Derby City

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: 6 March 2017–30 March 2017

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Children's services in Derby City are good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		Good

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

Executive summary

Children's services in Derby City are good. The director of children's services (DCS), chief executive, senior leaders and members are a strong, collaborative group with a proven ability to improve services for children and families. Effective strategic partnerships, aligned strategic needs assessments, clear governance arrangements and integrated commissioning of services ensure shared priorities and actions to improve outcomes for children. Investment in services and resources for vulnerable children has been prioritised, for example by maintaining a broad range of early help services, recruiting permanent staff to children looked after teams and securing housing for care leavers.

Performance management is strong at both strategic and operational levels. Local authority managers collect and use live data and key performance information across all services, and this, coupled with an extensive auditing and review process, means that they know their strengths and weaknesses well. Senior managers' and leaders' direct involvement in auditing and their interaction with staff enrich their understanding of frontline practice. When they become aware of service deficits, they take appropriate action to improve performance. An effective quality assurance framework means that actions that are set following regular audits are monitored and responsible managers are held to account for their completion.

Senior managers have had some success in the recruitment and retention of staff, but more needs to be done. Opportunities for career progression, competitive rates of pay and mortgage deposit subsidies contribute to an increasingly stable workforce, and there are no agency staff at team manager level or within the children looked after teams. However, the caseloads in the reception and locality teams remain too high, and this has an impact on the quality of work, particularly in assessments and plans.

Early help services are well established, with families receiving timely support from a range of services, and this prevents the need for statutory involvement. Partnership working is well developed, and increasing numbers of thorough assessments are completed by partner agencies.

The local authority has not been able to maintain the good rating for safeguarding services that was awarded at its last inspection in 2013, but many aspects of the service remain strong. For example, children at risk of harm benefit from good information sharing between agencies, appropriate decision making and a consistent application of thresholds. Partnership working is a strength, and the strategic and operational response to children missing from home, care or education, or at risk of child sexual exploitation is effective. However, the quality of return home interviews needs to improve. The quality of assessments is variable, and many lack in-depth analysis and recommendations, which in turn means that planning is weaker than it could be. Management oversight is evidenced by regular supervision, in most of these cases, but is not sufficiently reflective or focused on improving the quality of work.

Private fostering is an area requiring improvement, due to delay in responding to notifications and completing assessments and reviews. Delays in seeing children and

completing relevant checks on carers mean that a few children may be left in unsafe situations.

While homeless 16- and 17-year-olds are offered support, it is not always appropriately considered whether they should become looked after. As a result, services may not be best meeting their needs.

The local authority has built on the 2011 adequate judgement of its looked after children inspection to provide good services and improved outcomes for children. Decisions for most children to become looked after are timely, appropriate and based on thorough assessments. The Public Law Outline and letters before proceedings are used effectively, and the quality of reports presented to courts is well regarded by the local judiciary. Children looked after develop positive relationships with their social workers, who know them well. They also develop trusting relationships with their independent reviewing officers, who monitor and challenge social work practice effectively, when required, to ensure that services are best meeting children's needs.

The health needs of children looked after, living both inside and outside the local authority, are increasingly well met. Emotional health needs are now being addressed by 'The Keep' and the child and adolescent mental health services' RISE projects. This has led to easier access and support, and an associated improvement in children's functioning. Although the educational attainment of children looked after is in line with the national average, not enough are leaving school with a good range of GCSEs. Personal education plans lack specificity and the focus to ensure that children progress and have the right support to do so.

Children looked after numbers have fallen, year-on-year, due in part to the effective work of the 'Exit from care' team that assesses and supports special guardians, families or connected persons and prepares children to move out of care. Most children live in stable, well-supported foster placements, but there are insufficient numbers of foster carers to offer good placement choice and ensure the best possible match. The corporate parenting committee needs strengthening to ensure that it has sharper scrutiny and oversight of children looked after, particularly those with additional needs, and hears and uses children's voices to shape services.

Adoption services are good, and an increasing number of children are adopted from a range of ages and backgrounds. Family finding and matching are thorough, with good use made of the East Midlands consortium to assist in placement choice. Post-adoption support services are a strength of the local authority. They offer excellent support to children, families and birth parents.

Care leavers receive a good service, and staff remain in touch with nearly all leavers. Care leavers live in safe and suitable accommodation, and are supported to develop their independence skills. Increasing numbers are in education, employment or training, and care leavers state that they feel valued by their workers. More attention is needed for care leavers to have access to their full health histories in order for their health needs to be fully met.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates seven children's homes. All were judged to be good or outstanding at their most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements/ arrangements for the protection of children was in January 2013. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in June 2011. The local authority was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since July 2015.
- The DCS is also responsible for adult services and public health.
- The chief executive has been in post since January 2015.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since February 2011.

Children living in this area

- Approximately 58,852 children and young people under the age of 18 years live in Derby City. This is 23% of the total population of the area.
- Approximately 23% of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 16% (the national average is 15%)
  - in secondary schools is 15% (the national average is 13%).
- Children and young people from minority ethnic groups account for 29% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are (Asian/Asian British) Pakistani and (Asian/Asian British) Indian.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 25% (the national average is 20%)
  - in secondary schools is 20% (the national average is 16%).

[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.

Child protection in this area

- At 6 March 2017, 2,476 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,342 at 31 March 2016.
- At 6 March 2017, 309 children and young people were the subject of a child protection plan (a rate of 53 per 10,000 children). This is a reduction from 314 (53 per 10,000 children) at 31 March 2016.
- At 6 March 2017, eight children lived in a privately arranged fostering placement. This is an increase from five at 31 March 2015.
- In the two years before the inspection, five serious incident notifications have been submitted to Ofsted and no serious case reviews have been completed.
- There were two serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 6 March 2017, 427 children are being looked after by the local authority (a rate of 73 per 10,000 children). This is a reduction from 448 (76 per 10,000 children) at 31 March 2016. Of the 427 children:
  - 260 (or 61%) live outside the local authority area
  - 48 live in residential children's homes, of whom 35% live out of the authority area
  - three live in residential special schools, of whom 67% live out of the authority area
  - 329 live with foster families, of whom 67% live out of the authority area
  - 21 live with parents, of whom 38% live out of the authority area
  - six children are unaccompanied asylum-seeking children.
- In the past 12 months:
  - there have been 48 adoptions
  - 29 children became the subject of special guardianship orders
  - 214 children ceased to be looked after, of whom 2% subsequently returned to be looked after
  - 33 children and young people ceased to be looked after and moved on to independent living
  - one young person ceased to be looked after and is now living in a house in multiple occupation.

Recommendations

1. Reduce social work caseloads in the reception and locality social work teams to enable staff to carry out good-quality direct work with children.

2. Ensure that assessments are informed by the child's history, research findings and social work theory, and address all issues relevant to parenting capacity and unmet need, including those arising from disability, language and ethnicity.

3. Ensure that child in need and child protection plans clearly detail the support to be put in place to effect the changes needed to improve outcomes, and that they are updated to take account of changing circumstances and emerging risks.

4. Ensure that private fostering notifications are responded to promptly and that children living in such arrangements are seen in a timely way.

5. Ensure that assessments of homeless 16- and 17-year-old young people are appropriately offered support under section 20 of the Children Act 1989 and, when a young person decides to be supported as a child in need rather than becoming looked after, that they are making a fully informed decision.

