Doncaster Metropolitan 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: 14 September – 8 October 2015

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Children's services in Doncaster are inadequate		
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	Requires improvement
3. Leadership, management and governance		Requires improvement

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

Executive summary

At the time of this inspection, services to children in Doncaster are inadequate because services for children who need help and protection remain inadequate. Other areas of service, however, have demonstrated improvement since 2012, when all services inspected at that time were judged inadequate. In this inspection, there is evidence of the progress made with services for children looked after and care leavers that are judged as requires improvement. Adoption is good. Overall, this is a reflection of the progress leaders and managers are beginning to make in improving outcomes through better services for children in Doncaster.

In response to the findings of the 2012 inspection and the long-standing concerns about the safety of children in Doncaster, the government commissioned a review into how services for children and young people should be delivered. In August 2013, the Secretary of State made a Direction that an independent trust should be established. The trust went live on 30 September 2014. The trust is responsible for the delivery of children's services in Doncaster, with the exception of services for disabled children, the virtual school for children in care and the early help service, for which the council has retained responsibility. The council has entered into a contract with the trust to deliver services on its behalf. The contract sets out clear performance directions: that trust services should be judged good by October 2017 and outstanding by October 2019. Senior leaders do not underestimate the challenges that remain and are realistic in terms of actions that are needed in order to continue to improve services and outcomes for children by 2017. However, they are not there yet and there is still some way to go before services can be judged to be good.

The early help partnership offer, which is coordinated and led by the council, is fragmented and too many children and young people whose needs could be met at a lower level are referred for statutory services. In a small number of cases, inspectors saw serious weaknesses, including delay in holding strategy discussions, potentially leaving some children at risk of harm. The quality of assessments is not consistently good and for some children plans are not clear enough about the areas of concern or what actions are needed to be undertaken to reduce risk. Managerial oversight and supervision is not always sufficiently robust enough to address the variability of social work practice seen during this inspection. The circumstances of some children and young people do not improve quickly enough once risk is identified, and they are left in neglectful or risky circumstances for too long. Partnership working with the police needs to be better coordinated to ensure that child protection investigations are timely and robust and consider all areas of risk.

There is more evidence of progress in the children in care teams. These teams are increasingly stable and social workers have manageable caseloads, which enables more children in care to benefit from positive relationships with their social workers. Plans are regularly reviewed, but are not always informed by an up-to-date holistic assessment of children's needs. Placement stability is improving and children and young people, who need support for their mental or emotional health, have good

access to the Child and Adolescent Mental Health Services (CAMHS).Children in care have good attendance at school, but not all of them are making sufficient progress. Personal education plans (PEPs) need to be improved. The virtual school needs to improve the support given to children placed in schools outside the borough. The council recognises that these remain areas for improvement and is taking steps to address them.

Children whose plan is for adoption receive a good service. Plans move forward in a timely way and children are matched with appropriate families. Life story work is good. Support for adopters is strong. Statutory visits to children placed with their adoptive families are not always completed by their own social worker.

Since the trust was established, services for care leavers have been reconfigured and more care leavers now have the support of personal advisers to enable them to make progress; an improved position from the previous inspection in 2012.

The restructure of the assessment and child protection service (ACPS) teams is underway with the planning and consultation stage completed prior to this inspection. The new structure is set to be launched at the end of October. A rolling modular management training programme has already begun and improved performance management systems are under development. All of these activities are designed to address the known deficits in the current services.

Workforce stability has increased while reliance on agency workers and staff sickness has decreased. All children and young people are allocated to a qualified social worker. Social workers speak positively of working in Doncaster.

On election in 2013, the Mayor of Doncaster confirmed that improving children's services would be her top priority. Collaboration between the council, trust, Local Safeguarding Children's Board (LSCB) and partners has led to the recent development of new thresholds guidance; an early help strategy was issued. An 'Early Help Hub' was launched during this inspection.

Training has improved for elected members, who are now displaying a greater willingness to undertake their role as corporate parents. Improvements made to the corporate parenting board are too recent to show impact.

Relationships between the council and the trust are maturing. There is evidence of joint working to improve services for children and young people, for example in the investment of the council in refurbishing residential children's homes operated by the trust. Formal systems for the council to monitor and challenge performance by the trust exceed the requirements set out in the contract between the organisations.

Contents

Executive summary 2

The local authority 5

Information about this local authority area 5

Recommendations 8

Summary for children and young people 10

The experiences and progress of children who need help and protection 11

The experiences and progress of children looked after and achieving permanence 19

Leadership, management and governance 33

The Local Safeguarding Children Board (LSCB) 39

Executive summary 39

Recommendations 39

Inspection findings – the Local Safeguarding Children Board 40

Information about this inspection 46

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The trust operates four children's homes. Three were judged good or outstanding in their most recent Ofsted inspection.
- The trust operates an independent fostering agency and voluntary adoption agency. Both were judged good at the most recent Ofsted inspection, which was completed in August 2015.
- The previous inspection of the local authority's safeguarding arrangements / arrangements for the protection of children was in November 2012. The local authority was judged inadequate.
- The previous inspection of the local authority's services for looked after children was in May 2011. The local authority was judged adequate.

Local leadership

- The Director of Children's Services has been in post since August 2015.
- The chair of the LSCB has been in post since January 2014.
- The Chief Executive of the trust has been in post since July 2014.
- The functions that the local authority has delegated to a third-party provider are:

all services for children in need, in need of protection, children in care and care leavers with the exception of children with a disability, the virtual school and the early help service. Doncaster Children's Services Trust is also registered as an independent fostering and a voluntary adoption agency.

Children living in this area

- Approximately 65,000 children and young people under the age of 18 years live in Doncaster. This is 21% of the total population in the area.
- Approximately 24% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 17.3% (the national average is 16%)
  - in secondary schools is 14.9% (the national average is 14%)
- Children and young people from minority ethnic groups account for 7% of all children living in the area compared with 22% in the country as a whole.

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

- The largest minority ethnic groups of children and young people in the area are White Eastern European and Pakistani.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 9% (the national average is 19%).
  - in secondary schools is 7% (the national average is 15%).

Child protection in this area

- At 31 August 2015, 2,495 children were identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,239 at 31 March 2014.
- At 31 August 2015, 312 children and young people were the subject of a child protection plan. This is a reduction from 331 at 31 March 2014.
- At 31 August 2015, nine children lived in a privately arranged fostering placement. This is a reduction from 10 at 31 March 2014.
- Since the last inspection (November 2012), eight serious incident notifications have been submitted to Ofsted and one serious case review was ongoing at the time of the inspection.

Children looked after in this area

- At 31 August 2015, 498 children are being looked after by the local authority (a rate of 75.8 per 10,000 children). This is a reduction from 500 (77 per 10,000 children) at 31 March 2014.
- Of this number:
  - 161 (or 32%) live outside the local authority area
  - 46 live in residential children's homes, of whom 48% live out of the authority area
  - five children live in residential special schools, of whom 40% live out of the authority area
  - 383 live with foster families, of whom 30% live out of the authority area
  - 15 live with parents, of whom none lives out of the authority area
- Four children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 26 adoptions
  - 12 children became subject of special guardianship orders
  - 150 children ceased to be looked after, of whom 12 subsequently returned to be looked after

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

Recommendations

1. The trust should ensure that qualified social workers, in line with statutory guidance, undertake assessments in the response and referral team (paragraph 26).
2. The trust should ensure that joint child protection work with South Yorkshire Police and other partner agencies is robust, timely, coordinated and compliant with the requirements of Working Together to Safeguard Children, 2015 (paragraph 32).
3. The trust should ensure that all children and young people assessed as in need have a child in need plan (paragraph 37).
4. The trust should ensure that assessments for children in need of help and protection, children in care and care leavers are of a consistently good quality, are holistic, include relevant history, identify risk and reflect children's individual needs, wishes and feelings (paragraph 36).
5. The council and the trust should ensure that services to disabled children are equitable and robust and that expertise is available at the point of contact with children's social care to identify early indicators of risk and need (paragraph 40).
6. The trust should ensure that children are seen and seen alone during statutory visits and that this is consistently recorded on their case file so that the visiting frequency is subject to regular case audit (paragraph 45).
7. The council and the trust should ensure that all plans for any child or young person receiving a service focus on reducing risk identify the needs of all children in the family and are easily understood by parents and young people. They should ensure that plans are SMART (specific, measurable, assignable, realistic, time-bound) and reviewed regularly (paragraphs 37,38,40,61).
8. The trust should ensure there is robust management oversight of the use of Public Law Outline (PLO) at the pre-proceedings stage to ensure that decisions are made in a timely way and that progress is monitored by senior managers (paragraph 39).
9. The council and the trust should ensure that there is rigorous management oversight of children's plans, including appropriate challenge to reduce drift and delay, and that there is a clear focus on securing timely permanent placements for children and young people (paragraph 61).
10. The council and the trust should ensure that practitioners across all services receive regular reflective supervision in line with the council and the trust's supervision policies (paragraphs 26,116,135).
11. The council and the trust should monitor the offer and take-up of return interviews when children are missing from care or home. They should ensure analysis of these interviews informs individual and strategic planning to keep children safe (paragraph 60).

12. The trust should undertake an analysis of the needs of the cohort of older young people who have complex needs and are subject to frequent moves to ensure that appropriate care plans are in place to meet their needs (paragraph 67).

13. The council should ensure that the virtual school has the capacity to support children and young people, including those living out of the borough, to reach their potential through effective monitoring of their progress and to provide additional support where required (paragraphs 83,85).

14. The trust should ensure that there is sufficient capacity in the independent visitor service so that all children who need an independent visitor have one (paragraph 64).

15. The trust should ensure that the child's social worker undertakes statutory visits to children placed for adoption (paragraph 107).

16. The trust should ensure that all care leavers are suitably prepared for independent living and that accommodation is tailored to their specific assessed and changing needs (paragraphs 110,111).

17. The trust should improve the identification of risk for all care leavers who go missing or who are at risk of sexual exploitation (paragraphs 118,119).

