Newcastle Upon Tyne

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: 24 April 2017 – 11 May 2017

Report published: 7 July 2017

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

Senior managers know the strengths and weaknesses of their service very well. Inspectors identified very few areas for improvement where action plans were not already being implemented and that had not already been identified by senior managers. While progress can be seen in the quality of social work practice, with many examples of good work, this is not yet leading to consistently good outcomes for all children.

In 2015, senior managers established that too many children in the city experienced harm due to neglect. The wish of the senior team to better understand neglect and the needs and characteristics of families in which neglect occurs led directly to innovation and investment in evidence-based practice. In 2016, the council led an ambitious service transformation to redesign long-term social work in the city, intended to effect change within families. Through Family Insights (funded through the DfE Innovation Programme), a new unit-based model of social work has been implemented. Staff have responded positively to the transformation programme. This transformation is in its early stages, and, while inspectors have seen some evidence of improving practice in relation to early help, quality of assessments and plans, educational outcomes and a strengthening approach to securing earlier permanence, not all children are benefiting from a consistently good social work response.

Highly effective and dynamic partnerships focus clearly on shared priorities, which are clearly defined and translated well through strategic plans. Impactful partnerships with the courts and children and family court advisory and support services (Cafcass) are securing timely progression through legal proceedings. Early years and preventative services have been combined to better target support for the most vulnerable families and, when the need for help is first identified, there are improved outcomes for many children.

Comprehensive workforce planning, a strong focus on learning and development for staff at all levels, and reduced caseloads have resulted in high retention rates and a reduction in the use of agency staff. Vacancies and sickness rates are among the lowest in the region. Children have meaningful and consistent relationships with social workers, who know them well. Senior managers have ensured throughout the transformation programme that, where possible, children do not experience changes of worker. Social workers are regularly supervised by their managers. Group supervision also enables workers to have further reflection time. However, this does not always result in consistently good management challenge around the quality of children's assessments and plans.

The initial response service (IRS) has not yet been restructured, although, following a very recent external review, senior managers are now implementing plans for improvement. Inspectors found, and the local authority has identified, that the screening of contacts to children's social care is not consistently and sufficiently robust. Thresholds are not always understood or applied appropriately and, as a result, not all children receive the right level of intervention at the right time. While

there is a swift and effective response to child protection concerns through the multi-agency safeguarding hub (MASH), a small number of children wait too long before interventions effectively identify risk and need.

Child and family assessments are improving, with a better focus on strengths and risks, but not all assessments are sufficiently analytical, or history is not considered well enough within the assessments. In addition, some are not updated, which means that children's needs are not always fully understood and considered. Not all pre-birth assessments are carried out as early as they could be. Resultant plans in these cases are therefore not as sharply focused as they should be, which leads to drift, and delays for some children in permanence being achieved. Children benefit from regular reviews, although independent reviewing officers (IROs) are not consistently effective at challenging or escalating concerns about delays or about the quality of planning for children. Management arrangements have been strengthened to address this. Delegated responsibility is not secured in a timely way for all children.

There is effective risk management in response to domestic violence, homeless 16- and 17-year-olds, children at risk of radicalisation and female genital mutilation. There is a highly effective response to risks of child sexual exploitation, and inspectors saw evidence of some outstanding practice to protect children. When children go missing from home, the vast majority receive a return home interview, but these are not consistently analysed to inform individual planning and wider prevention strategies.

The majority of children become looked after when it is in their best interest. The recent development of a number of performance panels is providing senior managers with better oversight of decisions about when children should become looked after. These panels are leading to earlier identification of entrenched neglect and a better focus on achieving timely permanence planning for children, particularly through adoption. The legal proceedings panel is not yet being used effectively to consistently track all children in pre-proceedings or to ensure contingency planning when change is not being achieved or sustained in some cases. As a result, a small number of children are placed in an emergency in placements that do not meet their needs, and there are insufficient placements locally for children who have more complex needs. When a plan of adoption is agreed, the majority of children are matched quickly and placed with their permanent families at the earliest opportunity. The majority of children enjoy safe, supportive and stable placements with foster families close to home.

The educational achievement of children looked after is a strength supported by a well-led virtual school. The Children in Care Council (CiCC), 'Voices for Choices', is a strong and visible group that is actively promoting the voices and experiences of children looked after. However, advocacy and independent visitors are not used widely. Care leavers benefit from an effective service. However, services to support children's mental health are not meeting local need and some children and young people are waiting too long to receive a more specialist service.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates four children's homes.
- The previous inspection of the local authority's arrangements for the protection of children was published in March 2012. The local authority was judged to be **good**.
- The previous inspection of the local authority's services for children looked after was published in March 2012. The local authority was judged to be **good**.

