Darlington Borough Council

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

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 23 June – 16 July 2015

Report published: 1 September 2015

Children's services in Darlington Borough Council are inadequate
There are widespread or serious failures that create or leave children being harmed or at risk of harm. It is Ofsted's expectation that all children and young people receive the level of help, care and protection that will ensure their safety and help prepare them for adult life.

1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Inadequate

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

Contents

The local authority

Information about this local authority

Previous Ofsted inspections

- The local authority operates four children's homes. Two were judged to be good or outstanding in their most recent Ofsted inspection, and two were judged to be adequate.
- The previous inspection of the local authority's safeguarding arrangements was in January 2012. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in January 2012. The local authority was judged to be adequate.

Local leadership

- The Director of Children's Services has been in post since 1 September 2014.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since 1 April 2015.

Children living in this area

- Approximately 22,800 children and young people under the age of 18 years live in Darlington. This is 22% of the total population in the area.
- Approximately 21% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 19% (the national average is 17%)
  - in secondary schools is 17% (the national average is 15%).
- Children and young people from minority ethnic groups account for 6% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian and mixed.
- Darlington has higher numbers of Gypsy or Roma travellers than the wider UK with approximately six times the national average – a substantial number are domiciled only during the winter months.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 5% (the national average is 19%)
  - in secondary schools is 4% (the national average is 14%).

Child protection in this area

- At 31 March 2015, 823 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 897 at 31 March 2014.
- At 31 March 2015, 86 children and young people were the subject of a child protection plan. This is a reduction from 140 at 31 March 2014.
- As at March 31 2015, the numbers of children living in a privately arranged fostering placement remain low at four. This is a small increase from three privately arranged foster placements at 31 March 2014.
- Since the last inspection, one serious incident notification has been submitted to Ofsted and no serious case reviews have been completed or are ongoing at the time of this inspection.

Children looked after in this area

- At 31 March 2015, 200 children are being looked after by the local authority (a rate of 88 per 10,000 children). This is an increase from 190 (83 per 10,000 children) at 31 March 2014. Of this number:
  - 73 live outside the local authority area
  - 25 live in residential children's homes, of whom 10 live out of the authority area
  - one lives in a residential special school[2] that is out of the authority area
  - 157 live with foster families, of whom 60 live out of the authority area
  - two live with parents, of whom one lives out of the authority area
  - none are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 13 adoptions
  - seven children became subject of special guardianship orders
  - 90 children ceased to be looked after, of whom three subsequently returned to be looked after
  - 11 children and young people ceased to be looked after and moved on to independent living
  - seven children and young people ceased to be looked after and have lived in houses of multiple occupation. There are currently three young people living in this type of accommodation.

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

Executive summary

The local authority has not made sufficient progress in all areas identified by the last inspection in 2012. The standard of some social work services for children needing help and protection and the quality of leadership, management and governance have declined.

Managers at all levels of the organisation do not have sufficient grip or oversight of front-line practice for children who need help and protection. As a result a significant number wait too long for their needs to be assessed. This inspection identified a high number of assessments (94) that were not completed within timescales agreed by managers, with too many children left in situations of unassessed risk.

The local authority has failed to implement an effective system for monitoring and managing the single assessment. Where the authority's own performance reports have shown the majority of current assessments to be out of timescale, management action to respond and ensure children are safe and receiving timely services has been inadequate. This is a significant failure by senior leaders to ensure that the most vulnerable children receive a timely service from social workers that keeps them safe. When children do receive an assessment, not all are comprehensive and focused on all areas of risk. While some examples of good practice were seen, this is not consistent, and in the four worst case examples, children were left at potential risk. The highly variable quality of practice in Darlington is a critical area of concern. Where poor practice has been identified, the impact for children is potentially serious.

Leadership, management and governance are inadequate because of serious failures by senior leaders to take effective oversight of, and accountability for, Darlington's services to children. Elected members and the council's Chief Executive have not been sufficiently challenging towards children's services managers to assure themselves that children are safe. A reliance on inaccurate performance reports and upward self-reporting by senior managers means they were unaware, until this inspection, of the extent or impact of the service's underperformance.

Criticism by the judiciary of legal planning within the council in February 2015, including the inappropriate use of section 20 of the Children Act 1989, has not led to swift or effective action to address all areas of concern.

Social workers in Darlington are committed to children and their families and many know the children they work with well and ensure that they receive a good range of support, including services from the family intervention team. These services are resulting in good outcomes. However, not all social workers are adequately enabled to provide a good service. Some work in teams that have a high number of newly qualified social workers or high workloads and this leads to services that are inconsistent. Where services are weak, deficits occur too often. For instance, too few children are seen in accordance with their child protection plan, reports for child protection conferences are not always timely, the quality of too many child

protection plans is poor, and core groups are not always recorded well. This means that social workers cannot always be sure that children are making sufficient progress against plans and that risks are reducing.

The independent reviewing service does not provide sufficient rigour when overseeing the quality and progress of plans, or ensuring that when challenges are made about poor practice improvements are made for children. In a small number of cases, decisions about the need for permanence for looked after children have been delayed as the child's needs and timescale are not afforded sufficient priority. In these cases independent reviewing officers have not rigorously challenged that delay.

There have been some areas of improvement since the last inspection in 2012. For example, services to care leavers and the adoption service are now judged to be good. Services for children looked after overall require improvement and some recommendations from the last inspection have not been adequately addressed, such as the quality of care plans and the practice of independent reviewing officers.

A range of early help services is available in Darlington and, through effective monitoring of outcomes, the partnership is aware that some services are making a positive difference for children and families. However, the lack of an action plan to accompany the early help strategy and an overall lack of evaluation of services means that the council cannot be assured that the right children are receiving help at the right time.

The multi-agency response to child sexual exploitation is reducing risk for many children and young people and front-line practice is mostly well coordinated. Data on the completion of return interviews is not robust and information from return interviews is not collated to gather local intelligence.

There are improving outcomes for children looked after, and they have access to good quality therapeutic support and a wide range of recreational activities. However, their outcomes could further improve if those who were eligible for an independent visitor had one, initial health assessments were timely, and the quality of personal educations plans (PEPs) improved. The Head of the Virtual School should monitor children's educational progress more effectively, and take action to narrow the attainment gap.

When children have a plan for permanence away from their birth family it is progressed robustly. Children who need adoption receive good quality planning and support from the adoption service. Prospective adopters and special guardians are assessed, trained and supported well and the quality of post-adoption and post-special guardianship order support is a particular strength.

Not all 16- and 17-year-olds who are homeless have access to adequate housing provision. For the majority of care leavers, outcomes are positive with a very high proportion in touch with their personal advisors and currently in suitable accommodation.

Recommendations

1. Ensure robust management oversight of the single assessment process at both first tier and senior management level, so that children and families are seen and risks evaluated within timescales that meet the child's need.

2. Drive improvement through the quality assurance of assessments that ensures that all areas of risk to children are addressed, historical information is considered and analysis is robust, so that children's needs, including the need for protection, are fully addressed.

3. Improve the quality and timeliness of social work reports prepared for child protection conferences, ensure that initial child protection conferences are held within timescales that accord with statutory guidance, and ensure core groups are recorded effectively.

4. Review the current configuration of social work teams to ensure equity in workload distribution and that the working environment is conducive to good social work practice across the whole of the service.

5. Review processes and resources available for performance monitoring at all levels of the organisation and ensure that robust arrangements are put in place as a matter of urgency.

6. Ensure that elected members are rigorous in their understanding of children's services performance and are enabled to robustly challenge senior managers to improve.

7. Complete a thorough review of all children subject to section 20 accommodation to ensure that its use is legitimate and appropriate in all cases.

8. Ensure that independent reviewing officers (IRO) demonstrate rigour when overseeing both the quality and progress of plans, and the frequency of social work visits to children who are the subject of child protection plans.

9. When IROs challenge poor practice, make sure this is clearly recorded and monitored to ensure improvements are made and, where necessary, a lack of progress can be formally escalated to senior leaders.

10. Ensure when children are looked after that decisions about their need for permanence are timely with robust oversight, including by IROs.

11. Ensure that return interviews are offered for all children who go missing and that the take-up of these interviews is monitored and information is used to inform plans to keep children safe.

12. Make sure that early help is effectively targeted, coordinated and evaluated so that families receive appropriate support when need is first identified, and the quality of early help assessments is improved by robust quality assurance arrangements.

13. Extend the range of housing provision available to homeless 16- and 17-year-olds and for care leavers so that no young person is placed in bed and breakfast accommodation.

14. Ensure that all children looked after can access an independent visitor when necessary, and that the impact of advocacy is subject to evaluation and review.

15. Ensure that all children looked after have timely initial health assessments.

16. Improve the monitoring of educational progress of children looked after so that action is taken to narrow the gap in attainment compared with all children in Darlington.

17. Improve the consistency and quality of personal education plans and ensure that the pupil premium is effectively utilised to improve the educational attainment and achievement of looked after children.

18. Ensure that reports are completed on fostering and adoption services every six months so that elected members, senior leaders and other stakeholders receive information about performance, standards, achievements and service developments in line with national minimum standards.