18. Where 16- and 17-year-olds are assessed as a result of becoming homeless, the trust should ensure that they are made fully aware of their legal entitlements and the range of support options available to them. The trust should ensure that all care leavers have access to clear written information about their entitlements (paragraphs 57,115).

19. The trust should ensure that care leavers as well as young people in care have the opportunity to participate in the design and delivery of services and that the new arrangements for the corporate parenting board are effective (paragraphs 121,143).

20. Ensure that there are robust processes in place that enable the trust and the council to be assured that new arrangements to improve services are working well, for example the establishment of the early help service, and the restructure of the ACPS teams (paragraphs 134,136,137).

Summary for children and young people

- In 2012, Ofsted found that services for children and young people in Doncaster were inadequate. The government decided the best way to make things better was for an independent organisation to run children's social work services. This organisation is called Doncaster Children's Services Trust ('the trust') and has been in place since October 2014.
- The trust works very closely with the council and other agencies. They all want to make sure services for children and young people get better. Inspectors found that improvements have been made already, but because services have been poor for a long time, there is still a great deal to do and, overall, services are still judged to be inadequate.
- There have been too many changes of social worker for some children and young people who need help or protection. This makes it difficult for children to get to know and trust their social worker and for social workers to understand what the young person wants and how best to help them. The trust is working hard to employ and keep staff for much longer.
- There are a lot of services to help children and families in Doncaster, but these services are not always being provided at the time families need them. The trust and the council know this and have made plans that will help make sure that in future children and families get the right help at the right time.
- Some children who are at risk have not been helped or made safe quickly enough. People need to work better together to make sure action is taken quickly. Managers need to make sure they help social workers make the right decisions at the right time to keep children and young people safe.
- Professionals are working well to help children and young people who are missing or at risk of sexual exploitation stay safe. More work is needed to make sure that care leavers are not at risk through going missing or of sexual exploitation.
- Children in care mostly know their social worker well. The Children in Care council has only just been set up but they have lots of good ideas to make things better for children and young people. Councillors need to do more to understand how to do the best they can for children in care.
- The adoption service is good. Children who need to live with an adoptive family are helped to live with the right family and to stay with their brothers or sisters where that is the right for them.
- Support to care leavers has got better. More care leavers now stay with their foster carers after they reach 18 or live in other suitable places. More are in touch with their personal advisers than before and they get good help to look after their health.

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

Summary

Services for children in need of help and protection continue to be inadequate. Inspectors saw examples of serious weaknesses in a small number of cases during this inspection. Where children are considered to be at risk of immediate harm, strategy discussions do not always take place promptly. When they do, they are sometimes poorly recorded. In some cases seen, the response provided was insufficiently coordinated. For some children, this means they have been left in vulnerable situations for longer than necessary.

The quality of assessment and management decision making is inconsistent. Assessments and plans do not sufficiently focus on risk. They are not routinely updated and often lack consideration of all children in the household. Planning is weak. Not all children and young people assessed as in need have plans and when plans exist, they are not reviewed regularly. Some children remain in neglectful situations longer than they should because authoritative action is not taken in all cases where children's circumstances do not improve.

The council has been too slow to deliver its early help service. Early help and intervention services are not consistently available or well coordinated. Too many children and young people are assessed for statutory services when their needs could be met at a lower level

Although the trust has reduced the turnover of social workers and managers, changes in some teams continue. These have contributed to drift and delay that leave some children at potential risk of harm. Too many cases seen by inspectors lacked the appropriate level of involvement of children, young people and their parents and carers. Most case records fail to demonstrate that children and young people's voices are heard and that their experiences are being fully taken into account and acted on.

All children and young people are allocated to a suitably qualified and experienced social worker. Significant improvement has been made in the timescales for initial child protection conferences. Arrangements to respond to concerns where children are at risk of, or are suffering, child sexual exploitation are much improved. Recent changes to address concerns about children who are missing from home or care prioritise those children most at risk. Information from return home interviews needs to inform individual and strategic planning more effectively.

Inspection findings

21. When children, young people and their families are in need of early help and support, despite a wide range of services on offer, the coordination of the early help available is poor. This limits the potential to improve outcomes for children and families and prevent problems escalating.

22. Thresholds for access to children's social care (CSC) are not well understood across the partnership. This results in children and their families not always getting the help they need in a timely way. Too many referrals are made to statutory services when lower level interventions are more appropriate.

23. Partners are insufficiently engaged in the provision of early help. In the six months prior to this inspection, 504 early help assessments (EHAs) were completed. Over half have been completed by the Intensive Family Support Service (IFSS) in this period. Only two EHAs have been completed by health professionals and 11 by children's centre staff. The lead professional role is mainly undertaken by education staff or the IFSS. When cases step down to early help from children's social care, there are delays in allocating a lead professional. During the inspection, Doncaster Metropolitan Borough Council launched its early help service the early help strategy and revised threshold guidance document were still in draft form. The council acknowledges that the pace of developing their early help offer has been too slow.

24. Some effective early help services are available. Children and their families benefit from an effective Stronger Families service, which delivers the national Troubled Families programme. Project 3, provided by RDash, gives young people advice and support in relation to alcohol and substance misuse and links with adults' services to deliver a whole family approach to substance misuse. RDash is also commissioned to deliver CAMHS. All children and young people who have an urgent need such as self-harm are seen within 24 hours of the referral. There is good performance for those children and young people with non-urgent needs, with 95% seen within agreed timescales. In 2014–15, 109 young people were admitted to acute wards due to self-harm and 12 children and young people were admitted for attempted suicide. An extensive training programme is now underway focusing on early intervention in schools to help staff support children who are experiencing health and well-being issues.

25. The underdevelopment of coordinated early help services has led to inappropriate demand for statutory services. Very few contacts to children's social care are supported by an EHA. In the past six months, 51% of contacts have led to a referral, with 38% closed immediately following assessment. This leads to children undergoing unnecessary statutory assessment and puts unnecessary pressure on the ACPS teams.

26. Although the referral and response team provides a prompt and safe screening of contacts, including out of hours, there is a reliance on unqualified workers to undertake detailed enquiries involving elements of assessment and analysis. Robust management ensures that decisions

reached are safe but the process is cumbersome. This impacts on manager's ability to undertake other managerial duties, including providing supervision. Of five supervision files seen by inspectors, all were inadequate in terms of frequency and quality.

27. The trust has been effective in reducing re-referral rates from 37% in 2013–14 to 22% currently, which is lower than statistical neighbours at 25% and England at 23%. However, inspectors saw a number of re-referrals where children had been exposed to further risk or harm where cases have closed prematurely without risk being sufficiently assessed.

28. Of 2,351 contacts in the past three months, 784 were from the police, of which 541 were domestic abuse notifications. Not all notifications are supported with enough information to enable staff to assess the level of risk. Forty-three per cent of these do not progress beyond contact. This creates additional work for the referral and response team and reduces its efficiency.

29. Domestic abuse is a significant feature for children and young people in over 30% of referrals and is a key factor in 55% of statutory assessments. There is a wide range of effective services for families affected by domestic abuse. In addition, the trust has recently been successful in securing central government innovation funding for its Growing Futures Domestic Abuse Programme. At the time of inspection, the project had been operational for just eight weeks. While it is too early to see impact, inspectors have seen early evidence of children who have been exposed to domestic abuse receiving support.

30. Multi-Agency Risk Assessments Conferences (MARAC) are well attended and information is appropriately shared by children's social care. However, the re-referral rate for MARAC cases is 40%, which is over twice the regional average. This suggests that risk is not always being successfully addressed or reduced. The council and trust had recognised the high re-referral rate as an issue of significant concern. The need to tackle it informed the trust's successful bid for funding for the Growing Futures Project, which has a specific target of reducing MARAC re-referrals by 25%.

31. A multi-agency safeguarding hub (MASH), set up in June 2015, is at an early stage of development. At the time of inspection, arrangements were not sufficiently well-coordinated and did not involve a full range of partners. The trust, council and police accepted inspectors' observations and took steps to revise the MASH model and develop a strengthened approach.

32. Current safeguarding practice does not consistently ensure that the most vulnerable children in Doncaster are safe. Strategy discussions do not always involve relevant agencies such as police and health representatives. This does not comply with statutory requirements set out in Working Together to Safeguard Children 2015 and means decisions made may not be fully informed by all relevant information. In a number of cases seen by inspectors, police and social care did not work together in a coordinated way to safeguard children. Not all strategies are recorded or reflect the level of

discussion with police and partners. The outcome of section 47 enquiries is not routinely recorded, which makes it difficult for professionals to understand the actions taken.

33. Cases transfer quickly from the referral and response team to ACPS teams and are allocated to a qualified social worker. Not all social workers, however, have had recent child protection or joint investigation training. In one team, inspectors found some agency workers who were unaware of procedures to record strategy meetings and investigation outcomes.

34. Social workers in the ACPS teams undertake a broad range of work, taking cases from referral, through assessment to permanence. This impacts on their ability to be sufficiently knowledgeable and experienced in all areas of work they are expected to undertake. Caseloads vary across ACPS teams and in some cases are too high, with some social workers holding up to 30 cases.

35. While inspectors have seen good assessments in some teams, this is inconsistent across the service. This level of inconsistency means safeguarding practice is not yet good enough. During this inspection, 14 children and young people were referred to the trust where inspectors had concerns for their safety. Immediate safeguarding action was required in respect of one young person; an urgent strategy discussion was convened on this case. In three other cases, further action was needed to assess potential risk. In four cases, the trust accepted that children's plans had not been actioned sufficiently robustly leading to drift and delay. Additional information provided by the trust reassured inspectors about the safety of the remaining six. In addition, inspectors saw a small number of cases where there had been delay in instigating child protection procedures or where not all elements of risk had been identified. Plans that were in place at the time of the inspection ensured that these children were safe.