Local leadership

- The director of children's services (DCS) has been in post since April 2013.
- The DCS is also responsible for adult services.
- The chief executive (CEO) has been in post since January 2013.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since January 2015.
- The local authority is rolling out a systemic model of social work.

Children living in this area

- Approximately 56,619 children and young people under the age of 18 years live in Newcastle. This is 19% of the total population in the area. (Office for National Statistics mid-year population estimates 2015)
- Approximately 29% of the local authority's children are living in low-income families. (Child benefit data – as at 31 August 2014)
- The proportion of children entitled to free school meals:
    - in primary schools is 24% (the national average is 15%)
    - in secondary schools is 21% (the national average is 13%).
- Children and young people from minority ethnic groups account for 21% of all children and young people living in Newcastle, compared with 21% 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 Pakistani (4%), Bangladeshi (4%) and African 3%.
- The proportion of children and young people who speak English as an additional language:
    - in primary schools is 25% (the national average is 20%)
    - in secondary schools is 18% (the national average is 16%).

Child protection in this area

- At 24 April, 2,433 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,360 at 31 March 2016.
- At 24 April, 406 children and young people were the subject of a child protection plan (a rate of 72 per 10,000 children). This is a reduction from 424 (75 per 10,000 children) at 31 March 2016.
- At 24 April 2016, three children lived in a privately arranged fostering placement. This is similar to 31 March 2015.
- In the two years before inspection, three serious incident notifications were submitted to Ofsted and one serious case review (SCR) has been completed.
- There were two SCRs ongoing at the time of the inspection.

Children looked after in this area

- At 24 April 2017, 532 children are being looked after by the local authority (a rate of 94 per 10,000 children). This is an increase from 498 (88 per 10,000 children) at 31 March 2016.
- Of this number, 285 children (or 54%) live outside the local authority area.
- Sixty-eight children live in children's homes, (47 in independent and 21 in in-house children's homes), of whom 50.0% (34) live out of the authority area.
- Five children live in residential special schools, all of whom live out of the authority area.
- Four hundred and ten children live with foster families, of whom 61% live out of the authority area.
- Thirteen children live with parents, of whom 15% live out of the authority area.
- Four children are unaccompanied asylum-seeking children.
- In the last 12 months:
    - there have been 29 adoptions
    - forty-three children became subject of special guardianship orders

- two hundred and eighty-one children ceased to be looked after, of whom 4% (12) subsequently returned to be looked after
- nine young people ceased to be looked after and moved on to independent living
- no young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that initial screening is informed by consistent and robust decision-making in the initial response team.

2. Ensure that all assessments are informed by an understanding of historical information and children's experiences and that they are routinely updated to inform children's plans.

3. Ensure that the decisions for children's long-term permanence are made in a timely way, particularly for children living in long-term foster care, and increase the effectiveness of legal and permanence panels to reduce drift and delay in securing legal permanence for children.

4. Increase the effectiveness of the scrutiny and challenge by the IROs and the adoption panel chair to improve the quality of children's assessments and plans.

5. When children go missing, ensure that information from independent return home interviews is used and analysed effectively to inform individual planning and wider risk reduction strategies.

6. Ensure that children looked after and care leavers have timely access to specialist emotional and mental health support services.

7. Ensure that children and young people have timely access to advocacy and independent visitors.

8. Accelerate plans to ensure that sufficient placements are available, in order to meet the needs of children locally, particularly in an emergency, and especially those children who have more complex needs.

9. Ensure that all parents receive a timely pre-birth assessment to better inform early and appropriate services and support.

10. Ensure that delegated authority is agreed in a timely way when children become subject to section 20 arrangements.

11. Improve the quality of individual supervision and case records to better demonstrate how staff are supported and are able to reflect on their practice.

Summary for Children and young people

- Professionals in Newcastle work well together to support children and their families when they first need help, support and protection. However, social workers and managers do not always identify soon enough when children and young people need extra help.
- Specialised teams of professionals work very hard to protect children and young people from sexual exploitation. They provide lots of information and advice all over the city to raise awareness to keep children and young people safe and to help if they have suffered harm.
- Social workers are very committed and know the children and young people they work with very well. However, they do need to get better at making children and young people's plans and assessments clearer so that children know what is going to happen to them, when and why.
- Managers and IROs need to make sure that children and young people's plans make a difference and, when they do not, they need to take action to make things happen sooner.
- Managers and social workers need to make sure that children and young people have access to an advocate when needed to make sure that their views are heard.
- If children and young people need to be looked after away from their own home, very good foster carers and staff in children's homes keep children and young people safe and look after them well. Sometimes, when children first become looked after, it takes too long to find the very best placement. Managers at the council are working hard to put this right.
- When children have a plan of adoption, they go to live with their new family quickly.
- The council works very well with schools and colleges to make sure that children and young people get good support with their education and have the help they need to be the best they can be.
- When young people are ready to leave care, they get good support from their workers to live independently and live in good accommodation where they feel safe.
- The Voices for Choices group works very hard to let senior managers know what it is like to be looked after in Newcastle. Through this work, the group helps to make improvements in the services received by children and young people.
- When children and young people need support with their emotional needs or mental health, they wait too long. The council and its partners need to do more to make sure that help is available much sooner.