Summary for children and young people

- Inspectors found that services in Darlington overall are inadequate, although some parts of the service are good and others are improving. Managers do not always make sure that children and families receive a good social work service or receive the help they need quickly enough.
- Social workers and managers care about and are committed to helping children and families, but not enough children have good assessments and plans. Too many children and families wait too long to have their problems looked into. Some assessments do not explain clearly what help children need and some plans do not explain what will happen and when. We have asked the local authority to learn from the best examples of assessments and plans so that all children receive a good service.
- Children's centres, schools, health services and other partners work well together to support many children and their families when they first need help. The council needs to do more to make sure that all children are getting the help they need early enough. The family intervention team is helping lots of children and young people get the help and support they need.
- The local authority needs to work harder to make sure that all children's views are listened to, understood and written down. The Darlo Crew (Children in Care Council), are working hard to help the council understand what it is like to be a looked after child and how to make services better.
- Most looked after children and young people live in good foster homes and good children's homes. They are usually able to live with their brothers and sisters in homes that are not too far away from their families and friends. The local authority supports young people to live with their foster carer after their 18th birthday, and this is good. We have told the local authority that it is not acceptable for 16- and 17-year-old young people to live in bed and breakfast accommodation if they cannot live at home and are homeless.
- The local authority is working well with schools and colleges. Looked after children attend school regularly but not all have good enough plans to make sure they are getting enough of the right help. We have asked the council to improve personal education plans and to look at developing its own apprenticeships.
- The local authority is in touch with most care leavers and we have seen that care leavers are well supported and given lots of opportunities. We have asked the local authority to write a handbook for care leavers so they fully understand their entitlements.
- Children who have a plan of adoption do well and are placed quickly with their new families.

The experiences and progress of children who need help and protection	Inadequate

Summary

The service for children needing help and protection in Darlington is inadequate. When children need an assessment, a significant number have to wait too long for their need for help and protection to be assessed. This inspection identified a high number of assessments (94) that were not completed within timescales agreed by managers, and too many children were therefore left in situations of unassessed risk.

Where performance reports have shown the majority of current assessments to be out of timescale, management action to respond and to ensure children are safe and receiving timely services has been inadequate. When children do receive an assessment they are not always comprehensive and focused on every area of risk. While some examples of good practice were seen, in too many cases assessments were of poor quality and in the worst cases children were left at potential risk.

Where immediate safeguarding concerns are dealt with by the multi-agency safeguarding hub (MASH), the coordinated initial responses, including detailed multi-agency strategy meetings, ensure action is taken to protect children. In a small number of cases delays were seen in the completion of child protection enquiries due to delays in progressing joint interviews with the police to secure best evidence.

Children do not always have their plans reviewed in time to make sure they are making good progress. A high number of child protection conferences (98) have been postponed in the last year in part because assessments and reports are not ready on time. Some children are not seen in line with their plans, so workers cannot always be sure that risks are reducing. A high number of challenges by child protection chairs in the last 12 months due to poor practice has not been formally recorded and collated, and there has been no formal escalation of concerns.

The multi-agency response to child sexual exploitation is reducing risk for many children and young people and, in cases seen, front-line practice is well-coordinated with effective work evidencing reduced risk. The work is linked with missing children through the Missing and Exploited Group, which recognises that more needs to be done to improve the quality and timeliness of return interviews, and to raise awareness of the risk of child sexual exploitation in schools and the community.

The family intervention team (FIT) provides effective support to families and is the key element of the authority's response to troubled families. A range of early help services is signposted to families by the Child Access Point (CAP). Some early help services are resulting in positive outcomes for children, but services are not always well-coordinated and targeted. Insufficient provision for 16- and 17-year-olds who are homeless means that too many are placed in bed and breakfast accommodation.

Inspection findings

19. The service for children needing help and protection in Darlington is inadequate because when children need an assessment, a significant number have to wait too long for their need for support and protection to be assessed. Inspectors found 94 cases where there was delay in the completion of assessments. In too many of these cases, children were left for too long in situations of unassessed risk. This is a significant failure by senior leaders to ensure that the most vulnerable children receive a timely social work service.

20. The local authority has failed to implement an effective system for monitoring and managing the single assessment, which was introduced in Darlington in September 2014. Where assessments are timely, this is as a result of individual managers implementing their own systems to ensure that timescales are met, rather than a coherent and systematic approach to making sure children are receiving help and support in a timely way. Senior leaders were aware of the high numbers of assessments that had not been completed within timescales set by managers, but had not taken sufficient action to address this serious problem.

21. An unequal distribution of workload across social work teams results in some social workers having unacceptably high caseloads. This, together with some inexperienced social workers not receiving regular supervision and support, has resulted in a failure to prioritise and progress work effectively, and has left children waiting too long for the help they need. Inspectors referred 11 cases back to the local authority for a formal response due to children being left at immediate risk of harm or assessments being insufficiently robust to ensure that children are protected. Other cases of concern raised by inspectors led to further remedial action by the local authority to ensure that children were effectively safeguarded and receiving appropriate services. It is concerning that if inspectors had not identified these cases, children would have remained at risk.

22. Performance reporting on the timeliness of assessments completed by the MASH and area teams shows that too many are out of time. At the time of the inspection 49% of assessments (94) had missed the deadline set by the manager for completion. The average number of working days by which the deadline was missed was 38. Of the late assessments, 15 were over 70 days past their deadline and the worst case was 139 days over. This is a serious concern. In addition, 20 cases had no timescale set for the completion of the assessment. When reviewed by inspectors, there were too many cases where children had not been seen and risks not been assessed. During the inspection, the council took action to address the backlog of assessments. When these closed assessments were sampled by inspectors, there remained too many examples where assessments had not been completed or were inadequate, and further cases were referred back to the local authority.

23. When children do receive an assessment, the quality is too variable. Although some good assessments were seen, the majority require improvement and in too many cases assessments are inadequate. Most assessments lack chronologies, and historical information is not always considered to support an incremental analysis of risk. This was a particular feature in cases of neglect, meaning that some children are left too long in this situation. The child's needs and timescales are not prioritised in all cases, so that parents are given too many opportunities to 'start again' and this delays decisions about the child's need for stability and security. Significant male adults are not always involved in assessments and this means that a holistic approach to risk and need is not always taken. The rationale connecting the outcome of assessment to the decisions made as a result is not always clear.

24. Better examples of assessments were characterised by a clear focus on the child, with timely interventions to meet need and effective analysis of risks and protective factors. However, this level of practice was not consistent, and the high variability in the quality and timeliness of assessments is a critical area of concern. Where there is poor practice, the impact on the child is potentially serious.

25. Delays in information being effectively shared in an initial child protection conference (ICPC) means that too many children experience delay in plans to reduce risks to their safety and protect them. According to the council's own figures, over the last 12 months, '98 child protection conferences (number of children) had to be rearranged. The main reasons were as a result of no social work report, cases being stood down as waiting to go to court, professionals being unable to attend, and a change in social worker where they had no contact with the family'. Performance on the timely completion of initial child protection conferences has deteriorated from 92% completed within 15 days of the strategy meeting (2013–14), to 79% (2014–15). In-year performance to July 2015 has further reduced to 73%.

26. Child protection conferences observed during this inspection were well-chaired, with risks thoroughly explored, the effective participation of parents and professionals, and a clear focus on the child. Children's views were well-represented through the use of 'My Conference Pack', with good examples seen of the child's view influencing the plan.

27. All children who are identified as needing a child in need or child protection plan have one. Children subject to plans receive a range of support from partner agencies to meet the distinctive needs of different family members. For example, the FIT works with many children on plans, and its staff are persistent and tenacious in building and maintaining effective working relationships. The team provides a range of good quality support such as therapeutic and one-to-one work, and this is making a positive difference to children's lives. Some core groups and review conferences are regular and well-attended, and this too makes a positive difference for a minority of children, with timely and effective multi-agency working leading to good outcomes. Minutes of core groups are

not always shared in good time with all core group members. This is an outstanding recommendation from the last inspection.

28. Multi-agency practice is not always consistent and the quality and coordination of services is too variable. A very high number of challenges to agencies (157) by child protection chairs in relation to a range of practice issues in the year to March 2015 includes 57 to social workers. However, there is no formal system to record and collate these concerns and the formal escalation policy has not been used. Opportunities have therefore been missed to learn lessons and improve services for children on plans. Senior leaders have not ensured that effective systems are in place to keep them formally aware of the extent of poor practice.

29. Too many children are not seen in accordance with the timescales set in their child protection plan. This means that they do not have the opportunity to build meaningful relationships with social workers, their views are not always known, and social workers cannot be sure that risks are reducing. According to the council's own figures, which senior managers accept can be deficient, the percentage of children who are seen in accordance with the timescale specified in their plan was only 68% in June 2015 and in-year performance shows that this has deteriorated further to 44% at the time of the inspection. This is well below 2013–14 levels of 58% in England and 74% in comparable authorities.

30. In most cases, child protection and child in need plans are not specific enough about what needs to change by when and do not establish progress measures. This means children and their families may not be clear about what needs to improve and compromises the ability of professionals to monitor whether risk is reducing. Nevertheless, some social workers in Darlington know children well and complete thorough assessments that do lead to detailed plans. Where plans for children were judged good, they were well focused on key issues of concern for the child, with clarity on what needs to change and outcomes and timescales integral to the plan. Parents spoken to in these cases understood the plan and what needed to happen to secure positive change.

31. The early help strategy was implemented in 2014 but is not accompanied by a development plan to support the implementation of an early help offer. This means that the local authority cannot be assured that sufficient progress is being made to ensure children and families receive help that is appropriate to their specified needs, or that they receive it early enough to prevent problems escalating.

32. The local authority offers a range of multi-agency, universal early help services and targeted programmes across Darlington through children's centres, schools and the FIT. Children's centres are appropriately located in communities where the level of need is greatest. Surveys report 98% of centre users are happy or very happy with the service they receive, and parents spoken to by inspectors value the services provided such as the transitions group for pre-school children, which they report is helping their children develop social skills and

settle into school more quickly. However, uptake and completion of parenting programmes based in children's centres is very low (the completion rate was only 26% in 2014–15) and while the council is aware of this, action to provide an alternative offer of parenting support through children's centres has been too slow.