6. Ensure that supervision is regular and reflective, and has a clear focus on risk assessment and improving the quality of assessments and plans.

7. Improve the quality of return interviews so that these can better inform plans and wider intelligence about vulnerable children.

8. Ensure that all children looked after have analytical and targeted, specific personal education plans to capture their progress and any support needs.

9. Continue to prioritise the recruitment and commissioning of a variety of local foster carers to provide sufficient capacity to best meet the needs of children looked after in Derby.

10. Ensure that all care leavers are clear about their own health histories and are aware of any family health issues that may affect them as they go through life.

11. Ensure that the corporate parenting committee strengthens its oversight of children looked after with additional vulnerabilities and that children's views help to shape services.

Summary for children and young people

- Overall, services for children and families in Derby are good. Senior managers and councillors are determined to make sure that children have the best chances in life.
- Children are kept as safe as possible, because social workers act quickly to protect them when they are at risk of harm.
- Social workers, family visitors and children's practitioners spend time with children and are good at listening to them to find out what life is like for them, so that the right decisions can be made for them.
- When children and their families have problems or worries, social workers, family visitors, teachers, health visitors, nurses, the police and other professionals work well together to make sure that children have the right help at the right time. There are plenty of different services that provide good help and, because they are provided quickly, smaller problems do not become more serious.
- Social workers make sure that children who need support have plans which help to ensure that their lives improve. However, these plans would be improved if they stated what it was that everyone involved needs to do and when they need to do it by, and if there were more regular checks on how well the plan is going.
- After children have gone missing from home or education, they are spoken to by an independent person. This is so that workers can better understand the reasons for this, and provide help to prevent it from happening again.
- When children are unable to live with their parents, social workers find them a good home with caring adults. If it is the right thing to do, they keep brothers and sisters together and, if it is safe to do so, they make sure that children are still able to see the people who are important to them. When adoption is the best plan for a child, social workers help them to understand the reasons for this and make sure that they know all about their family background.
- Young people leaving care are well supported. They have a choice of accommodation, including staying put with their foster carers. They receive good practical support from social workers and personal advisers who assist them with things like attending appointments, finding jobs, apprenticeships or further education or training, and learning how to manage money, cook and do household chores. A group of care leavers have helped to make a guide for other care leavers so that, when they enter adulthood, they will know what help and support they are entitled to.
- Senior managers have plans to keep on improving services for children. They keep a close eye on the work of social workers to make sure that they are all doing their best for children. Plenty of training is arranged for social workers and other professionals who work with children to make sure that they understand the best ways to help children and their families.

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

Children receive an effective response when referred to children's social care, ensuring that their safety and well-being are prioritised. Professionals and families can access social work advice and guidance, which includes identifying the need for an early help assessment or signposting to early help services. Children at risk of harm benefit from good-quality information sharing by partner agencies. Management decision making at the initial stages of social work intervention is appropriate, in the majority of cases seen. Thresholds are consistently applied and the rationale for decisions made is clearly recorded.

Caseloads in the reception and locality teams remain too high and have an impact on the quality of work, such as in assessments and plans.

The quality of assessments across locality and disabled children's services is not good. Many assessments are lacking in depth, and analyses are often a summary of concerns, lacking in clear conclusions. This impedes the establishment of comprehensive plans and achieving positive outcomes for the children concerned. Most assessments are allocated promptly, and children and their families are visited in a timely way and their views secured. Children are seen on their own and direct work is undertaken. Plans are regularly reviewed by core groups, network meetings and review meetings that show good multi-agency engagement. This is not always preventing drift or securing improved outcomes for some children.

A well-established early help service enables access for children and families to the right support services at the right time. Partnership working is well developed. The quality of the early help assessments is generally good, and progress against plans is measured in review meetings and demonstrates improvements in children's lives. This prevents the need for escalation to statutory services.

Children at risk of sexual exploitation or who regularly go missing are carefully considered by complex strategy meetings. Children considered to be at high risk are further considered by task and monitoring groups, attended by senior managers from relevant agencies. These ensure that wider intelligence is shared and provide an additional focus on the effectiveness of the child's plan.

There is delay in responding to private fostering notifications, with delays in children being seen and assessments being completed and reviewed.

Not all homeless 16- and 17-year-old young people are being assessed as they should be, under section 20 of the Children Act 1989, leaving some supported as children in need without the benefits of services for children looked after and later entitlements as care leavers.

Inspection findings

12. 'First contact' services respond to all contacts involving a concern about a child, and most decisions made are appropriate to the level of risk. The experienced, stable team of non-social work qualified staff, overseen by two social work-qualified team managers, works efficiently to gather information to determine the next steps. Consent is secured, where appropriate, and does not compromise the safety of the child. Where a strategy meeting is deemed necessary, it is progressed by the multi-agency safeguarding hub (MASH). There is also separate telephone advice available to professionals from the social work reception teams. This provides an additional source of guidance and support.

13. The MASH ensures effective information sharing between the police, health, public protection and children's and adult social care. This enhances the quality of decision making. The domestic violence triage process means that all high-risk domestic violence notifications are subject to an immediate strategy meeting and referral to a multi-agency risk assessment conference (MARAC), and those assessed as standard or medium risk are individually discussed in order to determine the appropriate next steps. In a small number of cases seen, a delay was evident in the police notification which could potentially leave children at risk of harm. Although there is good multi-agency engagement in strategy meetings convened within the MASH, this does not consistently include a contribution from education. This means that the meetings do not always have full information about children to assist in decision making.

14. Management decision making at the initial stages of social work intervention is appropriate in the majority of cases seen. Thresholds for assessment and the need for a strategy discussion, a section 47 child protection enquiry and an initial child protection conference (ICPC) are consistently applied, and the rationale for the decision is clearly recorded. In most cases seen, management oversight is evident and assessments are allocated promptly. Supervision, though mostly regular, is mainly task and compliance focused and with little evidence of reflection or a focus on quality. (Recommendation)

15. Most children and their families are seen in a timely way and their views secured. Children are seen on their own. Direct work is undertaken by social workers in the locality teams who develop strong relationships with the children whom they support. There is less evidence of direct work in the reception teams, and this impacts upon the strength of the voice of the child in single assessments.

16. Where an assessment concludes that a child requires support through a child in need or early help plan, it is discussed by the relevant locality's vulnerable children's meetings. This is a well-attended multi-agency meeting which allocates the child to the appropriate social care locality or early help team and agrees the services that are required to enable the delivery of the plan. This helps to ensure timely and appropriate family support. Children who need to

be stepped up to social care or stepped down to early help are also discussed and the next steps agreed. Children needing an immediate response are safeguarded by escalation to social care through the 'First contact' service.

17. A well-established early help service, with a stable, committed and experienced workforce, offers a broad range of services. This gives children and families access to the right support services at the right time. Partnership working is well developed, with increasing numbers of early help assessments being undertaken by partner agencies. The quality of the early help assessments is generally good, but some lack detail in respect of the child's view. Children and families are fully involved in setting the targets of their early help plan and through regular 'team around the family' meetings. The progress against these plans is measured and demonstrates improvements in children's lives. This prevents the need for escalation to statutory services.