36. It is positive that the timeliness of assessments improved from 75% in 2013–14 to 92% in 2014–15. There is still more to do to improve the quality of assessment; not all assessments consider the needs of all children in the household. There is limited evidence of assessment tools used to support risk analysis, particularly in relation to the identification of neglect. Chronologies are not used effectively to inform assessments. It is difficult to see the child's story from some records, as many children's summaries are not up to date. Not all assessments and plans consider the voice of the child and their wishes and feelings. In the six months prior to this inspection, the trust's data indicate, of 1,660 assessments completed, 252 did not record that children were seen during their assessment. Of these, 33 were unborn babies and 13 were assessments closed on the same day with no further action required. The trust reports that the remainder of children were seen as part of their assessment but this was not recorded. Such inaccurate data mean managers cannot be sure if all children are being seen as part of their assessment.

37. Not all children in need have a plan in place, which means that interventions are not always supported by a structured approach with clear objectives. The trust's performance data show that at the end of August 2015 over one third of children in need did not have a plan. The trust reports that this is, in part, explained by plans not being signed off on the case recording system. However, inspectors sampled a number of cases where children had not been seen for several months and where child in need reviews had not been held. This means managers cannot be assured children in need are receiving the right level of service or indeed in some cases if they are safe.

38. There are 323 children currently subject to a child protection plan, with 56% of children subject to a plan for neglect, the highest category of concern. This reflects the local challenges around deprivation, along with some historic legacy of children and young people not receiving help at an early enough stage. This leaves some children in vulnerable situations for too long. For some children, changes in social worker have contributed to this position. While improvement is evident for some children, overall the pace is too slow

39. The Public Law Outline (PLO) is not used effectively in all cases when concerns escalate and change is not being achieved. In some cases seen by inspectors, decisions to move to pre-proceedings had been made, but were not progressed. Senior managers do not have a system to identify when this happens. There are currently only small numbers of children at the pre-proceedings stage of the PLO process.

40. The council and the trust acknowledge that children with disabilities are under-represented in child protection work with only ten children, (3%), subject to a child protection plan. At the point of contact and referral, there are too few skilled practitioners with knowledge of safeguarding disabled children to identify indicators of risk.

41. The timeliness of convening an initial child protection conference (ICPC) has improved from 46% in 2014 to 93% as at September 2015. Police do not routinely attend ICPCs and do not always provide reports in a timely way, which means conference members determine risk and need without valuable police information. Inspectors saw a small number of cases where conference reports were not shared with parents in time to enable them to participate fully in the meeting. In one case, documents were not translated into the parent's language. This inhibits parents' understanding of the risks to their children and how they should be working to reduce them.

42. Child protection chairs are an emerging strength demonstrating increasing challenge and escalation of concerns to senior managers. This is not yet consistently leading to an improvement in children's circumstances or social work practice. Child protection chairs visit children following child protection case conferences to help children understand the process and their plans.

43. There is increasing evidence that advocacy is being offered to children who become subject to child protection conferences. A newly commissioned

service has already received 82 requests since it began in August 2015. It is too soon to measure any impact of this service.

44. Most core groups are held regularly but the links between the actions of the core group and the reduction of risk to children are not always clear or sufficiently effective. Inspectors saw evidence of child protection plans drifting without challenge by core groups and a lack of challenge to agency partners who do not provide updated information in a timely way. This means that social workers are making decisions in some cases in the absence of all relevant information to enable them to monitor progress or assess risk.

45. Visits by social workers to children subject to child protection plans are mainly regular at 97% but not all records confirm whether children are seen alone by their social workers. The trust reports that this is a recording issue. However, inaccurate recording means managers cannot be sure all children are seen alone when it is appropriate to do so. The trust recognises this and has amended the case recording system so that social workers are prompted to record whether they have seen children alone. Most social workers are able to articulate their understanding of children's needs and circumstances better than is reflected in their recording.

46. The quality of social work for disabled children has improved in recent months and co-working arrangements between the council and the trust have improved. The current agency manager for the children with a disability service is having a positive impact on reducing the isolation of this service from mainstream safeguarding services as the role currently sits outside the trust within the council.

47. The council recognises that transition planning for young people with a disability, that supports them to move successfully into adult services is underdeveloped. The council recognises short break services while well-coordinated, have not provided children and their families with good enough quality or choice of provision. Consultation has been undertaken with parents and children to inform the re-commissioning of services for this group of children and young people.

48. Arrangements to respond to concerns where children are at risk of or suffering child sexual exploitation are much improved. The child sexual exploitation team has been strengthened over the last 18 months with additional social work and police officer resources. Section 47 investigations in the main are robust, well recorded and lead to multi-agency protective actions. Despite this, inspectors saw four children out of 25 cases sampled where risk has not been identified soon enough. This has delayed protective action being taken.

49. The child sexual exploitation team is working proactively with the voluntary and community sector, hoteliers and taxi drivers. This has resulted in enhanced intelligence gathering and greater reporting of potential indicators of exploitation by these professions. There have been a number of successful police-led operations, convictions and 23 abduction notices served

since March 2015. Effective joint working has taken place between the child sexual exploitation team and the UK Border Agency at Robin Hood Airport to raise awareness of child trafficking and child sexual exploitation.

50. There has been improvement in arrangements between police, social care and other agencies to address concerns about children going missing and in prioritising those children most at risk. Police undertake safe and well checks to all children when they return. The trust has taken action in response to poor performance by the service commissioned to complete return home interviews. A new service commissioned in September 2015 from the council's early help service. This is showing early signs of improvement with an increase in children being visited. However, not all children are seen and so far there is limited evidence of intelligence gathered being used to inform individual safety plans for children and young people. Information is not yet being extrapolated and analysed to identify patterns and trends to inform wider safety planning.

51. The newly formed Children Missing Operational Group (CMOG) meets monthly to share intelligence and discuss those children and young people most at risk. The group has only been operational for three months and is yet to secure full multi-agency attendance. Inspectors have, however, seen some positive evidence of children being discussed resulting in protective actions being taken, although these actions were without timescales, which makes it difficult to hold agencies or professionals to account for and prevent drift.

52. South Yorkshire Police have recently appointed two specialist officers to support force awareness and recognition of female genital mutilation and honour-based violence. There are no reported cases of female genital mutilation in Doncaster. The trust has recently developed a female genital mutilation task group that does not yet have representation from schools or midwifery – critical partners if the group is to be effective.

53. The council is aware of its duties in relation to the Prevent strategy and training has been provided to schools. In a small number of cases, concerns have been identified by teachers and appropriately referred to agencies, including the police. To date, this has not led to any young person being identified as at risk of radicalisation.

54. Allegations against professionals who work with children are robustly investigated. The role and function of the Designated Officer are well understood across the partnership. Cases referred receive a timely and robust response that ensures that children and young people are protected.

55. Private fostering is well publicised and targeted work to raise awareness has been undertaken with schools, GPs and faith and community groups. In 2014–15, 17 children were identified as living in private fostering arrangements, with five young people known to be in privately fostered at the time of this inspection. On identification of private fostering arrangements, the trust discharges its responsibilities in line with statutory

requirements, ensuring that children who are privately fostered are safe and that their welfare is promoted.

56. When 16- and 17-year-old young people become homeless, they receive effective support. Assessments undertaken by children's social care are not, however, compliant with case law, as the young people are not always fully informed of their legal entitlements and support options.

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

Summary

At the time of this inspection, there were 498 children in care in Doncaster. For some children, including recent examples seen by inspectors, there has been drift and delay in decision-making resulting in them not coming into care early enough. No children were seen who should not be in care.

Targeted work has been undertaken to increase the use of Public Law Outline (PLO) process and this is having some impact with significantly improved timeliness of care proceedings. The use of pre proceedings PLO is not yet embedded and for a small number of children early planning to identify and assess alternative carers is not undertaken soon enough. The new edge of care service has been effective in preventing some children from needing to become looked after.

Managers are not always sufficiently focused on progressing plans to secure permanency for children and where children have exited care to be placed with extended family members, plans for support and reviewing of progress have not always been robust.

Increasing stability in the children in care teams means that most children know their social workers well and they receive regular visits. For some other children, frequent changes of worker continue to impact on their ability to develop effective relationships with professionals.

Care plans are not routinely informed by updated assessments, and plans do not always clearly represent the child's views, their current needs and how these will be met. Children's plans are reviewed regularly and within timescale. Independent reviewing officers (IROs) monitor children's progress and challenge poor practice appropriately. Educational attainment for children in care is too variable and the gap between them and their peers is not consistent. The Children in Care council has only been effectively working in the last few months.

Children whose plan is for adoption receive a good service. Adopters receive good support.

Services for care leavers have significantly improved. More work is needed to improve the quality of Pathway planning, preparation for independence and the quality of management oversight and to embed good practices that have recently been put in place.

Inspection findings

57. The number of children in care in Doncaster is higher than that of statistical neighbours but is reducing slowly. The relatively high number is in part due to more effective work by the trust and partners in identifying children left in abusive situations for too long. Some children are not receiving help soon enough to prevent them from becoming looked after.

58. No children were in care who should not have been. In cases sampled where children had recently become looked after, decisions made were appropriate. Decisions are made at a suitably senior level and the rationale for the decision is recorded. In a small number of cases, including recent cases, there has been drift and delay in decision making and children should have become looked after sooner.

59. The newly established 'Cromwell Drive' edge of care service provides a range of support to children and their families and these are making a positive difference. Since February 2015, the team has worked with 23 children, preventing 18 of them from becoming looked after. The trust acknowledges that more work is needed to further develop edge of care services to support all children who can remain living with their family.

60. At the time of the inspection, there were only four cases in the pre-proceedings stage of PLO. In a small number of cases seen, decisions to progress to PLO either were delayed or did not happen, meaning that for some children early planning to identify and access alternative carers was delayed. The trust has undertaken focused work to promote understanding and use of the PLO process. Further work is needed, however, to ensure that all cases that meet the threshold for PLO are benefiting from this process. A tracker to monitor the progress of cases in PLO and proceedings has only just been introduced and a case manager appointed to oversee this work but this is too recent to evidence impact.