33. All universal and targeted services for children in Darlington are managed through a single point of contact at the CAP. CAP workers effectively signpost contacts to the appropriate early help service. However, this work is not sufficiently coordinated across Darlington as there is no comprehensive system for the quality assurance of assessments completed under the Common Assessment Framework (CAFs). This means that managers are unable to target improvement activities and provide training arising from quality assurance arrangements. The quality of CAFs is too variable. Targets and timescales are not always clear, so it is difficult for the lead professional to monitor the impact of the CAF and the effectiveness of support arrangements.

34. The number of CAF assessments completed reduced from 366 in 2013–14 to 312 in 2014–15, but recently numbers are increasing as a result of CAP workers helping to support lead professionals to undertake this work.

35. Families with the most complex needs have been identified and targeted effectively as part of the Troubled Families programme. The local authority reports that by May 2015 all 275 families have been 'turned around'. There are also many examples in evidence of very effective work with families delivered through the FIT. Some cases seen show evidence of good support, for instance in direct work to establish parental routines and in the management of children's behaviour, and this is making a positive difference to families' lives.

36. The CAP ensures a prompt response to contacts and referrals to children's social care. The quality of referrals seen was mostly good. In the majority of cases referrers are informed about the outcome of their referral. Cases that do not meet the threshold for children's social care are passed to the Darlington allocations meeting (DAM), where there is appropriate multi-agency consideration of children's needs and timely referral to other services. In the vast majority of cases seen, thresholds were appropriately applied and arrangements to step down services from statutory intervention were managed well. When children need a social care intervention, referrals progress promptly to the MASH.

37. When immediate child protection concerns are identified, the initial response of the MASH is effective. This is also the case with the response of the children with disabilities team. This means that children are seen, clear initial action is taken to reduce risk, and the views of children are taken into account. Strategy discussions are timely, well-attended by agencies and appropriately recorded. Child protection (section 47) assessments are not all timely (only 69% progress to initial child protection conferences on time) and the format for recording these assessments does not support clear management oversight to ensure

work is completed within timescale. However, in cases examined by inspectors, no children were identified as being left at potential risk at this stage of the child protection process.

38. Multi-agency responses to domestic abuse are effectively underpinned by a clear strategy. Police screening of all domestic abuse referrals to the MASH, means that those children most at risk are effectively prioritised, and action to address risk is timely. In all cases seen, the thresholds were appropriately applied and service response from the MASH was timely. Multi-agency risk assessment conferences (MARAC) are effective, with good information-sharing resulting in timely plans to reduce risks to children. However, the progress of plans is limited because there is an insufficient number of programmes for low level perpetrators, victims or to support children who have witnessed domestic abuse. The local authority does not routinely gather data on this area of service, and this means that it cannot be assured that it has services in place to meet need.

39. Although work with homeless 16-and 17-year-olds is underpinned by a clear joint-working protocol that is compliant with case law, insufficient provision has been made for these vulnerable young people. As a result, 12 young people have been placed in bed and breakfast (B&B) accommodation since July 2014. There were two young people in B&B accommodation at the time of this inspection. The use of B&B accommodation is not monitored by the council and senior managers cannot therefore be assured that vulnerable young people are not exposed to risk of harm.

40. The multi-agency service response to meeting the needs of children vulnerable and/or at risk of child sexual exploitation is reducing risk in most cases seen. The number of children assessed as vulnerable to child sexual exploitation has remained stable over the last two years. There were 27 cases in 2013–14, 32 in 2014–15 and there are currently 25 known cases of on-going work with children at risk of child sexual exploitation. The local authority knows these children and young people well.

41. Multi-agency front-line practice to respond to missing children and sexual exploitation is mostly well-coordinated through the Missing and Exploited Group (MEG). Children at risk are tracked effectively and a dedicated child sexual exploitation worker provides one-to-one support for children at high risk and supports key workers for the other children. Direct work is focused on reducing risk and practitioners effectively target young people who are hard to engage. A thorough mapping exercise earlier this year has resulted in better intelligence, leading to the earlier identification of potential victims who are now being supported through direct work from the child sexual exploitation worker. This work also identified specific high risk areas of the town, particularly public parks, and these are now targeted for patrols by police community support officers. Risks posed to children are assessed using a clear 'CSE matrix', which is widely disseminated and used routinely by front-line professionals.

42. The MEG effectively links child sexual exploitation activity to missing from home and care data. Partners from the secondary behaviour and attendance panel also sit on the MEG so that information about the education of those known to be at risk is shared. However, information about those frequently absent from schools is not routinely considered. The number of children missing from home has remained stable over the last two years, with 11 children reported missing in 2014–15. Clear arrangements are in place to monitor associated risk factors, such as substance misuse, with agencies working together effectively to provide joined-up services. Data on the timeliness and completion of return home interviews is not sufficiently detailed, so that agencies cannot be assured that all children have been offered one. Together with the poor quality of recording of many interviews, this means that information on return interviews is not captured to inform plans for children, nor is information collated across the local authority to inform local intelligence. The MEG is aware of this deficit and an action plan to tackle it is in place.

43. The local authority and schools work together effectively to locate children missing education and promote their welfare. Bespoke support and intervention packages are swiftly put into place to enable the child or young person to stay in education. The most vulnerable children and young people in the authority therefore benefit from all agencies being clear about the potential risks that exist for them. As a result, over the last three years, using the government's statutory definition of out of education for 20 days there have been no children missing from education. In addition, no children have been permanently excluded from school in the last three years. The authority knows the numbers of children on fixed term exclusions, which have been on a declining trend over the last three years, from 667 in 2011/12 to 500 in 2013/14.

44. There are currently 79 elective home educated (EHE) children in Darlington. Reasons for elective home education are assessed and any patterns or trends are analysed. Of these 79 children, 67% are from the Gypsy or Roma traveller communities. The EHE worker, traveller health worker and traveller education service work in partnership to gain the trust of the Gypsy or Roma communities and provide services such as education materials, and advice on programmes as well as information about other educational opportunities. The local authority tracks the children when out of area and monitors their return at key times in the calendar. The authority recognises that their current tracking processes are insufficiently robust with regard to planned returns to the area by travelling families, and are amending their processes and checks to be more rigorous.

45. The local authority maintains an appropriate record of children and young people who are accessing alternative education provision. It monitors the quality of this through a partnership group including schools, which commission the provision. The majority of alternative provision is provided through Rise Carr College, a pupil referral unit that was graded good in its recent Ofsted inspection. The local authority holds up-to-date records of all children who are not receiving their entitlement to 25 hours of education. These detail the hours

each young person is accessing education, the locations of their education and the reasons why they are not accessing 25 hours of education.

46. Ethnicity and culture are not consistently understood or addressed in all cases. Ethnicity is not reliably recorded by children's social care, so the attention given to this important aspect of assessments and plans is limited. Cases sampled by inspectors did not demonstrate a good understanding of different cultures and consideration of culture and heritage was not routinely addressed in assessments and plans.

47. The provision made for the local authority designated officer ensures that response to risk to children from people in a position of trust is effectively coordinated on a multi-agency basis. The designated officer is always available and a swift response is made to referrals. There are good links to the safeguarding unit and the MEG to share intelligence. Awareness-raising has ensured agencies know and understand the role of the designated officer and referrals are rising as a result, with 30 cases in 2012–13, 45 cases in 2013–14 and 56 cases in 2014–15. There were also 131 contacts seeking advice, information and guidance. However, insufficient work has been done to raise awareness of the designated officer across the diverse communities of Darlington, such as the faith communities.

48. Private fostering arrangements meet statutory requirements. A programme of awareness-raising is supported by the distribution of suitable publications and posters. Privately fostered children are allocated to a social worker and assessment, review and statutory visits are all timely. This ensures that the small number of children considered eligible are seen and their needs assessed well.

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Services for children looked after are not yet good. Independent reviewing officers' (IROs) oversight of plans, including the need to secure timely permanence plans, is not sufficiently robust. When IROs do provide challenge, this is not recorded and there is no system to track or monitor challenges and ensure improvements.

The local authority has yet to complete its review into the significant use of section 20 of the Children Act 1989, despite a recent court judgement questioning the legitimacy of its application. In the vast majority of cases sampled by inspectors, the use of section 20 was appropriate, although recent practice in a small minority of cases still resulted in delays in decisions to secure legal permanence in children's care. Without a review of all cases, the local authority cannot be assured that all section 20 arrangements are appropriate or necessary.

Care plans for most looked after children are regularly reviewed, but not all plans are informed by up-to-date assessments to ensure they reflect the child's changing needs. Personal education plans do not identify targets and outcomes and systems for monitoring and tracking children's progress are not robust. For some children, this means that may not receive early enough the help they need to achieve their full potential.

The quality of court reports is improving and timescales for completion of care proceedings are good, averaging 21 weeks during 2014/15 and 25 in the first quarter of 2015/16.

Children looked after know their social workers well and receive regular visits. Parents and family members are appropriately consulted. Contact plans are carefully considered and contact with family members is well organised, so that children are able to maintain important relationships. Children looked after have access to good quality therapeutic support and a wide range of recreational activities, and this improves their emotional and physical well-being. The timeliness of initial health assessments, although improving, is still well below the national average.

Most children looked after live in stable placements. When children have a plan for permanence this is progressed robustly. Children who need adoption receive good quality planning and support from the adoption service. Prospective adopters and special guardians are assessed, trained and supported well and the quality of post-adoption and post-special-guardianship-order support is a particular strength.