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

Summary

Services to children and families in need of help and protection are improving following a whole-service review. Appropriately focused strategic plans are being implemented and are having a positive impact on social work practice and improving the service response to children and families. However, it is too soon to see the full impact of these changes, and some children are not receiving a consistently good or timely service to meet their needs.

Newcastle's early help offer is a strength. Families benefit from well-coordinated and responsive early help services that are accessible and deliver positive results. Social workers are tenacious with families who are difficult to engage. Families affected by domestic abuse or substance misuse are supported effectively with good multi-agency oversight and services. Vulnerable children and asylum-seeking families receive good-quality help.

Work with children at risk of sexual exploitation and trafficking is highly effective, and there is evidence of some outstanding practice. There are also effective multi-agency responses to children at risk of female genital mutilation and at risk of radicalisation. Arrangements for reducing risks for children who go missing, although recently strengthened, are still not good enough. The quality of return home interviews is inconsistent and they do not all inform safety planning.

When immediate risks to children are identified, a highly effective response is provided. However, the threshold is not consistently applied by partners, and decision-making is not always robust in the initial response service. A small number of children receive a response at a lower level, when a social work assessment is needed. As a result, not all children receive appropriately focused help at the right time.

The quality of assessments is improving. However, not all assessments are sufficiently analytical to ensure that needs are fully understood and they are not leading to consistently focused plans. Contingency planning is not embedded and it is too soon to see the impact of the recently implemented legal proceedings panel on reducing drift for all children. An arrangement for child protection chairs to support social workers in their formulation of child protection plans during last year, when caseloads were previously high, is not leading to sufficiently consistent or robust challenge.

Inspection findings

12. Families are benefiting from effective, aligned and wide-ranging early help services, and have increased access through three community family hubs. Good multi-agency engagement ensures that services respond to community need. New early help assessments have been developed, and, as a result of this development, there has been a significant increase in partner agencies completing the assessments. These partner agencies are increasingly leading on plans, meaning that children and families are supported by workers they already know and have a relationship with. Early help plans support a range of needs, including domestic abuse, parental substance misuse and poor parental mental health. Practitioners engage children and families well with early help plans and are able to effectively meet children's diverse needs. When cases open to early help services require a social work intervention, these cases are escalated appropriately to children's social care.

13. The IRS provides a central point for the assessment of concerns about children's welfare. Although prompt, the screening of contacts is not sufficiently robust. Decisions are not always well informed by historical information or multiagency checks and this results in some children receiving a service that does not meet their needs. (Recommendation)

14. A wide range of services and community organisations appropriately respond to families affected by domestic abuse, substance misuse and poor parental mental health. When children experience domestic abuse, effective multi-agency arrangements coordinate responses well. Appropriate risk management through multi-agency public protection arrangements (MAPPA) ensures effective coordination of services to reduce risks to children.

15. Well-established relationships support effective information sharing with police and health representatives co-located in the MASH. Consent is appropriately considered to support open and transparent work with families. Strategy discussions are timely and effective in addressing risks for children. They are well attended by partner agencies and result in timely joint investigations. Children's views are gathered and wider safety planning ensures that all relevant children are included. Investigation outcomes are appropriate for the levels of presenting concern and lead to timely child protection conferences.

16. The threshold is not consistently applied by partners in all cases. Inspectors saw a small number of cases that should have been referred for a social work response sooner. Not all agencies are represented in the MASH, an example being education services, and this is a missed opportunity to further embed multi-agency working and to support schools to better understand the thresholds for referral to children's social care.

17. Effective out-of-hours arrangements ensure that children are protected. The emergency duty team works closely with day services, the police and other agencies to ensure the immediate protection of children.

18. The quality of assessments is improving, with a good focus on strengths and risks; many also result in appropriately focused services for families. However, for a minority of children, assessments are not sufficiently analytical or detailed to ensure that their needs are fully understood and to inform focused planning.

19. The pre-birth protocol is not being consistently followed in all cases and, while assessments for children are taking place prior to birth, in some cases this is not providing sufficient time for direct work to promote necessary change. (Recommendation)

20. Children in need of targeted support, including children who have disabilities and children on the edge of care, receive proportionate and sensitive support to meet their needs. Interventions are appropriate and include intensive support, for example the community fostering service. Foster carers work with families in their own homes to achieve positive and sustainable change. There is good access to a wide range of suitable services, including short breaks and bespoke services. Feedback through parent and carer forums shows that families are positive about the help they receive and this appropriately informs the planning of services.