61. Appropriate measures have been taken to improve the quality of evidence provided to the court. Further work is required to ensure a consistently high standard in the quality of all court reports. The average duration of care proceedings has reduced from 37 weeks in the quarter ending 31 March 2014 to 25 weeks in the quarter ending 31 March. At the time of the inspection, the figure for cases in proceedings is better, at 22 weeks. This represents significant improvement in reducing delay for children. Relationships between social workers and children's guardians have improved, resulting in guardians attending key meetings where appropriate and regular liaison when cases are in proceedings.

62. In the majority of cases seen where children return home to the care of a parent, social workers undertake clear assessments and work to ensure that the children are safe and their needs are met. There is focused and coordinated support, underpinned by regular reviews, that ensures that children experience stability and do not have further unplanned episodes of care. Where children have exited care to be placed with extended family

members, children were appropriately placed but plans for support and reviewing of progress are not always robust. This includes cases where children were subject to supervision orders.

63. Plans for permanence are made at the second review but are not always progressed as quickly as they should be. Decisions for adoption generally progress well, but in other cases permanency planning is weak and is not tracked or monitored by senior managers to ensure progress. The independent reviewing service is effectively challenging delay and drift, but a more robust system of management oversight would reduce the need for such challenge from IROs and ensure permanent arrangements for children were secured quickly.

64. Numbers of children being made subject of special guardianship orders (SGOs) have significantly reduced, from 44 in 2013–14 to 30 in 2014–15 and just five from 1 April to September. The trust's view is that this is explained by an unusual peak in activity by the council in the previous two years to address previous shortfalls in actively pursuing permanence for children.

65. Historically, children in Doncaster have experienced frequent changes of social worker. This is still an issue for some children and has had a significant impact on their ability to build effective relationships with professionals. Increased stability in most teams means that this is improving. Social workers see children regularly in the vast majority of cases, meaning that they know the children they work with well. Some impressive examples were seen of social workers working purposefully to develop positive relationships with children and their families, which was improving outcomes for these children. Social workers are committed to understanding children's experiences and supporting them to manage complex needs, often through effective multi-agency packages of support.

66. The Independent Visitor Service is well established, with one coordinator and 37 volunteers, all of whom are trained for the role. Children in care are aware of the service. Currently, 30 children have an independent visitor, three of whom are out of borough. There is a waiting list of nine children, which indicates there is not sufficient capacity to meet demand.

67. The trust has a clear and well-targeted recruitment strategy in order to enhance its in house fostering provision to meet current needs, but at the time of inspection, there were insufficient foster placement s for children in need of an emergency placement or for teenagers or sibling groups. The findings of a recent Department for Education research project that involved the trust working in partnership with seven Doncaster-based independent fostering agencies inform the strategy. The trust is well on its way to achieving its target of recruiting 20 additional foster carers this year. The service is also aspirational and has workers seconded into two Department for Education-funded projects aimed at providing 35 foster homes for young people vulnerable to child sexual exploitation across South Yorkshire and to promote placement stability by enhancing support to foster placements.

These are both in early stages of development and so cannot yet evidence impact.

68. It is positive the trust has committed financial support in order to restructure in-house residential services to provide places for children with complex needs. The trust aims to reduce demand for residential places from 66 to 44. It remains unclear how it is going to achieve this reduction, which is a potential weakness.

69. A small cohort of older children who have very complex needs are subject to frequent placement moves. Many of these young people have suffered long-term neglect and in a small number of cases, decisions about placement moves were reactive rather than planned. Sometimes, this involved out of authority placements that resulted in children continuing to go missing and placing themselves at risk.

70. The recent fostering inspection provides a solid evidence base for the good work of the fostering service in recruiting, assessing, supporting, reviewing and retaining foster carers. It is an efficient well-managed service. Those spoken to during this inspection were very positive about the high standard of support they receive.

71. Family finding is informed by the assessed need of young people. Social workers, fostering workers and the placement service work collaboratively to match children to both short term and permanent carers. They are able to consider all options including commissioned services and those managed by the trust to ensure that children's needs are met. Children with a permanence plan for long-term fostering or adoption are subject to a similar process, with matching forums making appropriate decisions about suitable matches. The fostering or the adoption panel makes a considered recommendation, which the Agency Decision Maker then uses to inform their decision.

72. Children are placed with siblings where appropriate and comprehensive 'together or apart assessments' were evident as part of the permanence planning process. Placement stability is improving and this is due to improved quality of in-house foster carer provision and the standards demanded of independent providers. Performance in relation to three moves in a year has significantly improved reducing from 12% to 8% in 2014–15 standing at 5% in August 2015.

73. There is improving performance in the percentage of children who have been in the same placement for two years. During 2013–14, 54% of children had been looked after in the same placement for two years. This increased to 56% during 2014–15 and to 67% in August 2015.

74. At the time of the inspection, 16% of children were placed more than 20 miles from home. This is a reduction from 19% in 2013–14 and in line with the England average of 16%. Where it is in the child's or young person's best interest, the trust has been working towards returning children where possible to live within the borough.

75. Foster carers maintain memory books for foster children and the action plan arising for the Annual Fostering Report 2014–15 addresses the need to improve the quality of life story work for children in permanent foster placements.

76. Children's health needs are not assessed quickly enough when they enter care. In 2014–15, only 28% of initial health assessments were undertaken within 20 days of admission to care, and performance for quarter 1 of 2015–16 was only 35%. Late receipt of consent forms and a shortage of community paediatricians have contributed to poor performance. The trust is aware of the problem and is taking steps to ensure that social workers in the ACPS teams complete the consent forms in a timely way. The proportion of children having review medical and dental assessments and immunisations is above or in line with national averages. Health assessments of looked after children are robust and leading to referrals to appropriate agencies when needed. Inspectors saw some good examples where the nurse with responsibility for children in care had developed very effective relationships with young people and this is helping to ensure that their health needs are met.

77. Children in care have good access to CAMHS. Where children do not meet the threshold for CAMHS, therapeutic support is accessed through the trust resource panel. Rotherham, Doncaster and South Humberside NHS Foundation Trust (RDash) funds therapy for those children placed out of borough who need it. In many cases, bespoke packages of therapeutic intervention and CAMHS interventions were seen to be making a positive difference for children.

78. Project 3 provides good quality health services for young people needing help with sexual health, substance misuse and smoking. This service is easily accessible for children looked after and children receive a speedy response when needed.

79. The youth offending team (YOT) maintains effective working relationships with children looked after with whom they work, including those out of area. Custody rates for children looked after have reduced from a high rate in 2013–2014 of 1.59 per 1,000 of the population to 0.69 per 1,000 in 2014–15 compared with 0.52 per 1,000 nationally for the 10–17 population. The trust and YOT acknowledge that there is a need to further develop restorative justice processes and reduce the criminalisation of children and young people looked after and have appropriate plans in place to undertake this work.

80. When children in care go missing from care, and for those at risk of child sexual exploitation, strategy meetings are held in a timely and proportionate way and result in coordinated multi-agency responses. Police are very effective in terms of looking for children and in the use of abduction notices. A dedicated children in care liaison officer, funded by the police and the trust, focuses on building relationships with children who have been missing from care to understand why and, and where they go and to ensure that

plans can be put in place to keep them safe. Care plans are not routinely updated to reflect increasing risk; while most placements ensure robust risk assessments are completed, this aspect of safety planning is not routinely integral to the child's care plans.

81. The proportion of children looked after who attend a school that is good or better is too low at 63%. The proportion of children in care who attend good schools mirrors the position for all children in Doncaster, where 35% of mainstream schools require improvement or are inadequate. In many cases, children in care become looked after during their time at school and there is effective liaison to ensure that children's needs are met. They remain in their existing school where their assessment supports this.

82. The quality of personal education plans (PEPs) is too variable and too many lack the detail and clarity necessary to help drive the progress of children and young people. Weaker PEPs do not adequately record an assessment of the child's needs, capture their views or set sufficiently detailed and measurable targets. PEPs are quality assured by the virtual school and recommendations for improvement made. This has not yet had a significant impact on improving their quality. The assessment of children's needs through PEPs has led to some additional support through the use of pupil premium in the form of 1:1 tuition in English and mathematics and support for teachers in managing attachment difficulties. The additional tuition has had mixed success but schools report that the attachment training has helped them to make improvements to children's behaviour and learning.

83. Educational attainment for children in care is too variable and the gap between these children and their peers is not consistently reducing year on year. At age five, 41.7% make good progress compared with 65.3% of all children in Doncaster. By the end of Key Stage 1, these children perform less well than their peers do nationally, especially in reading and writing. Attainment at the end of Key Stage 2 has improved and the proportions that leave primary school with a good level of skills in reading, writing and mathematics is better than for children looked after nationally.

84. The attainment of children in care at Key Stage 4 is too low and is not improving well enough. The proportion of children in care gaining five GCSEs at grades A* to C in 2013–14, including English and mathematics, was 15%, above the national average for children in care of 12%. The unvalidated results for 2014–15 indicate a drop to 8.75%, well below the unvalidated national figure of 52.8% for all children. The virtual school recognises that more focused work is needed to support children in care at secondary school. In response, the council has appointed a senior raising achievement officer with appropriate expertise to ensure earlier and targeted intervention to support children with their secondary education.

85. The virtual school monitors closely the school attendance of children in care. As a result, most children have good attendance. They miss fewer school days than children in Doncaster as a whole do and fewer children in care are persistently absent. There have been no permanent exclusions of children in

care during 2014–15, but the number of days lost due to exclusion has increased in 2014–15. The virtual school recognises that work conducted in primary schools to support children to settle to learn needs to be replicated in secondary schools. Children for whom attendance at school is difficult have access to appropriate alternative provision. The local authority has robust processes in place to quality assure providers of alternative programmes. Children who are temporarily unable to access 25 hours of education per week have appropriate plans in place to help them move towards a full-time programme. Five young people were receiving less than 25 hours education at the time of this inspection, all of whom were following programmes that met their needs. While the progress of these children is monitored, record keeping is not clear and it is difficult to assess their progress.