For the majority of care leavers, outcomes are positive and stable, with a high proportion in touch with their personal advisors and currently in suitable accommodation. 67% of care leavers are in education, employment and training, well above the national rate in 2013–14 for all care leavers of 45%.

Inspection findings

49. At the time of the inspection 194 children were looked after by the local authority which is a comparatively high figure. The stable and experienced looked after and through care team provides a service for children looked after once they have a plan for permanence, and this includes permanent fostering and residential care arrangements.

50. Inspectors did not see any children or young people entering care who should not have done so, though a small number should have been accommodated earlier. The decision that children should become looked after is made at an appropriately senior level. The rate of children coming into care, at 83 per 10,000, is significantly higher than the England rate of 60 per 10,000, and the reasons for this are not fully understood by the local authority. It believes that the higher referral rate and increased placements with connected persons are contributory factors, but this requires further analysis. At 31 March 2014, 54% of children looked after were accommodated under section 20 of the Children Act 1989, far in excess of comparable authorities (20%) and England (28%). At 31 March 2015 this had reduced to 47% and currently stands at 40%. This is still a high figure and a recent family court judgement criticising the local authority's use of section 20 has yet to lead to a comprehensive review despite assurances to the LSCB that this would be completed by May 2015.

51. In the vast majority of cases sampled by inspectors use of section 20 was appropriate, although in a small minority of cases recent practice had still resulted in children left subject to section 20 arrangements for too long. For example, it led to delays in decisions to secure legal permanence, although appropriate decisions have now been made in all such cases. The Child and Family Court Advisory and Support Service (Cafcass) had raised concerns about delays in securing legal permanence prior to the judgement in February. A legal gateway panel has now been established and partners including Cafcass report that this is beginning to have a positive impact. However, without a review of all cases, the local authority cannot be assured that all section 20 arrangements are appropriate or necessary.

52. The council's legal services team is now quality assuring court reports and this arrangement was seen during this inspection to be driving improvements in the quality of reports presented to court. When care proceedings are issued, timescales for completion are good, averaging 19 weeks during 2014–15 and 25 weeks in the first quarter of 2015–16. The vast majority of children returning home do so with the benefit of an up-to-date assessment and support plan. However, a very small minority (two) have returned home without an updated assessment, although support from the FIT is in place. This does not maximise the potential for successful rehabilitation. Numbers being readmitted to care are low: in the last 12 months four children from two families came into care for a second or subsequent time.

53. Children receive regular visits from social workers and this means they get to know them well. Social workers see them on their own and take time to make sure they understand their wishes and feelings. Most children looked after know their rights and entitlements and are advised on how to access an advocate. The take-up from the commissioned service is increasing, but only one child looked after has an independent visitor. Advocacy outcomes are not evaluated, so the impact has yet to be evidenced. No complaints have been lodged by a child looked after since 1 September 2014. The complaints information leaflet has recently been revised by the Darlo Care Crew and will be reissued to all children looked after to ensure that all understand and feel able to use the process.

54. In assessments undertaken in respect of looked after children, the views of parents are well recorded. They are invited to reviews, and contact plans are of good quality. Supervised contact is often undertaken by the same officer, which makes it a more productive session for both child and parent. Other agencies are appropriately consulted and most children looked after benefit from good quality multi-agency engagement.

55. Children's care plans are not routinely informed by up-to-date holistic assessments. Reports for reviews do include current information about the child, but these are not always sharply focused on progress against the care plan. Too many care plans lack clear targets and timescales. In these cases it is not clear how children's needs will be met and when.

56. Care plans are regularly reviewed, although recent capacity issues, which are now resolving, have in a small number of cases impacted negatively on the timeliness of reviews, with 93% completed within timescale as at 31 March 2015. Lack of capacity has also affected IROs' ability to speak with the child before their review. IROs' oversight of plans, including the need to secure timely permanence plans, is not always rigorous. When they do provide challenge to the progress of care plans, it is not recorded and there is no formal system to ensure that challenges are addressed by social workers and their managers. This also means that informal challenges are not formally escalated and IROs cannot be assured that they are driving improvement so that children receive a timely and appropriate service.

57. The large majority of looked after children benefit from a stable and secure placement. Nearly two thirds of children remain in the same placement for two years or more in Darlington, which is just below comparable authorities and the England average of 67% as at 31 March 2014. A slightly higher percentage of children than the national average had three or more placement moves during 2013–14 (13% compared with 11%). Through their effective sufficiency strategy, the local authority is taking appropriate steps to improve stability by enhancing both placement choice and quality. It is taking a collaborative approach to commissioning either through the NE Ten (a collaboration of 10 local authorities in North East England, or the Tees Valley Five (a collaboration of the five local authorities in the Tees Valley). Through the former for instance,

a national service has been commissioned to provide advocacy. The latter has commissioned independent fostering agency (IFA) placements. It is now extending this approach to residential placements as although there is a surplus of residential placements within the local authority boundary, thorough needs analysis demonstrates that they do not meet some of the complex needs of the young people requiring them.

58. The fostering sufficiency strategy sets out appropriate targets based on past activity and projected need. It addresses both internal and IFA recruitment targets which are consistent with the local authority's overall Looked After Child Strategy 2015–17. This includes recruitment to ensure children are placed together locally where possible and in accordance with their care plans. Of a total of 148 foster placements, including IFA placements, 63% are within the local authority boundary and 31% are located in neighbouring local authorities. Of the seven foster placements at a distance, two are with connected persons. There are also seven residential placements at a distance and these have been commissioned to meet the specific needs of the children concerned. The health and education co-ordinators ensure that children living out of borough access an appropriate range of services to meet their needs.

59. The targeted approach taken to fostering recruitment has successfully increased the numbers of in-house foster placements to 98. The current targets outlined in the strategy are well thought-through and realistic in meeting need, and will be further revised when spare recruitment capacity is released from the adoption service.

60. Once court decisions have been made about legal permanence, achieving timely permanent placements for children looked after is a strength in this local authority. Adoption and fostering work is allocated and managed within the same team of social workers. This helps to reduce delay and ensures continuity of foster carer support social worker when children's plans and placements change. The team is stable, well-managed and the standard of practice seen is high. There is no annual report from the fostering service and this means that the local authority and stakeholders do not receive information about performance, standards, achievements and service developments.

61. Foster carers are recruited, trained and supported well and they confirm that they receive a good service from the local authority. Carers receive regular supervision and training and they contribute well to children's planning and reviews. Where it is in children's best interests to be fostered on a permanent basis, their placements are formalised by the authority's well-managed Family Placement Panel. Where there are no in-house permanent fostering placements Darlington Access to Resources Panel (DARP) approves the purchase of a placement from the independent sector. Currently there are no children waiting for long term fostering placements. Six long term placements have disrupted over the past year and although this learning was used to inform future matching for the children involved, it has not been used for wider practice and service development.

62. Six special guardianship orders (SGOs) were granted during 2014–15, and three more in the first quarter of 2015–16. Special guardians receive timely assessments and good plans are put into place, supported by the specialist post-order support worker. However, some children in stable long term foster placements would benefit from a more systematic consideration of their foster carers applying for an SGO to enable them to leave public care.

63. The local authority, the Virtual School and all partners have high aspirations for children looked after, which is reflected in improving outcomes. The percentage of children looked after who are accessing the two-year-old offer for nursery provision in good or better settings stands at 90% and is well above the national average for all children (71%). The local authority reports that, in 2014, Key Stage 2 results in reading, at 68%, matched the levels for all looked after children nationally. Writing and mathematics were at 100%, compared with 59% and 61% in England, although this represents only three children. The gap between looked after pupils' achievement and that of all children is narrowing in writing and mathematics, though not in reading.

64. Performance in the GCSE examinations at five A* to C grades, including English and mathematics, is improving but from a very low base. The low numbers of looked after children eligible to sit examinations means that percentages can fluctuate and comparison from year to year is difficult. In 2012/13 no young people gained five or more GCSE grades at A* to C level including English and mathematics. In 2013/14 this had risen to 20% (two children) compared with 16% of children looked after nationally and 64% of all children in England. The rate of progress is not yet rapid enough to close the attainment gap, and strategies to address this are not yet in place. The Head of the Virtual School has not yet established adequate monitoring arrangements for tracking children's progress. He is allocated only one day a week for this role and this limited capacity has limited the progress made.

65. The Head of the Virtual School and the looked after children education coordinator have successfully ensured that all children, including those living out of borough, are now in good or better schools. The Head is very proactive in managing movement between schools for looked after children and, as a result, schools report that children settle into new provision well. Data on school exclusions shows no permanent exclusions over the last three years and this is confirmed by local schools. Fixed term exclusions have been reducing over the same period but in 2012/13, at 13%, were still higher than the regional average for children looked after of 8% and the England average of 10%. In 2014 the percentage of unauthorised absences for children looked after was, at 2.6%, higher than the SN of 0.8% and the England average of 1%. No child looked after is missing from education when defined as those children who are out of education for 20 days.

66. Appropriate plans and supporting strategies are in place to support the step up to full time education for five children who are accessing alternative provision. All are children looked after and all currently receive less than the minimum

requirement of 25 hours education per week. Two attend the pupil referral unit at Rise Carr College and the local authority monitors the quality of this provision through a partnership group of commissioning schools. This provider was graded good by Ofsted in its recent inspection. The curriculum is varied and challenging for young people, with high aspirations for them to achieve a range of GCSEs at A* to C level. Young people also have access to a good range of enrichment activities such as canoeing, rock climbing, archery, arts projects and educational excursions. This helps to build confidence and widen their horizons.