21. Child in need reviews, overseen by an IRO, are improving in their effectiveness by ensuring that appropriate support services are in place when a statutory social work intervention is no longer needed. This supports sustainability and family resilience. Neglect is now well understood in Newcastle, with the Newcastle Safeguarding Children Board (NSCB) leading multi-agency audits to review practice and to address concerns about the increasing number of repeat child protection plans under this category. As a result, many long-standing cases that reflect significant drift and delay in addressing neglect are now progressing through care proceedings.

22. Children are seen alone and within appropriate timescales, and there is some effective and appropriately focused direct work with families to support and improve outcomes for children. Social workers engage and listen to children well, although not all social workers are consistently reflecting on children's lived experiences.

23. Children's and families' assessments are not always updated when circumstances change. In a small number of cases, the absence of chronologies capturing significant events leads to a reduced understanding of children's lived experiences, particularly where involvement has been prolonged. In some cases, social workers and other agencies are relying too much on parents self-reporting and are not fully considering parental ability to sustain change.

24. When caseloads were previously high, the council made an arrangement for child protection chairs to support social workers in their formulation of child protection plans by developing plans in conferences. Now that caseloads have

reduced and are at an acceptable level, this continued arrangement is not best supporting consistent or robust challenge of children's plans when circumstances do not change. The requirement for the child protection chairs to develop the child's plan within the meeting reduces their independence and, in some cases, is impacting on their ability to effectively challenge drift and delay and escalate concerns.

25. Not all plans help families understand what needs to change or what support will be provided. This is particularly visible in long-term cumulative neglect cases that have not been addressed quickly enough, leaving some children in poor home environments for too long. Managers have recently strengthened this through the implementation of an additional (designated) conference for children who have been on a child protection plan for approaching two years. This is improving the escalation of concerns and ensuring more timely and appropriate decision-making. There is effective multi-agency work to support families to make changes. (Recommendation)

26. The Public Law Outline is not used effectively for all children in pre-proceedings and social workers do not consistently follow process. Letters before proceedings do not always address concerns well enough or explain to parents what will happen if children's circumstances do not improve. Care within the family or with connected persons is not always considered as the first option and this is leading to delays in securing legal permanence for some children. The council has established a legal panel to improve pre-proceedings processes, and this has been effective in improving the timeliness of care proceedings. Effective relationships with the courts and Cafcass support the timeliness of children moving through the court process.

27. Children are not consistently well supported to participate in their conferences and reviews. Few children take up the offer of the advocacy service. This limits children's ability to inform their plans and give feedback to help to improve services. Senior managers are aware of this gap and have made plans to improve opportunities for children to feed back using social media. (Recommendation)

28. Prevention work for children at risk of exploitation is highly effective and there are some examples of outstanding practice. There is increasing use of local organisations, including the fire brigade, community safety partnership and voluntary organisations, to raise the profile and improve community awareness. The multi-agency response to sexual exploitation is very well resourced, and the complex abuse process is used successfully to identify children at risk of female genital mutilation or human trafficking.

29. Partners and social workers identify children at risk of sexual exploitation and trafficking effectively, and appropriate and responsive services support children and reduce risk. Effective assessment tools are used appropriately and inform safety planning. Successful use of court orders disrupts offending

behaviour and safeguards children. As a result, the council and partners are reducing risks for these children.

30. Operational arrangements for reducing risks for vulnerable children have recently been strengthened. There is effective coordination by a specialist social worker, who tracks all missing episodes, and a commissioned provider, who undertakes return home interviews for children not known to children's social care. However, the quality of return home interviews is not consistently good or timely. Some meaningful discussions result in suitable recommendations, but not all inform safety planning and there are missed opportunities to further improve the coordination of this work operationally and strategically. Senior managers have recently improved arrangements for tracking children who are missing education. (Recommendation)

31. Private fostering arrangements are suitably monitored and supported. Despite much proactive awareness raising, numbers remain low.

32. Young people aged 16 and 17 who present as homeless are very well supported and safeguarded by good partnership working between statutory and voluntary sector organisations. Prompt assessments and successful commissioning of 'Your Homes Newcastle' provide appropriate advocacy and housing-related support to young people up to 25 years old.

33. Arrangements for reporting and responding to allegations are effective. Allegations have increased as a result of greater promotion of the role of the designated officer and effective work with the voluntary and independent sectors.

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

Summary

The majority of children become looked after when it is in their best interests. However, a small number of children become looked after in an emergency, and for these children some drift has occurred, as the planning of cases in pre-proceedings has not been effective. Recent practice is improving, but it is too soon to see an impact. The majority of children looked after live close to home and benefit from good-quality, stable and safe placements that meet their needs and contribute to improved outcomes. However, there are not enough local placements for children placed in an emergency or for those children who have complex needs.