86. The council holds detailed records of those children receiving alternative education and for those missing from education. There are currently 41 children missing from education. The council has clear and detailed processes in place for establishing their whereabouts culminating in referral to the police. Education representatives attend the newly formed Children Missing Operational Group (CMOG) and effectively share information on those missing from school.

87. The council has sound processes for managing transitions when children move out of the local area. The quality of schools and the needs of young people are considered carefully before a school is selected. However, the virtual school lacks the resources to be proactively involved in close monitoring of out of area children once they are settled and only become involved if the receiving school alerts them to a problem.

88. All children and young people in care receive a book of discount vouchers for local shops and amenities several times a year. Children in care receive some additional support to help them access social and recreational activities for example, gym membership paid for or support to complete the Duke of Edinburgh award. This is not well-coordinated nor overseen or supported by corporate parents.

89. The fostering and adoption service has developed groups and youth clubs for children in care and adopted children to attend which they enjoy. Foster carers are provided with clear written guidance about delegated authority and are routinely encouraged by their supervising social worker to raise any questions they may have about this issue. Some children spoken to felt that delegated authority should be managed better.

90. Care plans are not routinely informed by up-to-date assessments. Social work reports written for statutory reviews are seen as the mechanism for updating assessments, but these reports do not provide a holistic assessment of need. A small number of children with complex needs had experienced multiple placement moves without a thorough assessment of their needs being completed. Training to improve the quality of assessment work has taken place and is seen to be having an impact in some cases, but

the quality of assessments remains too variable ranging from inadequate to good.

91. Actions and updates from reviews are not always translated into plans. This means that plans are not always presented in a way that makes it clear what the child's needs are, how these will be met and who is doing what and by when. Most plans seen are very detailed with regard to the child's background, health, and education. Plans are not easily accessible for children and young people and they are not routinely engaged in the development of their care plans. The trust has recognised this and work is underway to develop a new template for care plans, and to develop an app to support engagement with planning. This was not in place at the time of the inspection. Plans seen that are good, are timely and updated to include changing needs.

92. Contact arrangements are set out in care plans and there is effective consideration of children's contact with family at reviews and in planning. This ensures that children have contact with those who are important to them. Care plans could more clearly address the intended outcomes of contact to ensure that plans are demonstrating how contact is meeting children's needs.

93. Looked after reviews are held regularly and within timescale. There has been a steady increase in the timeliness of children in care reviews rising from 79.1% in 2013–14 to 98.4% in 2015–16. In 2014–15, 62% of children aged over four years attended their review, an increase from 19% in 2013–14. The trust recognises that this needs to improve further. Children and young people's views were represented in 95% of reviews. Parents were seen to be appropriately involved in reviews and there are some good examples of children's wishes informing planning for reviews, for example in deciding who will be invited to attend, and one young person using a Power Point presentation to chair the review.

94. Independent reviewing officers' (IROs') caseloads are manageable and stability in this team provides children and young people with a consistent IRO. IROs monitor the progress of plans at reviews and are able to track children's progress between reviews. They are increasingly challenging poor practice particularly in relation to drift and delay of children's plans. A new dispute resolution policy is now in place but concerns and issues raised through informal and formal processes are only just beginning to be analysed. As a result, themes emerging have not been collated to inform improvements in practice.

95. Recording on children's files is up to date and in most cases seen, records are very detailed, including when children are seen alone. Children's views, wishes and feelings, however, are not consistently well represented on their record. Case recording does not routinely relate to the care plan nor always address its progress. Chronologies are not always completed and do not always contain a clear and coherent record of the key events in a child's life.

96. The Children in Care council has only been running for four months and there has not been sufficient time for it to have had a demonstrable impact on services for children in care. The group is dynamic and articulate and has clear plans on how they want to develop the group to ensure maximum impact. The newly appointed participation officer supports the group well.

97. Cases were seen where there had been good responses to children's needs arising from diversity, including ensuring that children's cultural and religious needs are met and their views taken into account in planning placements. A small number of examples were seen where issues of identity, specific needs in relation to learning disability and the needs of children with autism have not been addressed well.

The graded judgement for adoption performance is that it is good

98. On 1 October 2014, the Doncaster adoption service became a voluntary adoption agency (VAA). The agency was judged as providing a good service in an inspection conducted by Ofsted in August 2015.

99. There is a dedicated adoption team staffed by a stable and experienced workforce, with a good level of management oversight and a knowledgeable team manager who tracks and monitors performance. This helps to ensure that adoption processes are timely and of good quality.

100. When children are unable to return to the care of their birth family, they are considered for adoption and where this would meet their assessed needs it is pursued for them. There is an improving trend in the timeliness of children placed for adoption. In the three-year period from 2011–2013, the average time between entering care and placement was 632 days. Although this did not meet the national threshold of 547 days, it is in line with the average figure achieved nationally of 628 days. The latest 2014–15 in-year figure reported by the trust is 522 days. For the most recent period, April to September 2015, a further reported fall to 491 days provides further evidence that the trend is one of improvement.

101. Performance with regard to the average time between placement order and matching was 264 days in 2014–15. The latest 2015–16 information, for April to September 2015, shows slight improvement reducing to 250 days. This compares with the latest England data for 2014–15 of 234 days, which is nearly double the national threshold of 121 days. The trust is clear that this performance relates to their commitment to placing sibling groups and children with complex needs for adoption. Nine sibling groups were placed during 2014–15 and a further three sibling groups have been placed since the 1 April 2015. Of the 24 children currently awaiting a match, 12 are part of a sibling group and four have complex needs.

102. As part of the transfer arrangements from the local authority to the trust and the VAA, an audit was undertaken of all children subject to a placement

order. With the agreement of the children's IRO, revocation orders were applied for relating to 11 children. Alternative plans of long-term fostering are agreed for these children. The progress of plans for children who need an adoptive placement is now closely tracked and monitored.

103. Once the Agency Decision Maker has agreed the adoption plan, all possible preparatory work is undertaken so that when the placement order is granted, family finding for an appropriate match can commence quickly. Where an in-house match is unavailable, children are immediately referred to the local consortium and to Adoption Link and the Adoption Register.

104. The number of adoptions has been increasing in Doncaster: 27 children were adopted in 2012–13; this figure rose to 36 in 2014–15. The increase is likely to continue as 15 adoption orders have already been granted at the time of this inspection and a further 37 children are currently placed for adoption. Doncaster now compares favourably with the national level of adoptions with 21% of the children who ceased being in care in 2014–15 being adopted in Doncaster compared with 17% nationally. Concurrent planning is well established in the trust and currently there are three children placed in fostering to adopt placements, with two other children adopted since 1 April 2015.

105. The recent VAA inspection report, published in August 2015, provides a solid evidence base for the good work of the adoption service in recruiting and assessing prospective adopters and of the adoption panel in approving adopters and matching children. The VAA has a number of adopters approved for up to two years and they have made a deliberate decision to only progress applicants who are willing to adopt children who are: three years or older; part of a sibling group; have complex needs; or live outside Doncaster. This has significantly reduced the numbers of applicants progressing from stage one. Since 1 April 2015, 13 adopters have been approved and currently eight of the 13 are at stage one and only one at stage two. Managers acknowledge that a key issue in approving adopters in timescale during stage one is the delay in securing medical reports from some applicants' GPs and then in securing the medical adviser's report. A different commissioning arrangement is now under consideration. The average time from stage two to approval is 127 days, which is line with nationally set thresholds.

106. Two qualified social workers trained in 'Theraplay' contribute to the delivery of a good range of adoption support. Two social work assistants with an intensive family support background also provide support. Currently, there are 32 families, involving 37 children, who are receiving some form of adoption support. No adopters are waiting for support. There are three adoption support groups to support adopters and children of different ages. Therapeutic support, if not available through CAMHS, is commissioned from specialist agencies; nine applications have been made to the Adoption Support Fund. Adopters spoken to were all positive about the support they had received. The service routinely consults with adopters and adopted

children about the nature and quality of services and this has led to changes in how these services are delivered.

107. Where permanence is 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 the current 534 letterbox contacts. This can involve advice and support to birth parents to ensure that the exchanges are of good quality. Adopted adults and birth parents receive support from a commissioned adoption support agency.

108. Life story work with children is of good quality and is completed by trained social work assistants. Life story books seen were written in child-friendly language and contained many significant memory prompts, including a range of photographs.

109. The trust currently has a policy that, once a child is placed for adoption, the adopter's social worker and the child's social workers alternate statutory visits to the child. This confuses the roles of the respective practitioners and does not ensure that such visits are undertaken in line with statutory guidance.

The graded judgement about the experience and progress of care leavers is that they require improvement

110. In December 2014, following consultation with care leavers, the trust changed the teams remit to an 18 plus service. The team moved premises to the centre of Doncaster, co-located with the youth offending service. This has increased access for young adults to the service, but not all young people are positive about its location with the youth offending service. The redesign of the service provided an enhanced focus on the needs of older care leavers. Although there has been a determined drive by the trust to improve outcomes, the previous systemic failures and the scale of work required to achieve this across the service means that there is more to do to ensure that good services for all young people leaving care are available.

111. At the time of the inspection, there were 190 care leavers aged between 18 and 25 years. All young people in care are encouraged by their social workers to stay in their placement after they reach 18 years of age. The recent implementation of a 'staying put' policy has resulted in 22 young people remaining with their carers post-18. Young people report that if their first attempt at independence is unsuccessful the trust will support them to find suitable supported accommodation. A legacy of poor practice in placing some young people in unsuitable accommodation before they were ready for independence has resulted in a number of young people losing their tenancies.