67. The majority of personal educations plans (PEPS) require improvement. There are some examples of effective target setting with specific goals and appropriate support in place to help children and young people reach their potential. However, in most cases, targets and timescales are not clearly recorded and this makes measuring progress difficult. While many plans contain detailed information about the child or young person, this information is not always used well to identify key issues and actions required to support educational progress. The voice of the child is not routinely captured in PEPs and not all PEPs identify how the pupil premium is used.

68. During the last quarter, 55% of initial health assessments were completed within timescales and this has increased to 61% in the last month. This is improving, but performance is not yet good enough and the system's requirement that parents have to sign two forms continues to hamper progress. Performance regarding review health assessments, dental checks and immunisations is good and all are above the England average. Up-to-date immunisations are, at 94%, an improvement on 2013–14 when they were at 85% and the England average was 87%. Dental checks stand at 93%, the same as 2013–14 when the England average was also 93%. Completed annual health assessments are at 94%, an improvement on 2013–14 when it was 93% and the English average was 88%.

69. Strengths and difficulties questionnaires (SDQs) do not systematically inform health assessments. However, the FIT has recently reviewed the emotional health needs of all school age children looked after using SDQs. Where there are concerns, the FIT therapy service consults with the child's social worker about the need for therapy. There is good access to therapeutic services located in FIT and in child and adolescent mental health services. Children looked after have free and reduced rate access to local leisure activities through the LIFE card and the Healthy Darlington offer.

70. Senior managers identify when children looked after go missing, and monitor those deemed to be at high risk, particularly of sexual exploitation or criminal behaviour. Thirteen children had missing episodes between January and June 2015, of which 11 were children looked after. Procedures are appropriately followed by foster carers and residential staff in reporting the looked after child missing and seeking to locate them. Return interviews are undertaken by independent persons, although they are not offered after every missing episode. In most cases these are used to inform risk assessments and future

plans. Data on substance misuse by children looked after is not collected by the local authority, although young people can and do access the substance misuse services provided by an independent provider. A close working relationship between youth offending services and the looked after and through care team helps to ensure appropriate preventive work and support for young people when remanded in care. In 2013–14 10% of children looked after were convicted and cautioned compared with 7% in comparable authorities and the English average of 6%. During 2014–15 this reduced to 8% which represents seven young people.

71. A small number of children looked after of Black or Asian minority ethnic origin have not had their needs arising from diversity assessed well or planned for, indicating a lack of awareness among social workers of their distinctive needs. Foster carers receive training on how to protect children from bullying, homophobia and discrimination.

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

72. Achieving timely permanent placements for children who need adoption is a strength in Darlington. A significant proportion of looked after children are being adopted and increasing numbers of adopters are being recruited. The quality of preparation of adopters is good, as is the quality of adoption support. This means that security for children in the form of a stable permanent family is achieved in good time in many cases.

73. Adoption and fostering services are both provided by the family placement service. The social workers in this team are allocated both fostering and adoption cases. This means that children and carers are able to have continuity of worker when children's plans change from foster care to permanence through adoption. It also helps to avoid delay in progressing children's plans. The team is well-managed, stable and experienced. The family placement and looked after children's teams are located in adjacent rooms and there is regular formal and informal communication between the two services, which also helps to progress children's plans in a timely manner.

74. Children who need adoption placements are identified early by social workers, IROs and in care planning meetings. Workers use an effective matching tool to assess children's individual needs and identify the most suitable adoptive carers. The progress of plans for children who may need an adoptive placement is closely tracked and monitored. Cases within the family placement service are regularly reviewed by the team and its managers, which means they are familiar with the circumstances of all children who are waiting for permanent placements. The progress of children's contingency plans and the availability of suitable carers for children are also considered in these meetings. The meetings are recorded, so the progress of plans can be tracked and any potential delay is addressed. Life story work is undertaken with children, and social workers and

carers are trained and encouraged to contribute to children's information about their past.

75. Where permanence has been agreed, social workers plan and support contact well and in the best interests of children. There are robust arrangements in place for the management of letter-box contact. In cases reviewed by inspectors, contact was well planned and discussed in detail at the children's reviews. Counselling support to birth parents is provided through a contract with a small local charity and this is a well-used resource. All children who required adoption placements with their brothers or sisters were placed together last year.

76. There are increasing numbers of children being adopted. In 2014–15, 23 children were adopted compared with 20 in 2013–14 and 10 in 2012–13. There are 19 children awaiting adoption as at 31 March 2015 and four children whose plan had been changed from adoption to an alternative plan in the previous 12 months. In all cases this decision was appropriate. In the previous three years only 9% of children's plans were changed from adoption, which demonstrates that adoption is achieved in a very large majority of the cases where it is the plan for the child.

77. Adopters are recruited, prepared and trained to a high standard and the current average time between prospective adopters registering an interest and being approved is six and a half months; two weeks longer than the national target. Inspectors saw evidence of good quality recruitment and assessment practice, which was confirmed by adopters who spoke positively about the standard of communication, preparation, training and support from the family placement service.

78. Adopters are given clear and accurate advice about the different options available to them, including fostering to adopt, use of the adoption register and, more recently, Adoption Link. The authority has assessed one fostering to adopt placement with a new carer. Discussions have taken place to develop concurrent adoption and fostering placements collaboratively across the region, although there are no current applicants being considered in Darlington. Adopters are also helped to make decisions about the type of children they may be able adopt and about the support available to them both before and after approval. In particular, the post-adoption support and training available to adopters both from within the local authority and through external trainers were valued by adopters and seen to be making a positive difference for children.

79. Applications to adopt are progressed in a timely way by the local authority and are of a good quality. Recruitment of adopters increased significantly from 10 in 2012–13 to 16 in 2013–14, and the local authority reports an increase to 20 in 2014–15. This has been more than enough to meet the authority's needs for adoption placements and the target for next year will be reduced, so that adopters do not wait too long for placements and resources can be redirected

to the recruitment of more foster carers and to improve support to both foster carers and adopters. Graduate interns with expertise in marketing and needs analysis have been recruited to bring new ideas and extra capacity to the recruitment of adopters, and the authority has successfully attracted applicants from nearby communities who can meet the needs of Darlington children.

80. An active local adoption consortium with four neighbouring authorities means that recruitment, training and matching are organised collaboratively across the local area. Darlington has traditionally assessed any applicants who live in the local area, but because the town is small, most adoptive placements are made in neighbouring local authority areas. A very small minority of children in the area are from black and ethnic minority backgrounds and no children from these communities are reported to be waiting for adoption. The authority has taken no specific action to recruit carers from these communities.

81. Using the national adoption scorecard measure of average times over three years, the length of time between children becoming looked after and being placed for adoption improved each year since 2011 and stood at 431 in 2013–14 compared with the national average of 628 days. The local authority's reported performance against this measure has deteriorated in the past year and, at 519 days, is below the central government target of 487 days but still better than the last reported national average of 628 days for 2014. This is reportedly due to the authority persevering to achieve adoption for a sibling group of three older children where it was clear that it would take some time to find a suitable placement. In this case, the local authority's decision was in the best interests of the individual children concerned and they have now been adopted by their former foster carers.

82. The scorecard also measures the average time taken from the local authority receiving court authority to place a child for adoption, to matching them with adopters. The three-year average for 2011 to 2014 was 111 days, which is very good performance and much lower than comparable authorities' three-year average of 247, and the England average of 217 days. The authority's performance against this measure during the past year was reported as 238 days.

83. The quality of post-adoption support is good. In cases seen by inspectors this ranged from relatively simple requests, such as help with funding for a holiday, to complex packages of therapy or support with contact and bereavement counselling. A specialist post-order support worker works directly with children, carers and social workers to produce assessments and post-order support plans that are of a consistently high quality. The Darlington Access to Resources Panel (DARP) approves post-adoption and SGO support resources and is a source of advice, consultation and oversight of practice as well as the forum for approval of resources. During 2013–14, there were seven requests for post-adoption support and all of these received a service. In 2014–15 there were 10 requests, of which eight resulted in the provision of support. The FIT provides initial therapeutic support to adopters and adopted children, but this service has

been introduced very recently so it is not yet possible to evaluate its effectiveness.

84. A properly constituted and well-managed joint fostering and adoption panel was observed during the inspection and it has effective oversight of adoption decisions and the approval of adopters. The authority's medical adviser and legal adviser attend regularly. The family placement team manager acts as agency adviser, and carers and elected members are also represented on the panel. The panel chair gives detailed feedback about the quality of the applications to the agency decision maker (ADM) after each panel meeting, and all panel members are subject to regular annual appraisals, which informs the practice of the panel and identifies their training and development needs. Feedback from adopters who have attended the panel has been positive. The Director of Children's Services acts as ADM, and adoption decisions and the recommendations of the panel are managed and recorded in a timely way.

85. No annual report is produced by the adoption service, and there is no regular report by the adoption panel either. Although managers and elected members receive regular information about the performance of the service, this is not in a consistent format and is not collated to make it accessible. This is an omission as it means that the local authority and stakeholders do not receive a coherent overview of performance, standards of service and information about the development of the service.

The graded judgment about the experiences and progress of care leavers is that it is good.

86. Darlington is responsible for supporting 101 young people who are entitled to a care leaver service. Of these, 68 have left care already. The council is in touch with all bar three of its care leavers. This is good performance. This contact is meaningful and includes a persistent and prompt response by personal advisors to need, for instance for accommodation. Young people value this continuity highly, and it reflects the stability of staff and managers, who know young people and their histories well. Care leavers therefore feel comfortable in raising difficult personal issues with leaving care staff. The local authority is highly responsive to cases where young people are in immediate financial need, although the Darlington website contains insufficient information regarding care leavers' entitlements.