Permanence decisions are not made soon enough for all children and some children experience delays in long-term matching. Not all assessments of children's needs are sufficiently robust to inform placement choice, and this is not supporting sufficiently clear planning in these cases. Children do benefit from regular reviews, but IROs are not wholly effective in challenging drift or escalating concerns.

When adoption is pursued, children do not have to wait long periods to be matched with their permanent families. There is a comprehensive range of adoption support services, which give families every opportunity to succeed.

When children go missing or are at risk of sexual exploitation, timely action is taken to monitor, review and reduce risks. While return home interviews are undertaken when children go missing, these are not yet consistently informing risk assessment and planning for children. Children do well at school and attend regularly, and their educational achievements and progress are supported effectively by the virtual school. Up-to-date health assessments are in place for the majority of children. However, specialist provision of emotional and mental health support is insufficient to meet the needs of the looked-after population.

Children have meaningful and consistent relationships with social workers, who know them well. Life story and direct work undertaken with children is helping them to understand their histories. The CiCC, 'Voices for Choices', is a strong and visible group, that is actively promoting the voice and experiences of children looked after, and children actively participate in their reviews. However, advocacy and independent visitors are not actively promoted.

The majority of care leavers achieve positive outcomes and make good progress. An experienced and dedicated team of staff provides a wide range of services to care leavers, with access to good-quality housing and opportunities for education, training and employment, and keeps them safe from the effects of any harmful behaviours.

Inspection findings

34. The majority of children looked after in Newcastle, including unaccompanied asylum seekers, become looked after when it is in their best interests. However, for a small number of children, earlier identification of risk and decisive action would have prevented the need for emergency admission into care and ensured earlier planning for permanence. Children who become looked after in an emergency do not always benefit from robust multi-agency assessments to inform best placement matching and planning for permanence. When it is appropriate for children to remain at home while they are looked after, the council provides a good range of interventions and support. Unaccompanied asylum seekers and homeless children aged 16 to 17 who need to be looked after are well supported by a dedicated and experienced team, and have a range of accommodation and support services provided through effective commissioning and planning.

35. When children and young people return home in a planned way, the majority have appropriate plans in place to support them, informed by clear risk-based assessments. Effective intervention services provided to families mean that reunification is successful in the majority of cases where this is appropriate, and very few children become looked after for a further period. However, inspectors saw a small number of cases where older children returned home without a purposeful plan, and this was not always informed by multi-agency support to address and reduce identified risks.

36. There are well-established and positive relationships with the judiciary and Cafcass. Thresholds for care proceedings are appropriate and progress in a timely manner, with the majority completed within 27 weeks on average. Assessments of parents and family members are of a suitable quality, undertaken by well-supported and experienced social workers. The use of independent and expert assessments has been kept to a minimum, and the council is developing the skills and capacity of social workers to undertake specialist parental assessments.

37. The council has reviewed all of its long-standing cases of children looked after under section 20 of the Children Act 1989. This has led to an improved permanence for these children and includes returning home as well as care outside the immediate birth family. However, permanence decisions are not always in place at the earliest opportunity and by the second review. At the time of inspection, a number of children who were settled and thriving in their long-term placements had not been matched with their current carers long term. The council has recognised this and recently developed a permanency monitoring panel to improve senior management oversight of timeliness of permanence decisions and recognition of permanent placements for children. However, it is too early to see the impact of this for all children. (Recommendation)

38. The majority of children are placed with foster carers within 20 miles of their home. Long-term placement stability is good. Robust regional commissioning arrangements mean that children experience supportive, stable and safe placements. However, there are not enough suitable homes locally for children who have more complex needs and larger family groups of brothers and sisters. As a result, some children are living separately from their brothers and sisters when the plan is to live together, and children who have more complex needs are often placed at some distance from their homes. While senior managers identified this shortfall at the beginning of 2016, the action plan to improve capacity is not fully implemented. (Recommendation)

39. Children have meaningful and consistent relationships with social workers, who know them well. Visiting is mostly regular and purposeful, and children spoken to understand the reasons why they are looked after and their future plans. Senior managers have ensured, wherever possible, that children have not experienced changes of social workers as part of the transformation of services. Inspectors saw good examples of direct and life story work, which is helping children to understand their histories and experiences.

40. Recruitment processes for foster carers are robust. They receive appropriate training and support, equipping them with the skills they need to provide good care to children. Regular visits to foster carers by supervising social workers facilitate effective oversight and ensure that support can be provided when needed. Recent changes to management within the fostering team have ensured a renewed focus on the timely placement of children with foster carers who can meet their needs.