18. Although assessments are ensuring that children are safe, they are not yet good. Increasing referrals are leading to high caseloads, particularly in the three reception teams. Despite the local authority increasing the capacity of these teams, the size of the caseloads has yet to be reduced. Combined with the target 20-day timescale for completion, this is contributing to assessments that are not thorough enough to identify and address all presenting needs adequately. There is little reference to research findings or social work theories, such as attachment, and the graded care profile neglect assessment tool is not yet well used. Chronologies are of variable quality and, where present, are mostly simply copied and pasted into the assessment record with no attempt to link past and present concerns. Some analyses are simply a summary of concerns, and lack clear conclusions about the strengths and weakness in the child's situation or the degree and scope of unmet need. This means that assessments are not highlighting the level of risks or concerns and what needs to happen to improve outcomes sufficiently. (Recommendation)

19. Concerns about poor parental mental health, domestic violence or substance misuse are usually identified and addressed, but in a very small number of cases reviewed there is no assessment of needs arising from a parent's learning disability or the impact of the child's disability, such as autism or attention deficit hyperactivity disorder. Some assessments were not facilitated by interpreters when they should have been, and children's needs arising from ethnicity and culture were not addressed. Where further assessment is required, this is often not identified in the initial plan established by the reception social worker. Assessments are not routinely updated as they should be and are without a thorough, current assessment of risks and needs. This impedes the establishment of effective plans. (Recommendation)

20. In most cases, children benefit from regular core groups, network meetings and reviews. ICPCs, network meetings and reviews are timely and evidence good multi-agency engagement. Although discussions in planning meetings are often comprehensive, many plans reviewed were out of date, insufficiently specific or lacking in timescales. In some cases, this is leading to drift and delay. (Recommendation)

21. Practice is variable across the team for disabled children. Some children's plans are of a good quality, with evidence of children regularly being seen and the views of non-verbal children being captured through observations. However, in other cases, there is evidence of drift and support plans not being effectively coordinated or reviewed. This means that improvements in some children's circumstances are not being progressed as quickly as they could be.

22. The action taken in relation to the shortfalls identified by the local authority relating to private fostering arrangements has not yet had a positive impact upon practice. Although there have been no recent notifications, in cases seen by inspectors there was delay in responding to notifications, in children being seen and in undertaking assessments. Some of the necessary safeguarding checks and reference requests were also subject to delay, and not all reviews were held within 28 days of notification. This means that the suitability of private fostering arrangements remains unknown for longer than it should be. Once the reviewing process has commenced, practice is better, with children being seen regularly and alone. (Recommendation)

23. Homeless young people aged 16 and 17 years are assessed under the joint housing protocol, and 22 are living in independent accommodation, supported as children in need. Although these children have supported accommodation, with a multi-agency worker and social worker available to them, this does not equate to the support available to a child looked after, especially once they have reached the age of 18 years. Cases sampled did not sufficiently evidence that, when a young person chooses not to become looked after, they are making an informed choice. Plans, while addressing the need to develop independence skills, often do not address the need of the child to restore relationships with close family members so that alternative sources of support are available to them in adulthood. (Recommendation)

24. The out of hours (OOHs) service, 'Careline', covers both children's and adults' services, and all OOHs social workers work across the specialisms. This is particularly helpful when having to respond to children whose parent has a mental health issue, as the response is then better coordinated. The service is adequately staffed, with on-call managerial support and decision making. The cases sampled evidence appropriate responses, with information being passed to 'First contact' or the relevant locality team to follow up as necessary.

25. Child protection initial and review conferences are well chaired by child protection managers. As a group, it is seeking to ensure that the views of the child are clearly communicated. Child protection managers are also seeking to improve parents' attendance and involvement at meetings by direct discussion or phone calls to encourage their participation, and are monitoring the use of conference reports. Child protection managers are using the quality assurance notification process to highlight concerns. This has significantly improved the numbers of conference reports being completed on time and shared with the child's parents in advance of the meeting. This means that children, parents and professionals attending meetings have more time to consider both the

report findings and their response when making important decisions in children's lives.

26. Child protection managers also chair complex strategy meetings about cases involving child sexual exploitation, female genital mutilation, forced marriage, trafficking, radicalisation, children who harm other children and complex family groups. Children stepped down from a child protection to a child in need (CIN) plan remain children in need for a minimum of three months, and the decision to close or step down to early help can only be made by the three-month CIN review meeting. The first CIN review is chaired by a CIN reviewing officer, then this responsibility transfers to a team manager who has no line management responsibility for the case. Where a new referral is received about a child who was previously the subject of a child protection plan, a case management meeting is held prior to the ICPC to ensure that, when the concerns are the same, the Public Law Outline is considered as early as possible. Children who have been subject to a child protection plan for over two years are regularly reviewed, and now number only four. Overall, these are robust processes which help to ensure a consistent approach to the most vulnerable children that keeps them safe from harm.

27. Complex strategy meetings ensure a thorough discussion and make clear decisions that inform the plan for children at risk of sexual exploitation or who go missing. Children with high levels of risk are further considered at monitoring groups attended by senior managers from relevant agencies. These ensure that wider intelligence is shared and provide an additional focus on the effectiveness of the child's plan. In most cases seen, return interviews are completed within the 72-hour timeframe, but the content is often of limited value as it does not impact on the child's plan or wider intelligence sharing as much as it should. (Recommendation)

28. Wider partnership groups such as MARAC and multi-agency public protection arrangements (MAPPA) work well in this local authority. The case sampling evidenced that decisions made by MARAC are understood by social workers and incorporated into plans. Practitioners attend MAPPA when they are involved with a child who is potentially at risk from an offender, and training is available to ensure that they understand what is expected of them.

29. The local authority maintains detailed records of children who go missing from school, and when a child cannot be traced by either the school or the education welfare officer the case is escalated to other agencies, as appropriate. When a child's whereabouts are unknown, there are persistent and wide-ranging efforts by agencies to locate them. Such cases are regularly reviewed by the Derby missing person's monitoring group to ensure that all possible action is taken to locate the child. Absence from school is higher in Derby than in the rest of England (16.6% vs 10.5%). Although the local authority staff follow appropriate procedures to support the attendance of these children and young people by working with the early help teams and through the provision of parenting courses, this remains an area for improvement for this local authority. Comprehensive records are maintained

on children who are electively home educated, and the local authority complies with statutory guidance by undertaking annual home visits to see these children.

30. Local authority arrangements for considering allegations and concerns about paid employees or volunteers are effective. In 2015–16, all cases were completed within a three-month timeframe. There is prompt and appropriate engagement from across the professional network in strategy discussions and meetings. The designated officer tracks all enquiries and allegations, including the numbers of allegations made by or on behalf of disabled children, which has highlighted the high level of vulnerability of this group of children.

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

Children only become looked after when it is in their best interests and, when they do so, decisions are timely and appropriate. The Public Law Outline is used effectively with families to address areas of concern. Legal permanency through the courts is achieved promptly and within the government target time of 26 weeks.

Children looked after in Derby benefit from consistent social workers who develop meaningful relationships and hold high aspirations for them. Most children know their independent reviewing officers (IROs) well. The IRO service is sufficiently resourced and is robust in challenging the quality of social work practice and planning.

Well-coordinated systems and procedures for children looked after who are at risk of sexual exploitation and/or who go missing ensure a timely response. However, the quality of return home interviews needs strengthening to ensure that they support planning for children and are used to inform professionals of trends and hotspots.

The health needs of children looked after are well met, both inside and outside of the local authority. Children are increasingly and effectively supported by the collaborative development of 'The Keep' and the child and adolescent mental health services' RISE projects to meet their emotional health needs and well-being.

