead to a judgement of 'requires improvement.' Inspectors will apply 'best fit' and where the inspection team evaluates that good is not the best fit they will evaluate the severity and extent of the weaknesses in practice and the impact on children and young people to determine whether the LSCB 'requires improvement to be good' or is 'inadequate'.

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