41. Effective strategic and operational arrangements ensure that, when children go missing or are at risk of sexual exploitation, appropriate, timely action is taken to monitor, review and reduce risks. Children looked after who are at risk of sexual exploitation are reviewed within the Risk Management Group, to ensure that changes in circumstances and risks are carefully and effectively addressed. Children are looked after in placements that meet their needs and they are effectively safeguarded and supported to achieve good outcomes. When children go missing, the vast majority receive an offer of a return home interview provided by a commissioned service. However, the outcomes of interviews are not being used effectively to inform individual plans or broader service need. (Recommendation)

42. Assessment of children's needs is not always sufficiently robust to inform best placement choice, and children sometimes become looked after in an emergency without the benefit of an up-to-date assessment of their needs. This results in early placement moves to accommodation that is more suitable. A small number of children looked after who have complex needs, for example those children who are at risk of sexual exploitation, have experienced a number of moves as initial placements have not met their needs.

43. Not all children have an up-to-date assessment of need or clearly developed plans that reflect their current circumstances. As a result, service provision to address emotional, educational or contact needs are often delayed, and contact arrangements are not considered well enough. For children looked after under section 20 arrangements, inspectors found that delegated authority was not in place in the majority of cases, hampering carers' abilities to make decisions for care arrangements and leisure activities on behalf of parents. (Recommendation)

44. Plans for children are not always clear or sharply focused. Social workers no longer write reports for reviews. The task of assessing, evaluating and analysing the ongoing needs and risks for children is undertaken by IROs. This temporary solution was introduced to better support social workers when caseloads were high, but it is still in place and reduces the IROs' quality assurance function and independence of their role. Although children benefit from regular reviews, IROs are not effectively challenging or escalating concerns about delays in achieving permanence or about the quality of planning for children. (Recommendation)

45. The CiCC, 'Voices for Choices', is a well-established, strong and visible group, which is actively promoting the voice and experiences of children looked after. It has undertaken a range of work to support practice and service development and has produced a range of materials, including a DVD that illustrates the experiences of children looked after that has been shown in a range of forums. The influence of the group has led to the continuation of employment of viewpoint staff, who gain the views of children to inform reviews. The CiCC members are also involved in staff recruitment and the development of staff profiles, as well as a number of leaflets for adults and children. The group has contributed to the development of the pledge for children looked after and has direct access to senior managers, both via email and as members of the corporate parenting advisory committee.

46. Children and young people actively participate in their reviews, and as well as attending reviews, their wishes and experiences are consistently gained though the electronic viewpoint system, undertaken in the majority of cases by a viewpoint worker. Inspectors saw a number of good examples of children's views gained though this system on file and that these were considered and influencing decision-making in reviews. Arrangements for the promotion of commissioned advocacy and independent visitor services with children looked after are not sufficient. Fewer than 10 children currently have an independent visitor, which means that children looked after do not have the benefit of the support that such a service could offer to advise, befriend and assist them, particularly those children who are placed at a distance. (Recommendation)

47. A significant number of changes to the management and staffing of the virtual school in the last year has resulted in increasingly positive outcomes for the education of children looked after. The proportion of current children looked

after making expected or better than expected progress has improved over the past two years, and the majority of children at different key stages perform better than their peers in other parts of the country. However, the figure remains below that of other pupils in the city.

48. The virtual school is well led and has driven forward improvements in attendance, reducing the proportion of children looked after who are persistently absent, as well as the number of fixed-term exclusions. There has also been a rapid increase in the completion rate of personal education plans (PEPs) completed by out-of-area schools. Social workers and teachers use PEPs to plan the educational progress of children looked after effectively. The majority of plans are characterised by good recording of attendance, current attainment and progress against targets. An increasing number of plans report on and measure the impact of the pupil premium.

49. The recently restructured admissions and attendance service has successfully reduced the number of children identified as still missing from education after 12 weeks from 120 in 2015—16 to six in the current year. The same team has increased the number of visits to home-educated children to check the quality of the education being delivered and to ensure that children are safe. The number and quality of alternative education providers are insufficient to meet the different needs of children and young people who have disengaged from mainstream schooling. Just over half of the children looked after who are in alternative education do not currently receive 25 hours a week of education.

50. Performance in relation to the completion of health assessments is better than comparators, with 90% of children having an up-to-date health assessment, which is increasingly informed by strengths and difficulties questionnaires. Health staff work across the northeast region and liaise effectively with health services further afield to provide continuity and quality-assured health provision. They have developed a number of weekend and evening clinics to maximise accessibility of their service. Current arrangements in Newcastle for meeting children's emotional and mental health needs are not sufficient. Long waiting times and high thresholds for specialist services mean that some children experience poor mental health without more specialised support for unacceptable periods. (Recommendation)

The graded judgement for adoption performance is that it is good

51. The adoption team is experienced and well trained, providing high-quality support to children and adopters to ensure that children are able to benefit from living in a permanent home.