112. Increasingly, care leavers have access to a range of appropriate accommodation: 89% live in suitable accommodation, which is a higher

proportion than statistical neighbours and the national average. The majority live either independently, with parents and relatives or in supported lodgings. The trust has a policy not to place young people in bed and breakfast accommodation. At the time of the inspection, no young people were in bed and breakfast accommodation. Five care leavers in custody receive support and regular visits by their personal advisers (PAs). More work is required to improve the quality of care leaver's needs assessments and preparation for independence at an earlier stage. The trust has accepted that this work is vital in ensuring that care leavers receive accommodation that meets their specific requirements to prevent future homelessness.

113. Many young people now receive flexible and tailored support to help them achieve independence. For example, regional consortium commissioning arrangements are effective in increasing and procuring bespoke accommodation to meet the needs of young people with mental health difficulties or those at risk of sexual exploitation. Inspectors saw examples of care leavers with additional needs continuing to receive floating support, enabling them to live independently. Care leavers spoken to report that while they felt safe in their accommodation, previous options were limited, resulting in accommodation in hard to let areas in the borough. Most of them reported satisfaction with the quality of accommodation and the level of support provided by their PA's.

114. Concerted efforts by the trust have significantly increased the number of care leavers the trust is in touch with. In 2014, the council had no information about the whereabouts of 31% of care leavers. This has now been reduced to three young people with whom the trust has no direct contact: a 19-year-old missing asylum seeker and two 20-year-olds who have left the area. Tracking young people who are in touch via a third party is effective. Inspectors saw examples of persistent attempts, by committed PAs, to engage young people.

115. Care leavers benefit from a personalised dedicated health service specifically for young people up to the age of 19. This supports transition into adulthood and promotes independence in accessing heath care. Each young person has an allocated key practitioner providing access to a wide range of helpful advice. This includes support for their health needs, including their sexual and emotional health, and help to reduce risk-taking behaviours such as substance misuse. Contact varies depending on the level of need, nurses from the looked after service will track and visit young people at home.

116. Health staff can access reports on the Doncaster Children's Services Trust's (DCST) electronic system to inform their health plans for individuals. Children in care health champions, along with the child sexual exploitation nurse specialists, meet bi-monthly and focus on improving practice. Nineteen of 20 young people eligible to receive their leaving care health summary between February 2015 and the end of July 2015 did so.

117. Financial support for setting up home is available and additional funding is obtainable via the resource panel if required. Care leavers spoken to confirmed that they have access to their health histories and most are provided with key documents such as passports, national insurance numbers and birth certificates. The trust pays for 10 driving lessons and full driver's licences, which has increased job prospects for some young people. Care leavers report that this is unattainable for many, as they cannot afford to purchase the provisional licence. Young people told inspectors they are aware of their entitlements but information is not available in writing.

118. Management oversight of systems to monitor the quality of services is weak. Managers do not have a strong grip on the quality of individual work or the quality of the care leavers' experiences. They do not routinely undertake case audits of the work within the team. Supervision in all cases sampled has been infrequent. Actions have not been clearly recorded or sufficiently reviewed. Newly appointed managers are beginning to utilise performance information to drive up practice. This is a considerable improvement, as previously the local authority did not have information on the actual numbers of care leavers they were responsible for.

119. At the time of inspection, 98% of care leavers had a current pathway plan, but the quality of the plans seen is too variable. Most pathway plans seen do not focus sufficiently on reducing risk and many lacked analysis and did not focus on outcomes. For example, the educational component of pathway plans does not focus realistically on educational next steps or on gaining purposeful employment. The voice of the young person is not evident and plans are not sufficiently specific or measurable. Few plans make any meaningful comment on the culture and identity of care leavers.

120. A legacy of poor practice has resulted in some young people leaving school without the skills required to engage in further education and training or to enter the job market. Seven of the eight young people who met with inspectors are currently not in education, employment or training (NEET). The most recent data show that 56% of care leavers are in education, employment or training, an improvement from 28% in 2013–4. This improvement may be in part the result of the trust now being in touch with significantly more care leavers than the council was previously. Insufficient effort is made to monitor and support children in care and care leavers post-16. There are currently 14 young people in higher education. Four young people are following a traineeship programme in the council with the aim of preparing them to take up an apprenticeship. There are 15 young people accessing apprenticeships, eight of which are with the council. Three young people have moved from apprenticeships into employment.

121. The Children Missing Operational Group (CMOG) considers young adults at risk of sexual exploitation and those who are missing. The monthly missing person's report provided by South Yorkshire Police includes young adults reported as being missing including those placed with the semi-supported living providers. In order to ensure that vulnerable care leavers at risk are properly supported, an experienced, qualified social worker in care leaver's

team provides additional support for PAs in co-working more complex cases, focusing on young people at risk of sexual exploitation, those with mental health problems and young parents.

122. In April 2015, a formal event to celebrate the achievements of children in care and care leavers was held. Local dignitaries and celebrities from Doncaster Rovers Football Club Team, a Paralympic sports medal winner and a former care leaver attended to present prizes.

123. A young people's participation forum was launched June 2014. The 'Hear by Rights' action plan is being implemented and reviewed. A children in care and care leavers interview panel has been established and three care leavers identified to be young person advisers to the Chief Executive of DCST. While these are positive developments to involve young people in service development, it is too soon to evaluate impact.

Leadership, management and governance	Requires improvement

Summary

Services for children and young people in Doncaster are improving. For many years, they have been characterised by extensive and persistent failures. There is a legacy of children and young people not receiving the right help at the right time or being left in risky or neglectful circumstances for too long. Since the establishment of DCST, improvement is evident across a range of services. Senior leaders understand the service and improvement plans focus on the right areas to build sustainable improvement. Political will to improve services for children and young people is evident and the current Mayor and the council have made this a priority.

Social work vacancies have reduced, as has reliance on agency staff. Improving performance is evident in relation to the timeliness of initial child protection case conferences, visits to children in care, services for children and young people at risk of sexual exploitation or who are missing, the number of care leavers the trust is in touch with and an increasing number of children are placed for adoption. All children and young people have an allocated social worker. Staff morale has improved with social workers speaking positively about working in Doncaster.

The establishment of Team Doncaster, the strategic partnership of statutory, private and voluntary organisations, has strengthened partnership working and has increased the focus on improving services for children and young people. However, there have been delays in the development and implementation of key strategies such as the early help strategy.

Improvements are not yet embedded across all operational teams. Quality of practice is not consistently good for all children and young people and some children's circumstances do not improve quickly enough. Some social workers' caseloads are too high. Performance management systems are underdeveloped and do not support managers in properly understanding where performance is weaker. Management oversight through supervision is inconsistent and sometimes weak.

Delay in developing the council's early help service has led to some children not getting help soon enough. The council has not been a sufficiently informed or tenacious corporate parent for the children and young people it cares for. Historically elected members have been insufficiently involved in the corporate parenting panel.

Inspection findings

124. Following the inadequate judgement of the Ofsted inspection of Doncaster's child protection services in 2012, Doncaster Council commissioned an improvement partner to work with them to improve services for children and young people. Although the council considered progress was being made,

the Department for Education and the Department for Local Communities jointly commissioned a review into how children's services should be delivered. The review, conducted by Professor Julian Le Grande, described a context of serious, extensive and persistent failures in the delivery of services to children and families in Doncaster extending over many years. Professor Le Grande's report described 'a culture of failure and disillusionment' and considered that this culture contributed to staff absence, sickness and discouraged the retention of good staff.

125. In response to Professor Le Grande's report, the then Secretary of State for Education made a Direction in August 2013 that an independent trust should be established. In November 2013, the Secretary of State and the cabinet of Doncaster Council agreed a memorandum of understanding. In February 2014, the Secretary of State appointed the chairman of the trust and in July 2014, the chief executive of the trust was appointed. DCST became operational on 30 September 2014.

126. The trust is responsible for delivering services for children and young people who are in need of help and protection or who are looked after, with the exception of services for disabled children, the virtual school for children looked after and early help, which have remained the responsibility of Doncaster Metropolitan Council. DCST is also a registered independent fostering agency and VAA. The trust inherited over 500 staff from the council.

127. The Mayor and her senior leadership team acknowledge the historical failure of services for children and the need for their improvement. On her election in May 2013, the Mayor made improving outcomes for children her 'top priority'. During this inspection, inspectors have seen considerable cross-party political desire and commitment to deliver better outcomes for children and families. Scrutiny arrangements reflect cross party membership to ensure robust oversight and challenge.

128. The Mayor and the chief executive of the council have engaged with government, officers and partners to review and improve services. Following the direction made in August 2013, elected members and officers of the council made concerted efforts to develop the trust, meeting the deadline set by government, resulting in the trust going live on 30 September 2014. The Mayor, lead member and elected members spoken to during this inspection were all able to describe well the successes and challenges faced by the trust and council. The chair of the scrutiny committee summed up the position of the council: 'everyone appreciates the gravity of the situation and that there isn't another chance to get this right.'

129. The trust is accountable to the Secretary of State for Education. The Chair of the Trust Board provides a six monthly report to the Department for Education. The Trust Board and the sub-committees that sit below it – in particular, the Workforce and Professional Standards committee and the Children, Young People and Families committee – undertake internal monitoring of trust performance. Reports completed by the Trust Chair to

the Secretary of State, in January and July 2015, reviewed by inspectors, demonstrate a realistic reflection of practice and progress made. The reports note that thresholds are not understood by partners, social work practice is variable and although case audits show some improvement, the number of cases judged good remain low. Inspectors would concur with this view.

130. The government Direction notice determines the services commissioned from the trust by the council. Lines of governance are set out in the contract that has been drafted in response to that Direction. The contract sets out clear expectations for improvement, requiring inspection judgements to reach requires improvement by April 2016, good by October 2017 and outstanding by October 2019. A range of formal reporting mechanisms between the trust and council are evident with monthly and quarterly performance meetings that monitor progress against the contractual requirements. Meeting minutes show appropriate attendance at a senior level with the chief executives of the council and trust, the director for children's services and lead member all in attendance, as well as senior officers. Meeting minutes show evidence of scrutiny of performance and appropriate challenge. In addition, the contract is reviewed annually. The first review was scheduled for early November.