Children looked after make progress in education at a similar rate and attain as well as those across England as a whole, despite the significantly higher proportion of young people with a statement of special educational needs. However, the proportion that leaves school with a good set of GCSEs is too low and the quality of personal educational plans is not good enough to improve outcomes for children.

Children who need adoption benefit from skilled family finding and matching, and good support. Prospective adopters are assessed, trained and well supported. Transitions to adoptive placements are well planned, giving children a positive start in their new homes through high-quality post-adoption support.

Children in foster care live with dedicated, enthusiastic carers, but there are too few foster carers being recruited by the authority to provide a range of choice for children. Children only return to the care of their parents, carers or connected persons following intensive direct work with families and children, which is provided by the highly effective, experienced and skilled 'Exit from care' team.

Care leavers live in safe, secure accommodation, participate in education and employment and develop positive relationships with personal advisers and other support workers.

Inspection findings

31. Children and young people only become looked after when it is in their best interests. Thresholds for entry into care are applied appropriately and are informed by timely and comprehensive risk assessments.

32. Care proceedings are progressed in a timely manner and in less than the 26-week recommended timeframe. The quality of assessments, plans and information sharing is good, and is seen by the Children and Family Court Advisory and Support Service and the judiciary as a crucial component in minimising delays for children. Cases in the Public Law Outline process show clear letters before proceedings and well-evidenced court statements.

33. The number of children looked after in Derby has been steadily reduced over the past year. This reduction is an indicator of the authority's commitment to support families in crisis to keep the family together, the success of the 'Exit from care' team and the increasing, appropriate use of adoption and special guardianship orders.

34. Increasing workforce stability in the children looked after teams is helping to ensure that children are seen regularly, and seen alone, by social workers whom they trust. Records of social work visits show a sensitive regard to the child's lived experience. Several very positive examples of direct work with children were seen in which children were helped to understand their history and to be involved in the development of their care plans. The impact of parental mental health and substance misuse was well explored in assessments, and children's wishes and feelings and families' views were usually well represented.

35. Successful transitions by children from local authority care to the care of their parents, carers or connected persons, following intensive direct work with families and children, are enabled by the highly effective, experienced and skilled 'Exit from care' team. Since April 2016, the team has enabled 19 children to return home, either on a special guardianship order or a discharge from care. Small caseloads in the team ensure that social workers have sufficient capacity to concentrate on the direct work necessary both to effect change and to prepare families and children for the challenges presented upon returning home. Appropriate support services from a range of health, education and voluntary agencies are engaged to sustain these arrangements.

36. When children become looked after, the local authority prioritises planning for permanence for children effectively by the time of their second looked after review. Plans for permanence other than adoption are identified quickly due to a strong grip on court proceedings and timeliness. Well-written, detailed special guardianship assessments reflect children's current and future needs and show that children influence their plans. Connected persons receive the same level of training as all other foster carers, and this assists in their preparation for providing safe and effective care. The comprehensive offer of

special guardianship support, similar to post-adoption support, effectively supports permanence and special guardians throughout a child's lifetime.

37. Placement stability within Derby is improving, and approximately 8% of children had three or more moves in 2015–16. This is in line with statistical neighbours and better than the national average of 10%. A small minority of children have experienced more than three placement moves, but the disruption meetings, reviews and case management discussions collate the learning from these cases to improve future matching decisions and assessment practice.

38. The average caseload of independent reviewing officers is 65 children. IROs believe this to be manageable and enables them to fully monitor children's care plans in-between reviews, as well as to have the flexibility to respond to urgent requests for review and oversight. The use of informal and formal escalation procedures when concerns about children's care plans are identified are fully embedded and sufficiently challenging. The majority of children spoken to during the inspection knew their IRO and saw them as a constant and supportive presence in their lives.

39. The response to children missing from care or at risk of child sexual exploitation is well managed and coordinated. From the children's case files seen, the majority of children looked after were offered a timely return home interview to clarify the circumstances of them being missing and the consequent risks. The quality of the return home interview reports needs strengthening in order that the information gained is better used to inform children's plans. In addition, the information needs to be collated to provide all partner agencies with information regarding trends and hotspots.

40. The commissioning strategy for children looked after is comprehensive, but it is not showing an impact on foster care recruitment. The current sufficiency of in-house and external foster places is often stretched, with insufficient placement choice to ensure that children always have the best match. Recruitment strategies have not resulted in an increase in foster carers. The success of 'staying put' arrangements has also had an impact on foster care capacity. Due to the ageing profile of current foster carers, without successful recruitment the use of carers from independent fostering agencies (IFAs) will rise. Although these placements are of comparable quality, it may mean that children have to move further from Derby. The authority recognises these challenges and that a relentless focus on recruitment will be necessary. (Recommendation)

41. Sufficiency of provision is clearly a priority for the authority, with significant financial investment being made available to support actions identified as necessary in the sufficiency strategy. The refurbishment of in-house residential provision is well advanced, and the regional consortium framework has helped to identify resources. Inclusion in the East Midlands consortium is currently providing access to a range of IFAs to meet the needs of most of Derby's children for placements close to home.

42. An effective and sufficiently resourced system is in place to ensure that children have the right level of contact with those people who are important to them. Child-focused contact plans and arrangements for children looked after were in place in the majority of case files seen, and there was evidence of review following any increased risk or change in circumstances.

43. Children are supported to improve or maintain their health by a specialist team of looked after children's nurses. Health assessments are completed in time for 88% of children, but nurses and commissioners report that improvements are needed to the timeliness of initial health assessments. When children are in neighbouring authority areas, their health needs are carefully coordinated and monitored through well-negotiated reciprocal arrangements. If a child is placed a long way from Derby and has a specific recognised health need, social workers present requests to the complex case panel to ensure equity of support. The recent decrease in the proportion of dental checks undertaken, to 80%, is an area recognised as requiring improvement, and alternative ways of increasing performance are in progress, such as training for carers in the importance of oral hygiene.

44. The emotional and mental health of children is being increasingly and effectively supported by the development of the emotional health and well-being service at 'The Keep'. Since its inception in October 2016, over 100 children have been referred for assessment and support, with subsequent improvements in children's functioning and well-being.

45. Recreational and cultural activities are encouraged by the provision of free leisure passes and access to theatre tickets. Children spoken to by inspectors believe that these give them the opportunity to participate in a range of activities that will help to enhance their physical and emotional health, as well as their social development. Although children's hobbies and talents are encouraged by their carers, the authority could do more to formally celebrate individual children's achievements.

46. Children looked after make progress in education at a similar rate and attain as well as those across England as a whole, despite the significantly higher proportion of young people with a statement of special educational needs. However, the proportion who leave school with a good set of GCSEs is too low.

47. Around three quarters of children looked after attend a good or better school. For those children for whom this is not the case, the choice of school is usually made for well-considered reasons, such as the need to maintain particular relationships with school staff. There are clear processes in place for matching children with an appropriate school when they move to provision outside of the local authority area.

48. The quality of personal educational plans (PEPs) is not good enough to improve outcomes for children. Although reviews take place on time, a minority of PEPs are not fully completed. PEPs are often characterised by

insufficient analysis of the child's needs, inaccuracies and contradictions, or targets that are not specific, measurable or fully reviewed. (Recommendation)

49. The local authority maintains clear records of children who do not attend school for at least 25 hours per week and supports them well to continue to learn. Seven of these 12 children are between schools following a placement move, and five have particular needs that require reduced timetables. In addition to this, a further five children use alternative provision for at least part of their studies and are making good progress, which is overseen by the virtual school headteacher.