52. Referrals are made in a timely way to the adoption team, following the child's review recommending adoption as the permanence plan. This allows

dedicated family finders to begin the identification of adopters at an early stage. Family finders are fully appraised of a child's needs, enabling them to complete searches for the most suitable carers. When children who have complex needs are identified, national searches begin without delay to make sure that children are placed with carers who are able to meet their longer-term needs.

53. The majority of children are matched quickly and placed with their permanent families when it is agreed that adoption is the permanence plan. The in-year figures show that the council is close to the government threshold for this measure. This ensures that children are able to live in adoptive families at the earliest opportunity and reduces the uncertainty about their long-term futures.

54. Newcastle's adoption service has a limited number of adopters able to be matched with children who have complex needs or with large groups. The service has recognised this issue and has previously targeted recruitment at carers who could meet the needs of these children. The recruitment campaign for adopters is now managed in house, thus allowing a more adaptable and responsive approach to local need**.**

55. Child permanence reports (CPRs) are not yet of a consistently high quality, and this is an area for improvement identified by senior managers. The reports viewed contained sufficient detail for the agency decision maker (ADM) to make a best interest decision and to enable effective matching with adopters. However, some reports are lacking detail regarding birth parents' history, which is therefore not available to a child seeking this information at a later stage.

56. Life story work and later life letters are of a good quality. However, these are not readily accessible on all children's files and could result in some children not having access to birth family information once they are placed with their adoptive families.

57. Adopters are very complimentary about the professionalism and quality of service that they have received from the adoption team. The prospective adopters' reports are thorough and highlight strengths and vulnerabilities. The reports are completed with sensitivity and contain clear analysis and recommendations to the adoption panel. This facilitates informed approvals and careful matching with young people, minimising the risk of future placement breakdown and further disruption to a child's life. Prospective adopter reports are at times delayed, but this is not having a significant impact on the availability of carers for Newcastle children. In 2016—17, of 41 children placed for adoption, 36 were placed with carers assessed by Newcastle adoption team.

58. Support to adoptive families is comprehensive and the adoption team has dedicated adoption support workers and an adoption support specialist. Adoption support workers have a wide range of training to ensure that

support is effective and available to families from within the council's resources. The service has access to other therapeutic interventions when needed, and adoption support is considered early to maximise the potential for children to settle into their new homes. The adoption support fund is utilised when required.

59. The council has been creative in its approach to adoption support, developing a 'buddy' scheme that matches experienced adopters with new adopters. This less formal approach not only helps to build resilience within the child's new family, but it helps to extend the network of those with shared experiences.

60. Adoption support assessments are detailed and have a clear analysis of needs, resulting in plans that focus on those areas where support is required most. These plans are regularly reviewed to ensure that interventions remain appropriate. There have been no disruptions in over 18 months, and there was a clear commitment by the council to provide the right support at the right time in the adoption journey in order to give children every opportunity to succeed within their new families.

61. The chair of the adoption panel is experienced and has held this role for a number of years. The panel has a wide range of members, including adopters, independent members and a medical adviser. Panel members are knowledgeable about adoption and effective in their roles. The record of panel recommendations is clear and detailed and these are then signed and approved by the ADM. The ADM and panel chair meet on a quarterly basis, although this meeting is not maximising service improvements. The adoption panel annual report to the agency is descriptive and lacks a depth and focus on quality assurance to assist the agency to drive improvements. (Recommendation)

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

62. The council's 16 plus team is well resourced, with sufficient social work expertise and access to specialist services to provide effective support to its care leavers. Embedded in the team is a full-time welfare rights officer. The team currently supports 337 young people, a significant number of whom live outside the council's boundaries.

63. The team has regular contact with the vast majority of its care leavers. Its rate of contact with care leavers of all ages compares favourably to that of its statistical neighbours and of other local authorities in the rest of the country. This good level of contact reflects the tenacity and commitment of social workers and leaving care support workers to building and maintaining relationships of trust with their care leavers.

64. There is a good range of services available to care leavers exposed to risk-taking behaviours. Staff work particularly effectively with the city's community and voluntary sector to provide additional support to address issues of sexual health and exploitation, domestic violence, debt management, and substance misuse.

65. The range of accommodation available to care leavers is very good, because there is the support available to prepare them to take on their own tenancies. The proportion of care leavers in suitable accommodation is comfortably above that of the council's statistical neighbours and of councils in the rest of England.

66. The young people's service (YPS), part of 'Your Homes Newcastle', provides a highly effective support service to care leavers who are moving into supported accommodation and then into independent tenancies. Its well-qualified staff design a specific support programme for each care leaver based on information contained in their pathway plans. This encompasses independent living skills, budgeting and preparation for employment. Crucially, staff are only withdrawn from supporting care leavers once they are convinced that they can maintain their tenancies.