87. For a significant proportion of care leavers, outcomes are positive and stable. For instance, 'staying put' arrangements are enabling 12 young people to remain with their former foster carers after they reach 18, which is a high proportion of the authority's care leavers. Positive examples were seen of care leavers in staying put arrangements who regard their former foster carers as their families, manage their own family contact and have achieved well. These young people are also confident that the local authority will continue to support

them after higher and further education. The possibility of staying put is almost always raised with young people in a timely way. However, written information for care leavers and their carers about it is limited.

88. Pathway plans are commenced with young people at an appropriate time before their 16th birthday. This process ensures that key areas such as accommodation, employment, education and training are considered at an early stage. Care leavers have suitable access to the important documents they require. Plans include comments from care leavers and address contact with their birth families. Young people interviewed like their pathway plans and feel the process gives them a good opportunity to be fully involved in planning for their future and voicing their wishes and views. However, action plans do not always clearly specify the tasks that need to be undertaken to improve outcomes and ensure young people have all the skills they need to be independent.

89. Care leavers receive a letter detailing their final review health assessment and a summary of their current health needs. Care leavers are signed up for medical and dental services in almost all cases, although the most recent dental and health assessments are not routinely noted in pathway plans. Arrangements to support care leavers who are experiencing drug and alcohol problems are in place and provide a prompt service. However, pathway plans do not ensure that young people are provided with health histories and do not consistently address care leavers' emotional well-being.

90. Care leavers seen by inspectors understood how to keep themselves safe and protect themselves from bullying, with a clear awareness of the risks of child sexual exploitation and e-bullying. They are aware of bullying that occurs on social media sites and on other interactive technologies, including their mobile phones. One care leaver clearly articulated how her personal advisor intervened positively when she was receiving unwelcome messages on social media. Care leavers spoken to reported that they feel safe in their accommodation. There are no care leavers identified as at risk of child sexual exploitation. Leaving care workers are appropriately trained regarding child sexual exploitation and care leavers receive advice through a suitable range of discussions and structured interventions.

91. Local authority data shows that 98 of the 101 care leavers aged 16–21 live in suitable accommodation. There are currently 36 care leavers in independent living, 12 are staying put, three are in supported lodgings and four are in houses in multi-occupation. This single unit for care leavers is a commissioned service. One care leaver is currently in bed and breakfast accommodation under emergency circumstances and there have also been two other care leavers in bed and breakfast accommodation since April 2015. The local authority has not sufficiently analysed the reasons for care leavers' need for this type of accommodation.

92. The local authority currently has three 'taster' flats, which are helpfully located close to sources of support. These are used flexibly, for instance for young people thinking of moving on to independent living who want to experience it on a trial basis. While a taster placement is nominally for six months, it can lead to a permanent tenancy in the same property if required. One care leaver reported having had extensive choice and asked to be placed close to his former foster carers, a wish that the local authority respected. Care leavers were positive about accommodation, for instance its safety, décor and personalisation. The local authority is aware of the need to increase the range of accommodation provided, for instance to include single flats.

93. To date, four supported lodgings placements have been made, three of which are progressing well and only one has ended. Applicants undergo a thorough assessment process, which includes references and checks via social care and the Disclosure and Barring Service. Applicants are appropriately expected to attend the full 'Skills to Foster' training programme to develop their understanding of the key issues for care leavers. Records of the assessment process reviewed by inspectors evidenced thoroughness, and providers are well-supported through placement agreements and formal support plans. A lodgings provider commented on how well supported she felt by the personal advisor and supported lodgings staff, especially the promptness of their response when there is a need. All young people in supported lodgings continue to have a high level of support from a personal advisor with regular visits and a high level of availability.

94. Two thirds of care leavers are in education, employment and training, a significant improvement on last year's figure of 45%, and much higher than the national average of 45%. Personal advisors give good information, advice and guidance to young people on possible careers. Currently five care leavers are attending university and 26 are on further education programmes, which is good performance. Drop-out rates from higher and further education are low. Young people at university are well-supported both financially and with accommodation at vacation times. Care leavers spoken to were enjoying their A-level studies at colleges and valued highly the role of personal advisors in helping them find the right course. The local authority has recently commenced regular meetings to track those care leavers who are not in education, employment or training and encourage them to re-engage, but although personal advisors work diligently to support individual young people back into education and training, it is as yet too early to assess the impact of this exercise.

95. Almost all care leavers spoken to were enjoying their education or employment and were excited about the future. As a result, they are highly aspirational and are encouraged in this by their personal advisors. Unfortunately, local employability and study programmes have reduced, as some providers have left the area and some care leavers expressed disappointment at the limited support now available to them. The local authority has plans to meet this need. Four care leavers are on apprenticeships and another care leaver spoken to was

excited about a forthcoming apprenticeship. However, the local authority does not currently have any care leavers on apprenticeships within the council and as a large employer and corporate parent this is a missed opportunity.

96. Effective arrangements are in place for the transition of care leavers with disabilities into adult services. Similar services are not always in place for those care leavers who have mental health problems and are making the transition to adulthood. This may result in care leavers' needs not being met as adults. The local authority is aware of this issue and care leaver staff advocate for a service on behalf of care leavers.

97. Care leavers are routinely involved in the recruitment of social workers and they are regularly involved in the training of foster carers. They were significantly involved in developing the local authority's statement of care leavers' 10 entitlements and regularly meet the corporate parenting panel. This has been effective, for instance in the raising of care leavers' allowances to set up home. There have been no recorded complaints from care leavers. The local authority collects feedback sheets from care leavers regarding the services provided and these are positive. However, the local authority does not specifically celebrate the achievements of care leavers other than through the Vibe event, which covers the achievements of all children in Darlington. Care leavers have free access to the local authority's Dolphin Centre and other leisure facilities.

Leadership, management and governance	Inadequate

Summary

Leadership, management and governance are inadequate because of a serious failure by senior leaders to take oversight of, and accountability for, Darlington's services to vulnerable children. This omission leads to serious shortfalls in service provision, and these have gone unchecked. Elected members and the council's Chief Executive have not been sufficiently challenging towards children's services managers to assure themselves that children are safe.

A reliance on inaccurate performance reports combined with upward self-reporting by senior managers in children's services means that senior leaders were not aware, until this inspection, of the extent or impact of the service's underperformance. In addition, insufficient progress has been made in many areas identified as needing improvement in the last inspection. Performance monitoring lacks rigour as reports are drawn from an electronic system that is recognised within the authority as unreliable. No local targets are set and performance is reported against obsolete national targets. The council accepts that performance clinics have been ineffective in improving poor practice in some social work teams. Case audits are insufficiently robust and do not support senior leaders to maintain an overview of all aspects of social work practice. An extensive auditing process leads to generalised findings that are not clearly recorded and are insufficiently focused on driving and sustaining improvement across all areas of the service.

The effectiveness of services to children was judged to be adequate in 2012. Since then there have been improvements in some areas but overall the standard of practice for children needing help and protection has declined, as has the quality of leadership and management.

Senior leaders are not creating an environment in which good social work can flourish across all areas of the service. Workloads are distributed inequitably between the social work teams and the high number of newly qualified social workers within some teams means that more experienced workers have high caseloads, which is limiting their ability to progress work.

Strong processes are used to plan the provision of training. Social workers are highly aware and supportive of plans to give them the opportunity to share their skills. The principal social worker is adding value to the learning environment. However, her work is too focused on newly qualified social workers and could be widened to support practice development across the service.

The Children in Care Council ('Darlo Care Crew') is involved in a wide range of participation and improvement activities, including regular attendance at the corporate parenting panel and at regional, national and international events.

Inspection findings

98. Weak oversight by senior leaders results in the provision of services to help and protect children that lack consistency, with significant areas of poor practice that leave some children at risk of harm. Senior managers report that they feel they have insufficient capacity to undertake case audits in a meaningful way. A lack of rigour in managers' performance monitoring results in inconsistent service quality across teams and some practice is unsafe. Senior leaders are unable to demonstrate a shared awareness and understanding of the issues and an agreed approach to dealing with them.

99. A complex governance structure, with a high number of governance bodies and meetings between senior leaders, is not coordinated through an overarching set of service outcomes that are shared and clearly understood by all senior leaders. This situation has resulted in a general lack of clarity among senior managers about the strategic and operational elements of their role. Confusion over roles, combined with the absence of an agreed set of service outcomes, means that knowledge of and accountability for shortfalls in the delivery of front-line services is fragmented. Many of the deficits identified by this inspection were known to senior managers within children's services but they have not been tackled swiftly or effectively.

100. Performance management in Darlington is a particular weakness. Ineffective performance monitoring has resulted in wide inconsistencies in the way that services are delivered across the area, without a clear management action plan to address this. Inaccurate performance reports are drawn without data cleansing from an electronic record system that the council accepts is not fit for purpose. Targets are based on national performance indicators that were discontinued some time ago and no local targets are set. This inspection revealed several inaccuracies in reports that were drawn from the electronic record system and provided to inspectors. A consequent widespread mistrust in management reports has led some middle managers to keep their own separate spreadsheets of service activity. This is understandable but is poor corporate practice, as the lack of connectivity means that without accurate data, senior leaders cannot gain an overview of service provision and challenge poor performance.