50. The independent visitor and advocacy service, though in the process of change to a new provider, is embedded with some long-standing relationships that support children in residential placements. The Children in Care Council is used to capture children's views, but more needs to be done to ensure that it captures all children's views and to show how these subsequently shape services.

The graded judgement for adoption performance is that it is good

51. Derby considers adoption for all children in need of permanence outside of their birth family. There is proactive, tenacious practice, particularly in relation to older children and those children with additional needs or disabilities. The number of adoption orders has increased from 25 last year to 47 this year and this, coupled with an increasing use of special guardianship, means that more children in Derby benefit from a permanent family. The adoption service is stable, and staff are dedicated, knowledgeable and highly committed.

52. Good-quality performance data informs adoption tracking, and an early alert system is showing improved timescales for children recently placed. More children are now entering care and moving in with their adoptive family in less than 16 months. Derby's own performance information for 2016–17 shows this to be 61% for currently placed children, which is higher than the national three-year average of 47%. Some long-standing legacy cases have affected these figures, but the local authority remains persistent in its efforts to find adoptive homes for children from minority ethnic groups, older children and those with additional needs.

53. A small number of children experience delay in finding their adoptive family as, when other permanence options such as placement with relatives are considered, there is a lack of focus on a parallel adoption plan. Sequential, rather than concurrent, assessments of family members add to the delay, as when these prove unsuccessful the adoption planning starts again from scratch. This means that permanence by use of adoption is not secured as quickly as it could be. The local authority has recognised that more needs to

be done and is in the process of developing a permanence team to commence adoption work at the earliest opportunity. This, along with courts now making placement orders at the same time as care orders, should further assist in speeding up the adoption process.

54. Family-finding activity is strong and mitigates the earlier delay. Family-finding social workers know children well, meaning that children benefit from carefully considered matches. Once matched, good adoption placement planning means that children move to their family quickly. Good-quality 'together or apart' assessments ensure that children are able to live with their brothers and sisters when this meets their needs. Although matching reports, as stand-alone documents, do not reflect how well prospective adopters will meet children's needs, the overall quality of matching is good and there have been no disruptions in the past 12 months.

55. 'Foster to adopt' is always discussed as part of the assessment of prospective adopters, but there has been only one placement in the past 12 months. Another placement is due to be made in the near future, and the local authority needs to build on this to ensure that more children benefit from early permanence arrangements.

56. Children's permanence reports are mostly full, detailed and sensitively written, showing consideration and assessment of alternative options to adoption. Assessments of contact and changing needs are clear, with a focus on what is right for the child, both now and in the future. A dedicated birth family support worker in the post-adoption team works directly with birth families throughout care proceedings, but the take-up of this service is low. The birth family support worker also offers support in letterbox contact, which results in adopted children receiving high-quality letters.

57. The quality of life-story books and later-life letters is variable, but most are good. Most books are colourful, age-appropriate and informative, and are enhanced by the use of a child's own words and drawings. Some later-life letters use too much formal language but, overall, both letters and books assist children in understanding their history and why they cannot live with their birth family.

58. Derby City has a rolling recruitment programme and holds monthly information sessions. Enquirers receive a very prompt response, and staff in the adoption service understand the profile of children waiting in Derby, ensuring that the right adopters are recruited to meet their needs. Derby City has eight adopters currently waiting, five of whom can offer homes to older children and to brothers and sisters. There are currently 19 children waiting for placements, nine of whom already have matches identified. The remaining 10 children are older or have complex or additional needs. Link Maker is used extensively to identify matches. The adoption register is not routinely used, as approved adopters' details are shared within the East Midlands consortium, after three months of approval. As part of the regionalisation of adoption, a

pilot starting in June 2017 will see all waiting children and prospective adopters shared across four local authority areas, which include Derby City.

59. Assessments of prospective adopters are comprehensive and timely. They are clear on adopters' skills and experience, and are perceptive about how these translate to meeting the needs of an adopted child. All adopters spoken to spoke highly of the service and the assessment process, and many had chosen Derby over other adoption agencies. Adopters feel listened to, and they gave examples of influencing service development, such as the content and delivery of training.

60. A highly experienced, knowledgeable chair provides good leadership to the adoption panel, whose membership includes people with direct experience of adoption. Panel minutes reveal a sensitive yet probing approach, resulting in well-considered recommendations and advice to the agency and applicants alike. The agency decision maker and panel chair meet regularly, and both confirm mutual challenge and respect. The agency decision maker is confident in the recommendations made by panel and responds promptly to any issues raised.

61. Post-adoption support is good, and creative, sensitive work, particularly with older children, helps families to manage challenges. Adoptive families benefit from a wide range of services, and the team makes good use of the adoption support fund. Thirty-five children are receiving post-adoption support and 10 adults are receiving birth records counselling. A strong relationship with 'The Keep' means that families continue to access therapy for as long as they need. It is an ambitious service which has a renewed focus on prevention, rather than responding to crises. Adopters in contact with the post-adoption support service describe it as responsive, supportive and 'brilliant help'.

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

62. Local authority staff work hard to remain in contact with care leavers, and consequently are in touch with almost all of them. For the very few with whom they have lost touch, workers are persistent in their attempts to re-establish contact.

63. Workers encourage those in care to remain looked after until it is appropriate for them to become more independent. As a result, only nine of 119 (7.6%) 16- and 17-year-olds have left care and an increasing number of care leavers, currently 21, remain in 'staying put' placements. When a care leaver expresses a wish to live independently, workers assess their readiness and discuss the options with them.

64. The vast majority of care leavers who move into independent or semi-independent accommodation live in suitable and safe properties. The local authority provides access to a good range of supported accommodation and gives assistance to young people living in private housing. Staff prioritise care leavers' access to the local authority's own housing stock, and will make an offer of a property to care leavers before it becomes more generally available. Houses in multiple occupancy are only used when this is the young person's preferred option, and only then after the suitability is fully assessed.

65. Local authority staff provide good support that helps care leavers to maintain successful tenancies. When tenancies do break down, personal advisers help young people to secure safe alternative accommodation. A partnership arrangement means that the local authority can access up to 30 emergency beds when needed.

66. Care leavers receive appropriate support to help them to develop the skills that they need to live independently. Those who move into supported accommodation receive help to develop skills such as cooking, cleaning and managing their own finances. Where young people remain in a foster placement, personal advisers support and encourage their carers to help them to develop independence skills.

67. Personal advisers understand how to access a range of support services for drug and alcohol misuse. In the small number of cases in which drug use has been a problem, they have provided appropriate support that has resulted in substantial improvements in the young person's well-being. Personal advisers are also knowledgeable about the potential risks of sexual exploitation and take appropriate action where this is a concern.

68. Personal advisers review care leavers' pathway plans on time and at appropriate intervals. Almost all pathway plans are clear and detailed, and focus appropriately on the themes most likely to have a positive impact on each young person's life, including their health, education and relationships with others. Care leavers describe how reviews of their plan help them to focus on the things that they need to improve, although they find the plans themselves of limited value. In a few cases, young people choose not to participate fully in their reviews, but personal advisers work tenaciously to engage them.