131. While monitoring arrangements are dictated by the contract, there is evidence of maturing relationships and a growing trust between elected members, council officers and senior leaders of the trust. This was demonstrated during this inspection with keep in touch meetings with the lead inspector attended by both the director for children's services and senior managers of the trust. A decision by the council to invest £500,000, at the request of the trust, to refurbish Doncaster's children's homes is evidence of positive relationships and a shared ambition to improve services for children and young people. A further example is the consideration by the council of corporate support they might offer to the trust in its effort to recruit foster carers.

132. Strategic planning in Doncaster has been strengthened through the establishment of Team Doncaster. The four key partnerships are the Children and Families Board, Enterprising Doncaster Board, Health and Wellbeing Board and Safer and Stronger Doncaster Board. Clear links have been established across the key partnerships and this is demonstrated through improved collaboration in developing strategic plans, including, for example, the recent Joint Strategic Partnership Commissioning Plan for Children.

133. The strategic arrangements for commissioning in Doncaster are relatively new. The arrangements are appropriate and are likely to streamline and simplify commissioning. The new Joint Strategic Partnership Commissioning Plan for Children 2015–2016 was due to be finalised on 7 October 2015. Commissioning arrangements will also include third sector providers through a reference group coordinated by a newly appointed market development officer. Quality assurance of commissioned services is already well established with robust arrangements through a framework, which works

across local authorities within Yorkshire, developing the service provision and decommissioning where necessary. This commissioning framework looks at Independent Fostering Agency provision, 16+ services and services for children and young people with special educational needs. Where necessary and appropriate, services have been decommissioned, including a project for sexualised behaviour and a service for children missing.

134. While work has taken place to review the Children and Young People's Partnership Board's responsibilities, function and interface with other bodies, such as the Health and Wellbeing Board, there is still more to be done. The lack of coordinated strategic drive has led to developments, such as the early help strategy, being delayed. This results in children not always getting the service they need at the right time and too many assessed by children's social care who do not meet the threshold for a statutory service.

135. The annual Children and Young People's Needs Assessment (CYPNA) is key to informing the Team Doncaster partnership. While the CYPNA provides the strategic assessment, it is acknowledged that more specific assessments are also needed. Links are in place between the Local Safeguarding Children Board (LSCB) and the Health and Wellbeing Board, which receives the LSCB annual report. Minutes of the Health and Wellbeing Board meetings show attention to children and young people's issues. An example of this is the redesign of the integrated substance misuse service, which included the commissioning of a service for children and young people affected by parental substance misuse. Initial evaluation shows positive impact for children and their parents and a second cohort has just begun the programme.

136. The trust has been successful in attracting funding for four key innovative projects: Growing Futures; the Empower and Protect scheme; the Mocking Bird scheme; and Pause. Each scheme is designed to tackle a key priority area for Doncaster such as domestic abuse, child sexual exploitation and mothers who have multiple children removed from their care. Although in their early stages of development, there is already some evidence of early impact.

137. Management oversight of practice through supervision is inconsistent and often weak. The trust is aware that consistently good quality work is still to be achieved. In a small number of cases where practice is poor, inspectors saw uncoordinated work between the police and social care to plan section 47 investigations and recent examples of drift and delay where some children were left in situations where risk was not assessed or insufficient progress had been to reduce risk.

138. Similar issues in relation to the consistency of social work practice are seen in the children with disabilities team run by the council. An improvement plan is in place. The council and trust recognise closer alignment between the children with disabilities team, the response and referral team and ACPS teams is required to improve recognition and responses to disabled children who may be at risk.

139. The trust and council understand their services and recognise where progress has been slower and practice needs to strengthen. Steps have been taken to ensure that the foundations for improvement have been put in place, stabilising the workforce, investing in the signs of safety model, setting up a training programme for managers and designing a new locality based structure that promises to address some of the capacity issues in the ACPS teams identified during this inspection. Morale is mainly positive. Most social workers who spoke to inspectors reflected very positively about their experience of working in Doncaster and consider they feel more valued and supported.

140. Children and young people have told the trust and inspectors of the impact frequent changes of social worker has made on their ability to develop relationships with them and that it has contributed to the drift and delay experienced by some children and young people seen during this inspection. The trust has rightly focused on stabilising the social work workforce. The picture is improving, with vacancies now standing at just below 5% compared with slightly over 30% at the point of transfer to the trust. Reliance on agency staff has reduced from 13% in October 2014 to 9.5% in September 2015, which is lower than the national rate of 15% in September 2014. The trust recognises that there is still a need to employ agency workers while recruitment to vacancies is completed. In recognition of this, agency workers were included in the assessment centre held in January. There is an indication of growing confidence within the trust workforce evidenced by 12 agency workers transferring their employment to the trust.

141. Performance information systems and reporting arrangements inherited by the trust from the council were not fit for purpose. These are now developing and provide team managers, service managers and the senior leadership team with a range of basic management/performance reports. The trust recognises that this is an area of development. There is a clear action plan established to both improve the suite of reports provided to managers, and to develop managers' understanding and ability to use the information they receive to improve their services.

142. Effective relationships exist between the trust, Cafcass and the courts. The local Family District Judge sees senior managers as responsive and reports an improvement in the quality of social work in care proceedings and a noticeable improvement in the stability of the workforce. The trust has been effective in reducing the timescales of court proceedings, which now stand at 22 weeks, reducing delay in achieving permanence for children.

143. A quality assurance and learning framework is now in place. The trust has invested in training a group of auditors to improve the quality and consistency of judgement in case file auditing. Audits of case files conducted by senior managers for this inspection were in the main secure, identified strengths and shortfalls and largely accorded with the views of inspectors.

144. The trust, council and wider partners have a number of vehicles for collecting feedback from young people to inform service design and delivery.

Young people's views are included in the training and development strategy as to what makes a good social worker. Children and young people have been involved in the design of the new CAMHS and influenced the mental health and Wellbeing strategy. Similarly, meetings with parents and children, as well as the use of Survey Monkey to review the autism pathway, have resulted in improved family support and more timely assessments for children with complex needs. Four Young Advisors, who have experience of using social care services, meet with the chief executive of the trust regularly and the 'Big Summer Survey' received 50 responses from children and young people who had receive services from the trust. Their feedback will inform practice and act as a benchmark for future surveys. Elected members and staff attend Total Respect training and 14 young people are trained to participate in staff interviews.

145. Previously, corporate parenting arrangements within the council have been ineffective. Historically, there has been reluctance on the part of elected members to take on this role underpinned by difficult relationships with children's social care. The council recognises this and has recently revised the terms of reference of the corporate parenting board and appointed a new chair. Elected members' awareness in respect of their role and responsibilities as corporate parents is improving, with 12 elected members involved in the board. They have been supported by mandatory training. Twenty-seven elected members have attended specific corporate parenting training. While these changes are positive, they are too recent to evidence any impact.

146. The trust recognises its own role as corporate parents to the children who they care for. Recent trust board meetings have included a video of children in foster care talking about their experiences, a meeting with foster carers and younger children and a presentation by a birth child of a fostering family.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

Summary
Doncaster Safeguarding Children Board (DSCB) has made progress from the low base found at the last inspection in 2012. There have been improvements made in most areas but some aspects of the work remain weak. Many of the recommendations from the 2012 inspection are complete but not all. The Board recognises where deficits remain and are actively addressing these areas in order to ensure the Board is fully effective.

The new, experienced DSCB Chair has brought a high degree of challenge to the Board. There is now more engagement from partner agencies and a culture of challenge is evident. Examples of some better work has led to improvements in the coordination of multi-agency work in relation to child sexual exploitation, tackling the serious deficiencies in multi-agency early help work; and reviewing safeguarding arrangements in local schools. The quality of multi-agency training has improved leading to increased take up by agencies. The section 11 audit currently underway is following a more robust process than previously. Much of this work is very recent and although positive, the influence of the Board in contributing to changes in safeguarding practice in Doncaster is limited at this time.

Audit and performance information reports are not sufficiently detailed or analytical to be helpful in confirming progress, identifying trends or highlighting concerns that enable the Board to develop further or to challenge partners where this is required. Understanding the needs of those children suffering neglect and those young people admitted to hospital because of self-harm and suicide attempts remain areas for more work. The Board also recognises that to further improve, the experience of the child must remain at the centre of activities; improvement in the representation in Board activities by the voluntary sector and a clear communications strategy needs to be developed to publicise the work of the Board.

Recommendations

147. Monitor partner agencies contribution to early help through robust audit and tracking of the number of early help assessments completed and lead professional roles undertaken.

148. Monitor partner agencies understanding and application of thresholds for referral to children's social care by case audit and the scrutiny of performance data.

149. Ensure that high quality performance data is available and robust analysis occurs to enable the Board to have a good understanding of child protection and safeguarding activities across Doncaster.

150. Ensure there is a programme of audits, and re-audits, to identify the strengths in multi-agency practice and where weaknesses are identified these are addressed promptly.

151. Ensure the challenge log is effective in evidencing areas of concern that have been raised, addressed and show what improvements have been made as a result.

152. Undertake a review of those children and young people admitted to hospital for self-harm and attempted suicide to determine reasons that will inform suitable preventative work.

153. Improve the measurement of the impact of the DSCB work, including ensuring the experience of the child is at the centre of partnership working and monitoring of activities

154. Implement a system to evaluate the effectiveness of training delivered and monitor the impact on practitioner's work.

155. Develop a communication strategy for the Board to ensure that the work of the Board is well publicised and that the learning identified through the Board's scrutiny and review functions is disseminated across the children's services workforce and the communities in Doncaster.

Inspection findings – the Local Safeguarding Children Board

156. Serious failures were identified in the functioning of the Doncaster Safeguarding Children Board (DSCB) at the time of the last Ofsted inspection of children's services in 2012. Agency cooperation and joint planning continued to deteriorate following the inspection; recommendations made were not responded to in full, nor within the timescale, set by Ofsted. At the time of this inspection, most of those recommendations are now implemented. For instance, the annual business plan now includes all the key priorities of the Board and the subgroups have realistic plans, which are being monitored. Other recommendations are still to be fully addressed. Performance data is not yet comprehensive with only limited analysis provided for consideration by the Board. This hampers the Board's ability to influence, change or challenge poor performance. Compliance by all agencies with multi-agency thresholds has been subject to a one off evaluation but has not been regularly monitored which means the Board cannot be certain of compliance being sustained.