101. Weak performance information means that services cannot be rigorously monitored for effectiveness, and this has led to the provision of services in some areas that fall below an acceptable standard and leave children at potential risk. Children's services managers meet in a cycle of performance clinics to discuss management information drawn from their quality assurance activities. These meetings are poorly recorded, and specific and measurable actions to improve poor performance are not clearly identified or monitored. Scrutiny of the case audit conducted by the council for this inspection indicates that the clinics are insufficiently rigorous and effective in identifying and correcting performance deficits. All of these activities rely heavily on front-line and middle managers self-reporting upwards to more senior managers, and are

therefore insufficiently robust in recognising and responding to serious performance shortfalls and ensuring that children are protected. This inspection identified a high number of concerns about children, and there were 11 cases within which those concerns were deemed serious and referred back to the council for immediate action.

102. Management oversight of social work practice is not leading to consistent improvement. Significant resources are allocated by the council to case auditing. However, this extensive process that audits hundreds of cases each year has not resulted in the adoption by social workers of a baseline standard of practice, in accordance with the practice standards published in the local authority's performance handbook. Action points drawn from audited cases are basic, such as instructions to assess families, see children or hold regular supervision sessions, and this indicates a very low level of practice. Compliance with audit findings is not tracked or monitored and senior managers cannot therefore be assured that all deficits identified have been addressed. Good practice is not routinely recognised and disseminated.

103. Where performance reports have identified shortfalls, such as significant delays in the completion of assessments, senior managers have not responded quickly enough to address them. Weaknesses in the individual performance of some managers and social workers have been identified but not appropriately addressed to ensure that services provide timely and appropriate responses to children's needs.

104. Senior managers are not creating a cohesive environment in which good social work can flourish across the service. The workforce is generally stable, but this masks fluctuations between the teams. Services at the front door and in some geographical areas find it more difficult to recruit and retain social workers. The current configuration of teams is inequitable in terms of workload. In localities identified as performing poorly in this inspection, services are more likely to be provided by inexperienced social workers. Where teams have a higher number of newly qualified social workers with protected caseloads, more established social workers hold a higher number of cases than their counterparts in other teams, and in some cases this means they are unable to prioritise and progress work effectively.

105. The Director of Children's Services has recognised that the current electronic recording system does not support effective social work practice and has been supported by the council in the procurement of a replacement that is planned to be operational by the end of this calendar year.

106. Criticism from the judiciary of legal planning by children's services has not led to a swift and coordinated effort to address the concerns identified in the judgment. For example, an audit of the local authority's use of section 20 of the Children Act 1989, which was specifically censured, has to date reviewed only 14 cases. Following delays, the audit is now due for completion in September 2015 with action to follow, while the judgement was publicised in February

2015. In the meantime, practice regarding the use of section 20 remains unchanged. Senior managers of the council have not previously been sufficiently challenged by their partners on the Family Justice Board to improve their performance in proceedings.

107. Elected members and the council's Chief Executive have not been sufficiently challenging towards children's services managers to assure themselves that children are safe. A reliance on inaccurate performance reports, combined with upward self-reporting by senior managers, means that they were not informed until this inspection of the extent of the service's underperformance, and they were caught unawares by inspectors' finding that children were being left at potential risk.

108. Where they are acting as a corporate parent to looked after children, the lead member for children, members of the scrutiny committee and of the corporate parenting panel can demonstrate a high degree of awareness of the barriers affecting these children's lives, and express a commitment to removing them. The lead member has a high level of face-to-face contact with looked after children, including regular meetings with the Darlo Care Crew. Senior scrutiny committee members can evidence a number of successful thematic improvements to services for looked after children, such as their dental health. Thorough monitoring and coordination of scrutiny committee agendas to avoid duplication means that improvements are particularly effective when they cut across services for both children and adults, such as services for young carers. However, a lack of rigorous scrutiny, analysis and planning means that elected members' activities are not always aligned with service priorities for children.

109. Appropriate arrangements are in place to coordinate the activities of the local authority area's statutory boards. These operate to a written protocol and currently communicate primarily through the LSCB's Prevention of Harm subgroup due to overlapping priorities. The large number of governance boards means that there is a very high level of formal and informal contact between all senior leaders, including the chair of the LSCB.

110. Health and Wellbeing Board (H&WB) members interviewed by inspectors, including the Director of Children's Services, were thus able to demonstrate a keen understanding of the borough's wider strengths and weaknesses. They described a range of suitable examples where the board had made a difference to children's lives or was planning to, such as to young people's mental health and alcohol services. One weakness identified by the H&WB is the service provided to children and young people from the Gypsy or Roma traveller communities. This shortcoming was confirmed during the inspection as a service gap that requires the board's urgent consideration. Numbers identified as receiving a service from children's social care are very small, when nationally available data indicates that Darlington has the largest Gypsy or Roma sub-population in England. Given the local prevalence, the council cannot be assured that services to meet the needs of this group are suitable to their needs.

111. Commissioning processes within the council and its NHS partners are robust. Strong analytical processes ensure that commissioning activity meets local need. A well-established methodology is in place for identifying specific needs, together with a willingness to be collaborative, creative and innovative in meeting them, as partners are operating within an environment of reduced funding. Considerable expertise within Darlington of delivering sound commissioning practice means that it is a key strength of the organisation. For example, the effective procurement of suitable care placements for looked after children in line with the published sufficiency strategy. Commissioning activities are generally undertaken effectively but their monitoring and evaluation is not always delivered well. This occurs particularly where a decision is reached to provide the service 'in house' using the council or the NHS's own services. For instance, the therapeutic social work service has begun providing services as part of the FIT without the establishment of service outcomes, and this has not happened for services that had been procured externally.

112. A suitable programme of training for social workers is delivered, using a well-thought through three-tier model of internal, partnership and externally commissioned provision. Internal training is provided by dedicated training officers and other staff with specific expertise; partnership training is sourced from partner organisations to avoid duplication; and commissioned training is sourced externally. Social workers spoken to during the inspection reported very high levels of availability of training and could provide evidence of this through extensive training profiles. The principal social worker is adding value to the learning environment by actively promoting the development of social work skills within the workforce, but her time is too focused on newly qualified social workers and it could be expanded to take a wider role.

113. The Darlo Care Crew (Children in Care Council) consists of two very active groups of children looked after. One for older young people has approximately 12 members and the other for the younger cohort has approximately seven members. The achievements of these groups are numerous and include: enhancing communication with children looked after through both social media and a quarterly newsletter; participating in the recruitment of social workers and IROs; delivering training to elected members and foster carers; attending regular meetings with councillors and officers, who they say listen to them and act on what they say; reviewing the information pack given to newly accommodated children; and attending regional, national and international events.

The Local Safeguarding Children Board

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.

Executive summary

Darlington Safeguarding Children Board meets its statutory requirements. The commitment of partner agencies to improve safeguarding is sound, as evidenced by their attendance at the board and its subgroups, and also by their financial contribution.

The board has strong governance arrangements in place and it has published an effective document on agreed multi-agency thresholds for intervention. Evaluation of child deaths where there are no concerns about parental misconduct is strong, as is the board's comprehensive training programme.

The newly appointed independent chair of the Local Safeguarding Children Board (LSCB), the joint business unit with the Adult Safeguarding Board, the involvement of lay members, and the development of a children's group all have the potential to further improve the work of the board.

LSCB learning and improvement, auditing and performance management frameworks are in place but have not been joined up to deliver a suitably thorough and detailed knowledge of gaps in the quality of services provided to the most vulnerable children in Darlington. The board was not therefore fully aware until this inspection of serious deficiencies in the delivery of assessments by children's services.

An audit to identify whether agencies are meeting their safeguarding requirements under section 11 of the Children Act 2004 is ongoing but its completion has been delayed due to lack of capacity. In the interim, issues are identified for individual agencies at performance clinics but action planning to address deficiencies has been insufficiently swift. Dissemination of learning from processes such as case reviews has been limited across the children's workforce and the wider community and there are no specific and measurable plans in place to address any identified deficits.

Intelligence drawn from a board audit has significantly improved the partnership's response to sexual exploitation.

Inspectors saw some evidence of an appropriate culture of challenge. However, there is no single mechanism in place to record what has been done to address the

board's concerns about professional safeguarding practice and challenges at a board leadership level are not routinely documented.

Campaigns to raise awareness among communities in Darlington about the risks of child sexual exploitation have been appropriately initiated. Targeted plans are firmly in place to ensure those working in licenced premises, hotels and as taxi drivers are aware of the warning signs, as potential risks to young people are not yet being fully recognised and responded to in the night-time economy.

Early help has been prioritised by the board. However, there is no designated subgroup for the governance of early help, and oversight of the effectiveness of early help services is therefore limited.

Recommendations

114. Ensure that the work programme of the board is underpinned by detailed action plans that are specific and measurable, with actions and timescales clearly set out.

115. Ensure that, on a regular basis, the board satisfies itself that statutory obligations are fulfilled across all agencies in accordance with section 11 of the Children Act 2004.

116. Ensure that performance monitoring systems consider the safeguarding work of all partner agencies, and that data supplied by children's services includes all stages of the child's journey from early help to being looked after. To include consideration of how lessons learnt from audits and case reviews are understood and disseminated across agencies.

117. Introduce a single system for recording all challenge, which is inclusive of concerns raised on individual cases, and indicates what has happened to resolve any challenge.

118. Ensure that the wider community is better aware of the risks of sexual exploitation faced by children and young people in Darlington, including what to do if they have concerns.

119. Ensure that monitoring of the effectiveness of early help provision meets the requirements of Working Together to Safeguard Children 2015.