69. Personal advisers understand the health needs of their young people and usually document them clearly in pathway plans. Almost all care leavers register with medical services such as doctors and dentists and, where necessary, their personal adviser ensures that they access services when they need to. Personal advisers provide effective support for young people who need specific help with, for example, their mental health, and there are examples of personal advisers advocating for them when the service that they have received has not been good enough. Disabled young people receive a good standard of care and support.

70. The proportion of care leavers who participate in education, employment and training has risen. The figure reported to inspectors of 64.6% is higher than the England average of 49%, and most participate on a full-time basis. Around half of children looked after access additional careers advice and guidance during Year 11, and this helps them to make appropriate post-16 choices. Relationships with local post-16 providers are good, and enable local authority staff to successfully support both the young person and the provider when difficulties arise. Currently, 13 care leavers are studying at university.

71. Staff provide training sessions to help care leavers who are not in education or employment to prepare for work and find suitable education or employment opportunities. The local authority has begun to prioritise care leavers for its own apprenticeship vacancies through a guaranteed interview scheme. It currently employs four care leavers as apprentices, two of whom joined through the authority's traineeship programme. One care leaver who has successfully completed an apprenticeship now works for the authority on a permanent basis. Two care leavers are undertaking a traineeship programme with a view to moving into an apprenticeship.

72. Care leavers receive the documents that they need to begin their adult lives, including their birth certificate, national insurance number and bank account details. Not all receive a passport, but work is underway to remedy this. Care leavers do not always receive details of their full health histories or those of their birth families, meaning that they may be unaware of susceptibility to health risks or conditions as they go through life. (Recommendation)

73. Care leavers receive appropriate advice that helps them to understand the support and benefits to which they are entitled. The local authority has worked with care leavers to produce a guide that is available both in print and online. Personal advisers explain entitlements to young people during pathway plan reviews and when they become eligible for, or in need of, a particular benefit.

74. Most care leavers feel good about themselves. They state that their personal advisers genuinely care about them and are proud of their successes. The local authority holds events to celebrate their achievements, such as a recent event in which care leavers were presented with certificates in recognition of the progress that they had made in various aspects of their lives, such as living independently, education and improving their health and well-being.

Leadership, management and governance	Good

Leadership is strong and the local authority has significant knowledge about itself which is used in a constant drive to improve children's experiences. Coordinated governance structures and a healthy approach to challenge between partner agencies support improvement, further strengthened by the effective, independent challenge provided by the chair of the Derby Safeguarding Children Board.

High-quality performance reports and an effective quality assurance framework give leaders and managers confidence in their oversight and knowledge of the quality of the experiences of children and families who are receiving the services. Senior managers respond quickly to identified deficits in practice following regular audit activity and put action plans in place. 'Closing the loop' reports hold managers to account for the implementation of actions to improve services and outcomes for children.

Corporate financial commitment to early help and an edge of care service contribute to positive outcomes for children. A strong early help offer and the development of an effective 'Exit from care' team are contributing to the gradual downward trend of numbers of children looked after. The recruitment of permanent staff at team manager level and across the children looked after teams enhances consistency in services and enables children to develop positive relationships with social workers.

Children receive coordinated help and support from well-developed integrated commissioning arrangements between the local authority and health partners. The development of services to improve the emotional health and well-being of children is evidence of recent success. The corporate parenting committee is not strong enough and requires a sharper oversight of services for children looked after, including those with additional vulnerabilities. Their voice and involvement need strengthening to ensure that their views fully inform priorities and service development.

The quality of children's assessments and plans, particularly in help and protection services, is too variable. Senior leaders recognise that improvement is hampered by high caseloads in some teams and that a focus on quality, as well as compliance, now needs to be implemented. Staff access regular supervision, but have inconsistent opportunities for reflective practice. A revised workforce strategy and staff training opportunities are in place, but variations in practice remain. For example, the graded care profile is not established across all services and therefore is not yet consistently improving the quality of practice.

Inspection findings

75. An impressive strategic director for children's services has significant knowledge and experience of children's social work, and provides exceptional and consistent oversight of children's experiences. His involvement in regular auditing and meetings with staff ensures that he has a good grasp of social work practice. This appointment, following major structural reorganisation in 2015, led to the creation of a people's directorate, incorporating children's and adults' services with public health. An experienced and strong chief executive officer holds the strategic director appropriately to account. Due to the director of children's services (DCS) holding responsibilities for children's and adults' services and public health, the chief executive arranged a local government association test of assurance review in November 2016 to ensure that all these services were equally effective and well managed under one director. The review reported positive findings on the effectiveness of the governance arrangements at the political, organisational and partnership levels.

76. The leadership team and managers have a realistic understanding of service strengths and weaknesses through the effective use of good, evaluative self-assessment. They demonstrate a constant willingness to embrace internal and external challenge and scrutiny to improve services for children. This ambitious approach to learning led to a creative peer review in April 2016 that identified areas requiring improvements in the 'front door', including thresholds, decision making and management oversight of referrals and assessments. Swift action taken by senior managers alongside the implementation of a strong multi-agency safeguarding hub in June 2016 means that there is now an efficient and effective response to referrals for children in need of help and protection.

77. Ownership of children's priorities is embedded across the local authority's political and corporate governance arrangements. The children and young people's plan's four key priorities are governed by the Children, Families and Learner's Board (CFLB) trust arrangements and the Derby City and neighbourhood partnerships, which also oversee the overarching Derby plan 2030. This gives efficient alignment to the planning and delivery of services to children and a 'think family' approach to service design and financial investments. Intelligence is supported by effectively coordinated joint strategic children's needs assessments. Needs assessments accurately identify inequalities in neighbourhood deprivation and growth in diverse populations, resulting in appropriate plans and design to meet future demand for services.

78. Senior leaders promote a transparent process and open culture in internal challenge that complement the effectiveness of the arrangements of the Inspiring Young People Scrutiny Board. Additional regular meetings between the Health and Well-being Board chair, strategic director and lead cabinet member for children, young people and safeguarding support effective information sharing outside of formal meetings. Monthly safeguarding assurance meetings between the lead cabinet member, strategic director,

chief executive officer and the chair of the Derby Safeguarding Children Board (DSCB) give additional independent oversight of the progress of children's priorities. A specific and detailed challenge log records clear and robust decision making, and the progress of agreed actions is tracked effectively. These safeguarding meetings help senior managers and the DSCB chair to hold each other to account, give an opportunity for updates on operational practice and help to plan future audit activity.

79. Multi-agency partnerships work successfully together, and implement recommendations from internal and external audits and reviews to achieve positive outcomes for children. A good example of this is evident in the outcome of the local government association child sexual exploitation diagnostic peer review in July 2016. This thorough analysis of the effectiveness of the local authority's and partners' strategic and operational approach has resulted in all recommendations being implemented. Quick identification and intervention help and protect children subject to and at risk of child sexual exploitation, including those presenting with additional risks and vulnerabilities. This includes children missing from home, care and education, supported through effective individual and strategic plans. Partners appropriately share intelligence such as information passed to the police from return home interviews. Resources are also shared, and the film, 'Kayleigh's Love Story', which has been translated into a number of different languages, is an example.