157. The DSCB Chair took up his post in January 2014. He quickly developed a plan to improve the participation of all agencies in strategic planning and provided clarity in respect of individual responsibility and accountability. Members of the Board confirmed that this change in expectation of individuals and partner agencies is now making a difference to the way the Board is operating. Initially, there was delay in improving the work of the DSCB, in major part, due to changes at a strategic level in children's services at that time. Since the launch of the Doncaster Children's Trust in October 2014, progress is evident from this low base. Inspectors saw good work, in particular, around child sexual exploitation during this inspection. Some key aspects of the DSCB's work remain under-developed with more needing to be achieved to demonstrate a positive and sustainable influence on the safety of children and young people in Doncaster.

158. An effective protocol is in place detailing the responsibilities of the DSCB, Health and Wellbeing Board, Children and Families Strategic Partnership Board, and the School, Children and Young People Overview and Scrutiny Panel. The protocol requires that appropriate communication and discussions occur across the strategic bodies. There is also developing partnership working between the DSCB and other partnership groups, including the Adult Safeguarding Board, the Health and Wellbeing Board, and Safer and Stronger Communities. The agreement of a set of shared priorities between these strategic groups has resulted in initiatives on 'hidden harm' and health improvement campaigns on safe sleeping and smoking in pregnancy being developed. DSCB has also worked with Safer Doncaster to respond to specific local issues that have arisen in Doncaster. This includes some innovative work to tackle domestic abuse and awareness of road safety issues.

159. The Chair has regular meetings with key individuals including the chief executive and lead member of Doncaster Metropolitan Council, the director of children's services and the chief executive of the Children's Trust. All of these individuals report that these meetings are challenging. However, they are not minuted to evidence the actions agreed.

160. There are five DSCB subgroups focusing on: child sexual exploitation; workforce development, including training; faith and culture; learning and improvement; and the child death overview panel (CDOP). There is also a Chair's subgroup that coordinates the work of the Board and it does this well. All of the subgroups have terms of reference and action plans to implement the priorities of the Board. Inspectors saw that minutes of all of the subgroups are detailed and clearly identify and agree actions. Membership of all of the subgroups and the main board is broadly representative of the statutory agencies, though the voluntary sector is significantly under-represented on the Board. Inspectors spoke to lay members on the Board who are experienced in wider children's work. They were able to confirm that more recently, they have seen a change in the way the Board operates describing it as an active board and this is an improvement.

161. The main partner agencies contribute appropriately to the Board's budget. This includes financially supporting five members of staff from the DSCB budget, which enables the Board to discharge its duties effectively.

162. The Board has four main priorities, but these are too general and do not sufficiently identify the most important areas of multi-agency safeguarding, which require improvement locally. For instance, although neglect is a significant feature in many child protection plans, there is not a neglect strategy to coordinate the contribution of the partner agencies. There are also a significant number of children and young people admitted to hospital for self-harm and attempted suicide, and this is not on the Board's agenda.

163. A private company is commissioned to produce the multi-agency Child Protection Procedures and these are completed to a good standard. The DSCB also commissions task and finish groups to ensure that the procedures are updated to reflect local need: for instance, groups met recently to update the missing children and female genital mutilation procedures. The Chair of the Board has also considered the procedures and confirms that while they are not always localised they are fit for purpose.

164. Under the new national guidance for local safeguarding boards, published earlier this year, DSCBs have the responsibility of having an overview of early help services. In response to these new responsibilities, the Chair and the DSCB significantly challenged all of the partner agencies over the poor early help services in Doncaster and the lack of significant progress in tackling the serious and systemic weaknesses. The DSCB commissioned an external review of early help services. The subsequent report identified inadequate cases and highlighted significant concerns about early help work across the agencies, including the poor understanding of thresholds. Subsequent work by the Board has acted as an excellent catalyst to launch the new early help framework and operational arrangements across the partner agencies.

165. The faith and culture subgroup, which was introduced this year, has begun to engage with faith and ethnic minority communities. A set of safeguarding standards and an audit tool have been developed, but it is too early to determine any impact. Similarly, a conference with representatives from the minority ethnic communities of Doncaster is planned to be delivered two weeks after this inspection is completed. While it is positive that the Board through the Faith and Culture subgroup has undertaken some promising work it is too early to determine the impact of this work in Doncaster.

166. The learning and improvement subgroup appropriately looks at a wide range of material including serious case reviews (SCRs), audits and performance data. The case review subcommittee reports to this subgroup and focuses on cases where there may be multi-agency safeguarding themes that do not meet the threshold for a SCR. In the main, the scrutiny is carried out to a satisfactory standard. However, further work is needed to ensure that the experience of the child is at the centre of the process and that the learning is disseminated across the children's workforce.

167. Senior managers report that, two years ago, take-up of the multi-agency training programme was limited across the partnership because the quality and organisation of some courses was poor. In the last 18 months, training has become well organised and is delivered by a committed group of regular trainers. Take-up of training has improved, with 2,000 participants involved in recent training sessions. This includes twice-yearly high-profile conferences, the online 'common room' for the children's workforce, and lunchtime seminars with a good range of topics including female genital mutilation, self-harm and fuel poverty. The workforce subgroup and the new training manager have focused on ensuring level three training is in place for childcare practitioners. The focus on monitoring the impact of training though is under-developed. The Board cannot be certain that training delivered is having the desired impact on improving the skills and knowledge of the children's workforce in Doncaster.

168. Although the Board can evidence progress across a number of areas of activity, many of the improvements are measured within the context of a low starting point from the Ofsted inspection in 2012. There remain some significant areas where the DSCB work needs further improvement. The DSCB had produced a learning and improvement framework that describes 'a culture of continuous improvement'. However, this focuses on the gathering of information from child death reviews, audits, performance data, and complaints and pays insufficient attention to the dissemination of that learning across the wider workforce. The DSCB does not have a communications strategy, to raise awareness of its work with the communities of Doncaster and within the children's workforce, which limits its effectiveness. Social workers and managers met during this inspection reported a limited understanding of the work of the Board.

169. This year performance data available to the Board have improved. However, some data continue to be unavailable and analysis is limited. The data do not enable a sufficient understanding of local issues about the delivery of child protection work and the wider safeguarding services.

170. Only two audits were conducted in 2014–15, with two more conducted so far this year. These focused on section 47 work, child sexual exploitation and neglect. The quality of those audits was poor, looked at a small number of cases and lacked sufficient analysis or detailed recommendations based on the learning identified from the cases examined. The involvement of children and young people in the work of the Board is poor, although an action plan, drawn up as part of the annual business plan for 2015–16, has identified that this issue needs to be addressed.

171. The DSCB Chair and others met as part of this review had a good awareness of the issues in relation to child protection services. They described well the variability, poor quality, and drift and delay for some children and young people. The DSCB maintains a 'challenge log' of issues that have been raised about multi-agency working. However, this does not focus sufficiently on individual cases and escalation of issues. The log also does not record the challenges made to the South Yorkshire Police on the presentation of the

Her Majesty's Inspectorate of Constabulary (HMIC) report, which highlighted shortfalls in child protection procedures, and the review of the actions taken by the police to address these.

172. There has been good coordination by agencies in order to tackle child sexual exploitation in Doncaster. Following publication of the 'Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)' by Alexis Jay, the DSCB Chair provided an assurance report for Doncaster councillors on the strengths and areas needing further partnership working. The Board also challenged the South Yorkshire Police following publication of the critical HMIC inspection reports in 2014 and 2015. The Chair met with the local Borough Commander and drew up an action plan to tackle a number of issues including around missing children; as a result, the numbers of young people missing from care have declined significantly.

173. A child sexual exploitation subgroup and work stream chaired by a Police Superintendent coordinates well the operational partnership working. There are also good links with businesses in Doncaster and, as a result of the work of the subgroup, all local hotels and bed and breakfasts have been visited and made aware of indicators of child sexual exploitation. All taxi drivers now have mandatory training in this area before being issued with their licence.

174. The DSCB carried out a section 11 review of the quality of the response to safeguarding issues by all partner agencies in 2013. The Board has recognised that this audit was poor and lacked evidence of challenge. At the time of this inspection, a further section 11 review was already taking place and this included a more detailed self-assessment and a rigorous set of challenge meetings. The work had yet to be completed and so no improvements in the impact on children, young people and families is evident. Parallel to this process, 100% of all schools in Doncaster completed section 175 safeguarding assessments, which is positive.

175. The child death overview panel (CDOP) work is satisfactory. There were 26 child deaths in Doncaster in 2013/14. The majority of these were of children with life limiting conditions. No concerns were identified about abuse, neglect or failures by children's services. There was, though, a lack of understanding of how best to identify 'modifiable' factors that impact on the deaths. The chair of the panel is undertaking work with other child death overview panels to improve understanding.

176. The council and trust appropriately notify Ofsted of serious incidents when they occur. This includes some of the high profile sexual exploitation cases under investigation by the South Yorkshire Police and Children's Trust staff. One serious case review has been commissioned and one learning lessons review commenced. All of the notifications have been considered appropriately and the decision making to undertake the reviews has been ratified by the National SCR Panel.

177. The Annual Report 2014–2015, in draft during this inspection, describes the functioning of the DSCB well. The evaluation of the quality of safeguarding

practice and what is done to address the issues is weaker, limiting the effectiveness of the report in improving safeguarding across Doncaster. The report does confirm that the Board has a good understanding of the local child protection services, mirroring the findings of this Ofsted inspection, and concludes appropriately that 'there are still many areas which require further development and some which require urgent attention'.

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 8 of Her Majesty's Inspectors (HMI) from Ofsted.

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