Inspection findings – the Local Safeguarding Children Board

120. Darlington Safeguarding Children Board meets its statutory requirements but has notable areas for improvement. Some aspects of the board's operations are strong, including its training programme and its approach to analysing child deaths. Several positive developments, such as the recent appointment of an experienced independent chair, demonstrate the potential for further improvement. However, there is more to do to ensure that the board's systems for performance monitoring are sufficiently robust, and that it can demonstrate that it is operating within a culture of appropriate challenge.

121. The board has a clear governance structure in place. Effective links with other strategic boards include board members attending and presenting the messages from the Annual Report to the Darlington Partnership; the Children's Collective (former Children's Trust); the Health and Wellbeing Board; the Police and Crime Commissioner and the local Family Justice Board. The independent chair also has regular meetings with the Chief Executive and Director of Children's Services but the recording of these meetings needs to demonstrate how the chair is held to account and actions agreed.

122. The board has ensured that a multi-agency threshold document is in place in accordance with its statutory requirements. The document is of good quality and readily accessible to all agencies. Good use is made of it to inform decision-making on thresholds across the partnership, and this was observed by inspectors throughout the inspection.

123. A new independent chair commenced in April 2015 and has chaired one full meeting of the board to date. He has brought with him significant experience from chairing other LSCBs. He views the commitment of agencies across Darlington as a strength, and is looking to improve the work of the board based on the foundations already in place. He had identified deficiencies in the operation of the board that were also identified by inspectors during this review. However, his appointment is too recent and planned changes to address these deficits have yet to be implemented.

124. Strong commitment by partners to the board includes regular attendance by agencies at board meetings and active participation in its subgroups. All relevant agencies contribute to the budget, which is sufficient to deliver the board's programme of activity. A joint business unit with the Adults Safeguarding Board includes shared administrative support and two development officers. The benefits include the coordinated provision of training across both children's and adults' services to encourage a focus by professionals who work with individual adults or children to take a 'whole family' approach to providing help.

125. Strong potential for further development is in evidence from the recruitment of nine members of the public to participate as lay members on both the children's and adults' boards. At the time of the inspection, three people had begun to sit

on the children's board and they described their involvement as being in its 'early days'. A Children's Group has also very recently started and met twice. This group has the potential to improve the board's ability to listen to the child's voice, but attendance so far is low and its priorities have yet to be determined.

126. The work of the Child Death Overview Panel, which is convened jointly with a neighbouring authority, is completed to a high standard. Annual reports produced by this group are clear in their analysis of trends and patterns. A recent analysis of child deaths in Darlington over the past seven years has not identified any deficiencies in agencies' response.

127. The board's comprehensive training programme is designed and delivered by its Training subgroup. It is evaluated highly by participants and has an extensive reach, with 1,779 people participating in the programme in 2013–14. Innovative work is being undertaken in partnership with a private company to ensure that a full evaluation informs the development of future training. The board's training manager has carried out a gap analysis and introduced new training sessions to meet identified need. Social workers interviewed by inspectors spoke very positively about the quality and availability of LSCB training.

128. The Prevention from Harm subgroup's current priority focuses on responding to self-harm and suicide among young people. Awareness-raising has been undertaken with staff at Darlington College about the risks of self-harm, and this, together with a new improved pathway for referral to services, aims to improve the timeliness of agencies' response to young people at risk. Significant further development covering the work of all other agencies is planned for this year.

129. Darlington's child protection procedures are currently being managed by the board due to the takeover of the private company that was previously carrying out this task on a national basis. The Procedures subgroup ensures that procedures are updated to reflect national requirements and locally identified good practice. They are working effectively to ensure that they incorporate the recently updated national guidance on Working Together to Safeguard Children 2015.

130. The board's Missing and Exploited Group (MEG) coordinates partners' response to child sexual exploitation. Inspectors identified good front-line work across the partnership to address child sexual exploitation. Awareness-raising of the risks associated with child sexual exploitation across the broad population of Darlington has begun but is not yet being delivered as part of a coherent communication strategy. Although schools are delivering awareness-raising of exploitation as part of the curriculum, this is not yet sufficiently coordinated, monitored and evaluated by the MEG. Further targeted awareness-raising is planned within the night-time economy, including for licenced premises, hotels and taxi drivers, on the warning signs of child sexual exploitation and routes for referral to raise any concerns.

131. Strengths identified in the LSCB Annual Report 2013–14 published in November 2014 include the identification of key safeguarding messages for the local community. Annual private fostering and LADO reports are considered by the LSCB as part of an annual reporting cycle. However, the report lacks consideration of what auditing has identified; the effectiveness of front-line work to protect children; and an analysis of published data. For example, there is no examination of the significant changes in the child protection population, which had risen exponentially in-year (2013–14) from 60 to 141, nor of the looked after children population, which had reduced from 210 to 189 in the same year. A draft version of the board's Annual Report 2014–15 was made available to inspectors and was more detailed than the previous report, although the sections considering data have yet to be written. A prospective delay of six months in publication leaves an inappropriate gap in evaluating last year's work and planning this year's work streams.

132. There is a lack of a systematic approach to joining up learning by the LSCB and this leads to an overall lack of awareness by board members of serious deficits in front-line practice. Gaps across the board's performance management, audit and learning improvement frameworks mean that, where concerns are recognised, action plans are not always put in place to address them. Even when they are, they are not always specific and measurable, with clear outcomes for improvement identified. There is also an insufficient focus on how to disseminate learning from the board's performance monitoring processes across the workforce.

133. The Performance Management subgroup focuses on evaluating front-line practice. Some evidence was seen by inspectors of the board impacting positively on the effectiveness of front-line multi-agency safeguarding arrangements. For example, the board monitored contacts and referrals into the MASH. They then ensured that there was regular review and discussion among partners so that they were aware of patterns and trends. Together with learning from case audits, this exercise contributed to the review of 'front door' arrangements by children's services and the subsequent development of the Children's Access Point. However, in the main, the subgroup's focus is on children's social care, and not on other agencies. There is as yet no coherent multi-agency performance framework in place that would enable the board to evaluate safeguarding practice across all partner agencies. In addition, gaps in performance information lead to deficits in the knowledge of board members. Children's social care data is limited and does not facilitate an understanding of the quality of help provided at all stages of the child's journey. During this inspection, inspectors reviewing assessments identified widespread delay, variable quality and children being left at risk of further significant harm, and board members were insufficiently aware of these circumstances.

134. Some examples were seen by inspectors of appropriate challenge from board members to children's services to improve its performance. For instance, following criticism from the judiciary, the former independent chair wrote to key agencies highlighting concerns about legal issues raised by the courts.

However, the board has no formal system for recording challenge in which it can formally note concerns that arise between partners, or issues about individual cases and what has been done to resolve them. The new independent chair has recognised that this is an area for development. The board has challenged children's services and partners agencies over a long period of time in relation to the absence of chronologies on case records from which to assess historical factors, and on the timeliness of initial health assessments (IHA) for looked after children. These challenges have been partially effective. However, there has been some improvement in the timeliness of IHAs, with 55% being completed in the last quarter within the timescale identified by national standards, a significant increase from 7% in December 2014, although this is not yet a satisfactory level.

135. Multi-agency auditing processes are not consistent, although some have had a positive impact. Inspectors found much-improved practice in relation to child sexual exploitation, compared with that described in an audit carried out in January 2015. Case audits also contributed positively to the development of the Children's Access Point. Others do not clearly identify strengths and weaknesses in services, and their recommendations are also insufficiently clear. On occasion, sample numbers are disproportionately small and do not assist in an understanding of how widespread a particular issue may be.

136. The Learning and Improvement Group (LIG) suitably operates to a written multi-agency framework that meets the requirements of Working Together to Safeguard Children 2015 by focusing on serious case reviews (SCRs). However, there has not been an SCR in Darlington since 2011 and the group has no programme of additional activity to identify and disseminate learning from a range of other reviews and audits across the partnership. In 2014–15 only one case was looked at in depth by this group and this exercise did not identify any issues that would improve the quality of front-line practice. In the last two months, two further cases have been looked at in depth and good practice has begun to be considered. This is a positive development. Review by inspectors of the LIG's minutes shows that criticism of children's services in court and a management review of an individual case identified other current issues in relation to the quality of child protection plans. However, apart from being discussed, it is unclear how these deficits have been taken forward by the group.

137. The board has limited understanding of how effectively partner agencies are delivering their safeguarding responsibilities to meet national standards. It was agreed that an audit of partners' obligations under section 11 of the Children Act 2004 would occur every two years and only for statutory agencies. Following completion of agency audits, 'challenge clinics' occurred for some agencies but, due to staff vacancies, not all of these have yet taken place. Where they have occurred, there is no documentation on what is going to be done immediately in relation to the gaps identified, as some partners are inappropriately waiting until the audit is collated as a whole before taking action.

138. The board's work programme focuses on the work of its subgroups. Priority themes are chosen annually, but these fit uneasily into the board's structures. For instance, this year's themes are child sexual exploitation, self-harm, neglect and early help. However, neglect and early help do not have a subgroup or a task-centred group charged with driving them forward. Consideration is being given by the board to their priorities being cross-cutting themes across each of its subgroups. However, at the time of inspection it was already four months into the business year, and plans for ensuring that activity relating to the priority themes was reported to the board were not yet in place.

139. Inspectors who met with children's services staff during the inspection found their knowledge of board activity to be mostly focused on training, which they reported as good. Workers expressed limited knowledge of the board's other activities, and only a very small number reported that they had seen e-bulletins which reportedly were available to all staff to raise awareness of key safeguarding issues.

Information about this inspection

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

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

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

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

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

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

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