80. Strong strategic partnerships, aligned strategic needs assessments and integrated commissioning of services ensure the implementation of children's plans to meet shared priorities and improve outcomes. This can be seen in the 'Future in Mind' local transformation plan (2015–20) to improve access, provision and support for children's and young people's mental health. Children's involvement in the design of mental health pathways and the development of a single point of access to services are working well. A child and adolescent mental health services' RISE innovation project provides an effective rapid response service which has resulted in a 40% reduction in hospital admissions in recent months and a positive impact on children's mental health and well-being.

81. Senior managers have confidence and assurance in a co-located integrated commissioning team that is able to respond flexibly to children's needs. For example, devolved budgets and use of an outcomes framework model in service specifications have resulted in commissioning a successful new emotional health and well-being service pilot, 'The Keep'. This service supports children looked after and children in need of targeted therapeutic support, and has helped over 100 children effectively since implementation in November 2016.

82. A comprehensive quality assurance process within an accessible learning and improvement framework is a significant strength in Derby. This provides senior leaders with a cogent line of sight on the quality of the experiences of children receiving services. Repeated and consistent scheduled audit activity

means that leaders have a secure knowledge and understanding about what is happening in practice and hold managers to account by tracking the effectiveness of changes to children's outcomes. Quality assurance extends from focused audit activity to regular direct observation of operational practice by senior managers, including the strategic director, and is enhanced by lead cabinet members' unannounced visits to frontline teams. Investment in a new post in the quality assurance team demonstrates a commitment to improving the quality and quantity of reports. This has led to 88% of planned audits being completed this year to date, improving on 77% last year.

83. A financial commitment and the implementation of a new children's social care recording system in 2015 have resulted in better-quality, accurate and wide-ranging performance management information that complements this effective quality assurance process. Senior managers can access live data from the business intelligence launch pad and key performance information to understand the impact of services to children, identify areas of progress and implement action plans in service areas that need further improvement. The launch pad holds 158 detailed management information reports across the service, including early help, adoption and children looked after, dashboards, children's profiles, the involvement of teams and scheduled reports. This oversight has, for example, led to increased timeliness of completion of return home interviews and coordinated strategic work with courts and the Children and Family Court Advisory and Support Service, leading to increased numbers of permanence arrangements.

84. Senior managers investigate performance to understand the story of the children behind the data anomalies and trends. They recognise that the drive for improvement is continuous, with managers being held accountable for implementation of change, tasked with 'closing the loop' on recommendations from audit activity and presenting progress reports to the improvement board. The gradual reduction in the number of children looked after is relentlessly audited, checked and analysed to inform cause, effects and impact on other service areas. A 'turning the curve' analysis concludes that effective and strong early help, a proactive 'Exit from care' team, increasing numbers of children adopted and higher than average numbers of children leaving care at 18 are reducing the numbers of children needing to be looked after and improving children's outcomes overall.

85. Corporate parenting responsibilities are well understood and shared in Derby City. All directorates promote and support a revised children looked after pledge, resulting in positive opportunities for children. Examples include significant investment and pride in the children's home regeneration programme and housing priorities for care leavers, alongside leisure and apprenticeship opportunities. However, the corporate parenting committee needs to demonstrate more effectiveness in holding its members and partners to account. Meeting minutes do not evidence sufficient challenge or show, in particular, how children looked after with additional needs or vulnerabilities are having their needs met. In addition, further work is needed to increase the

voice, involvement, range and influence of children in care and care leavers in the corporate parenting committee and scrutiny process, already identified as a significant area for improvement by senior managers. (Recommendation)

86. Senior leaders' self-assessment of children in need of help and protection accurately identifies the areas requiring improvement identified by inspectors. They have focused on improving compliance and now recognise the need to address quality. It is too early to determine the impact of some recent plans. For example, the implementation of assessment tools, including the graded care profile, is beginning to improve assessment quality and analysis, but it is not yet in full use by all teams.

87. Children's social workers in some teams have caseloads which are too high. The necessity to use agency social workers, in response to increasing demands and a higher than average staff turnover, is recognised by senior managers as a significant factor that has an impact upon the quality of service that children and families receive. Investment in good initiatives to mitigate these challenges include career pathway opportunities, a mortgage deposit subsidy scheme, a regional memorandum of understanding with neighbouring local authorities on the recruitment of agency workers and a recent job evaluation that implements new pay grades for senior practitioners and social workers. The absence of agency staff in team manager posts or workers in the children looked after service demonstrates that these strategies are beginning to have a positive impact on the children's workforce. (Recommendation)

88. Inspectors have seen that, for the vast majority of staff, supervision is regular, but does not always include reflection, sufficient assessment of risk or how to improve the quality of assessments and plans. The quality of children's records reflects that this is an area needing further improvement.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is outstanding

Executive summary

Derby's Local Safeguarding Children Board is making a sustained and significant positive difference to how well the agencies in the city protect children and promote their welfare. It is a highly influential strategic partnership. The board is very well led. A culture of respectful challenge, in which enquiry is expected and there is no place for complacency, is modelled by the board's highly capable and experienced independent chair, is owned by board members and is used to drive continuous improvement. Suitably senior representatives of all key agencies sit on the board. They are clear about the responsibilities and expectations of a board member.

The board's evaluation and analysis of performance is well focused and rigorous. An active board and effective sub-groups make sure that extensive audit activity and performance monitoring are not only well targeted but also continue until sufficient improvement is achieved. This work is aligned with the ongoing evaluation and targeting of training on priority areas for improvement. For example, a November 2016 audit of the multi-agency safeguarding hub and first response team led to the completion of a training needs analysis and the delivery of additional targeted training to improve knowledge and practice. One review of progress has been completed and a further audit is planned to ensure that the desired improvements are fully achieved. A similarly rigorous approach has been taken regarding work to tackle neglect. When audit and performance information analysis showed an insufficient pace of improvement, the board more than doubled the number of training courses on neglect that it runs and introduced a specific neglect element in key mandatory multi-agency safeguarding courses. A further audit is planned for December 2017 to assess the impact of this additional training on improving practice. Although the board engages well with children in aspects of its work, their feedback is not used to understand performance as consistently as it could. This is an area for development that the board is aware of.

The board has a clear oversight of work to tackle the danger to children from sexual exploitation, going missing and related risks such as radicalisation, and provides strong leadership. Awareness-raising and preventative work with children and young people in schools, driven by a very active education sub-group, is particularly effective. Increasingly effective engagement with faith settings is helping to promote not only broader safeguarding awareness but also more specific knowledge of the risks posed by dangers such as child sexual exploitation and radicalisation. This work is exemplified by safeguarding sermons preached by the imam of a large local mosque.

Inspection findings – the Local Safeguarding Children Board

89. The Local Safeguarding Children Board (LSCB) provides consistent, well-targeted and highly effective challenge and leadership to the partnership of agencies. A culture of respectful challenge in which enquiry is expected and there is no place for complacency is modelled by the board's highly capable and experienced independent chair, owned by board members and used to drive continuous improvement. All key partner agencies play an active role in the board. New board members receive an induction that makes clear the expectations for, and responsibilities of, board members. The board is sufficiently financed and well structured, with a full range of active sub-groups. The board benefits from the long-standing engagement of two capable lay members.

90. The LSCB works closely and effectively with other relevant boards, including the Health and Well-being Board (HWB), Children, Families and Learner's Board (CFLB) and the Adult Safeguarding Board. This supports the board not only to discharge its statutory responsibilities but to be an effective critical friend to partner agencies. During the course of the inspection, the independent chair attended the CFLB on behalf of the LSCB and secured an agreement to update the joint strategic needs assessment and the children and young people's plan to better reflect the needs of children in new communities in Derby, such as the growing Slovak and Roma communities. This is to be followed up in the independent chair's regular meetings with the health and local authority joint commissioning manager.

91. Through the independent chair, the board provides regular challenge to the local authority at a senior level to ensure that the people's directorate, which provides services to both children and adults, keeps a sufficiently sharp focus on the needs of children. This challenge is exercised through monthly strategic safeguarding assurance meetings that are attended by the independent chair and senior local authority leaders, including the director of children's services (DCS) and lead member for children. This meeting considers a full range of performance and quality assurance information, and uses a challenge log to ensure that areas for improvement receive ongoing attention until the necessary progress is achieved.

92. The LSCB's 2015–16 annual report is a very high-quality and detailed 'health check' for agencies. The board's 2016–17 priorities of combatting the risks from child sexual exploitation, going missing, domestic abuse and neglect, and continuing to improve early help, stem from this report and provide a solid basis for the 2016–17 business plan. Progress against the plan is regularly and effectively tracked by the board's sub-groups. New or unexpected priorities that arise are considered by the relevant sub-group and raised at board meetings, at which an action log is used well to track progress.

93. Regular and rigorous monitoring of frontline practice through audit and performance monitoring is well targeted and used effectively to understand performance and to drive improvement in the quality and impact of services

provided by partner agencies. For example, a multi-agency LSCB audit of the work of the first response team and MASH in November 2016 led to undertaking a training needs analysis with staff and the delivery of additional bespoke training to improve knowledge and practice in identified areas of concern. A review of progress took place in January 2017, and a further audit is planned to ensure that the desired improvements are fully achieved. The board does not just provide challenge at a local or regional level, but also at a national level when this is appropriate. For example, when the LSCB was scrutinising and challenging the local authority about how well it assures itself of the welfare of electively home-educated children, the local authority's response, detailing the limitations to its statutory powers, led to a letter from the independent chair to raise the issue with the Secretary of State for Education.

94. The LSCB's analysis of the quality of services and their impact on improving children's lives is strong, because it is based on good triangulation between quantitative performance information and qualitative learning from such sources as audits and practice observations. The board does not limit its oversight of practice to its priority areas and those children receiving 'mainstream' safeguarding services, but focuses on early help and on particularly vulnerable groups, such as disabled children, children looked after who are placed out of the local authority area, those who are vulnerable to radicalisation and those with emerging mental health problems. The feedback from children and their families is not fed into this process as consistently as it could be. This is an area for development of which the board is aware.

95. A thorough and effective section 11 process ensures that partner agencies are discharging their statutory responsibilities, and highlights areas where agencies could do better. This is complemented by a section 175 audit that has successfully engaged almost all schools. The audit has been driven by the board's highly successful education hub. This group has engaged many schools, and extensive work with them and the wider school network has been successful in driving up both the awareness and the quality of safeguarding in schools. Work to counter child sexual exploitation and promote online safety has been commendable. Children and young people have been engaged well in the process of creating and disseminating learning materials that have directly led to greater awareness and the prevention of harm, such as the short film 'Alright Charlie'. A group of Year 6 girls used their learning from watching this film to protect themselves from harm and to provide evidence to the police that supported the successful prosecution of a perpetrator. The board also promoted a similar film, 'Kayleigh's Love Story', targeted at secondary-aged children, which also received very positive feedback from teachers and pupils alike. As a result of this, one young person said of their social media use, 'I think I will unfollow all the people I don't know.'

96. A reciprocal arrangement whereby the serious case review (SCR) panel is chaired by a senior manager from another local authority brings not only

relevant knowledge but also objectivity and transparency to the process of decision making. This brings real benefit to complex and challenging discussions, particularly when partner agencies may have differing perspectives on how best to learn from children's individual circumstances. Importantly, the board has not waited for the completion of SCRs or learning reviews to use the lessons learned to improve agency practice. For example, initial learning from the case of a child about whom it has only very recently been agreed to carry out a SCR led to an LSCB audit of the cases of children who came off a plan at their first child protection review conference and, in turn, to updated and improved procedures and guidance. The LSCB learning and improvement framework is compliant with statutory guidance and is detailed, clear and up to date. It provides a well-structured framework for undertaking SCRs, learning reviews and related activities, and for the dissemination of the learning that arises from them.

97. The child death overview panel is appropriately constituted and carries out its function well. It links to the SCR sub-group when necessary, oversees rapid response arrangements for when children die unexpectedly and promotes public health messages about relevant issues such as safer sleeping, the use of smoke alarms and nappy sack safety. This means that the board is doing all that it can to ensure that awareness is raised in the local community in the hope of preventing further deaths.

98. The board has effective oversight of the quality of work to tackle child sexual exploitation, the risks arising from going missing and related areas of vulnerability, such as radicalisation and female genital mutilation. As a result of this and strong agency 'buy-in', the board has been able to drive up the quality of agencies' practice through disseminating good-practice learning, awareness-raising materials and by exercising effective challenge and leadership. Robust challenge to the local authority about the quality of return home interviews and the low number that were completed within 72 hours has led to a significant improvement in their timeliness and an ongoing focus on improving their quality. The board is also engaging well with faith settings to promote not only broader safeguarding awareness but also more specific awareness of the risks posed by dangers such as child sexual exploitation and radicalisation. This work is exemplified by safeguarding sermons preached by the imam of a large local mosque. It has recently been bolstered by the board's multifaith strategy, developed over the past year with significant mosque, Hindu temple, church and gurdwara consultation.

99. The board provides a broad range of relevant training of which social workers speak highly. While driven by statutory expectations and the board's priorities, the volume and content of training are updated on an ongoing basis to reflect new priorities. An audit to assess the impact of the LSCB's neglect strategy on improving frontline practice showed that it had not been as successful as had been hoped in promoting the use of the graded care profile, a tool to identify and assess the severity of neglect. As a result of this, the LSCB not only amended multi-agency procedures to make the use of this tool compulsory in

certain circumstances but also more than doubled the number of training courses on neglect that it runs, and has introduced a specific neglect element to key mandatory multi-agency safeguarding courses. An audit of the quality and impact of services for children who are suffering from neglect is planned to assess the impact of this additional training on improving practice.

100. A well-thought-out validation process is being successfully used to drive up and assure the quality of single-agency training. Good evidence of the impact of training on improving practice is being provided by 'three month on' telephone interviews that are carried out with a selection of training attendees. While this is positive, the overall findings from this ongoing evaluation process have not been analysed to gain greater value from them and to identify any specific themes that could be used to support further improvement. Learning from the last two SCRs in Derby, published in January and February 2014, informs the content of training. Social workers interviewed by inspectors are overwhelmingly aware of the key messages from these SCRs. However, their knowledge of the specific details of the two reviews is not consistently good.

101. The LSCB's website is clear and user friendly, and contains a broad range of information and guidance for professionals, children and their parents. This includes a full range of appropriate policies and procedures, relevant research and information on important national and local issues, such as child neglect. It also has helpful advice to children and parents on matters such as child sexual exploitation and online safety. The LSCB policy and procedures sub-group ensures that policies and procedures, including a clear and well-presented threshold document, are kept up to date. Many policies and procedures are shared with Derbyshire to help to ensure that children receive a consistent response from agencies, such as police and health, that provide services to both the city and the county.

Information about this inspection

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

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people 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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

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