67. In the past year, the proportion of care leavers achieving positive placements in education, training and employment has risen from just below half to the current level of nearly two thirds. This improvement is the result of a strategic commitment by the council's leadership to its most vulnerable young people and more effective partnership working between agencies responsible for post-16 education and training in the city. The Connexions service plays a pivotal role in providing bespoke information, advice and guidance to care leavers about their training and employment options both before and after leaving formal education. The council is further developing its duty as corporate parent by ring fencing some of its apprenticeship positions to care leavers. For those not yet ready for an apprenticeship, it has designed a pre-apprenticeship programme.

68. The majority of pathway plans provide a thorough record of the social care chronologies of care leavers and the range of interventions put in place to support them. Social workers use the plans effectively to assess each care leaver's capacity to become more independent, particularly in housing and financial matters. In a minority of plans, social workers set targets that are too general and open ended to drive measurable progress.

69. All care leavers register with doctors and dentists, whose contact details are included in pathway plans and in the health information packs that they receive when they formally become care leavers. The majority of care leavers receive an annual health check, and actions to improve their health are followed up by the small team of children looked after nurses. However, a lack of capacity within the team has resulted in the slow implementation of plans

to analyse the unmet health needs of care leavers to inform the commissioning of services, and in the withdrawal of drop-in sessions.

70. Care leavers have insufficient access to emotional and mental health services. Social workers and teachers working with care leavers report that the thresholds to access mental health services are too high, and the length of time it takes to receive a service after referral is too long. The council instigated a review of the current strategy for children's and young people's emotional and mental health last year and is still awaiting a response from the clinical commissioning group. (Recommendation)

71. Care leavers have a good understanding of their legal entitlements. They make use of the grants available to furnish their tenancies and they are aware of the continuing financial bursaries that can support them in further and higher education. As a result, there are currently 21 care leavers studying for degrees.

72. Senior managers ensure that their care leavers are aware of how proud they are about their achievements and progress by hosting annual awards ceremonies in prestigious venues. They listen attentively to the views of care leavers, for example by responding to their requests for financial support to obtain subsidised passes into local leisure and sports facilities.

Leadership, management and governance	Good

Summary

The senior leadership team and elected members are committed to transformational, long-term change and service improvement for children's social care in Newcastle. There is strong political support to steer a realistic course through this process. The senior management team across children's social care and education have been strengthened in the last 18 months. Early years and preventative services have been combined to better target efforts on the most vulnerable families, and children's outcomes are improving, for example by increased school attendance, safer home environments and healthy families. There is a highly effective response to sexual exploitation, and evidence of some outstanding practice.

The senior team has invested in evidence-based practice so that social workers can work more effectively to tackle the scale and impact of neglect in the city. Early help services and long-term social work have been restructured. There has been a significant improvement in educational outcomes for children who are looked after. Care leavers are particularly well supported to achieve independence and live in good-quality accommodation.

Highly effective workforce planning and a strong focus on learning and development for staff at all levels, as well as reduced caseloads, have resulted in high retention rates and a reduction in the use of agency staff. Vacancies and sickness rates are among the lowest in the region. A strengthened performance management culture and a more rigorous focus on quality assurance mean that senior managers now know the strengths and weakness of their service very well.

Inspectors identified very few areas for improvement where action plans were not already being implemented and that had not already been identified by senior managers. While some progress can be seen, securing consistently good social work practice will take longer to achieve.

The recent development of a number of performance panels is providing senior managers with better oversight of decisions for children who become looked after. These panels are leading to more timely permanence planning for some children, particularly through adoption. However, it will take some time to see more positive results in instances securing early permanence for children where there has been previous drift and delay, and in instances of those children who become looked after in an emergency and where previous interventions have not been preventative or robust enough. Staff at all levels receive regular supervision, although not all records are able to show how managers are supporting and challenging social work practice. Similarly, where IROs are scrutinising children's plans, evidence of their challenge and impact is not well recorded and could be stronger.

Inspection findings

73. In 2015, senior managers identified that too many children in the city had experienced harm due to neglect. The wish of the senior team to better understand neglect and the needs and characteristics of families in which neglect occurs led directly to innovation and investment in evidence-based practice. In 2016, the council led an ambitious service transformation to redesign long-term social work in the city, which was intended to effect change in families. Through family insights (funded through the DfE Innovation Programme), a new unit-based model of social work has been implemented. Staff have responded positively to the transformation programme. The chosen model of social work practice is intended to support staff to think and respond more holistically to children's and family's needs. It is too early in the implementation for inspectors to identify that this has led to wholescale, improved outcomes for all children.

74. The CEO is very impactful and has demonstrated strong leadership, with effective oversight and accountability for Newcastle's services to children. Since coming into post in 2015, the CEO has brought together children's and adult's social care into one council's people directorate. There is a determination to support children through their life courses. The senior leadership team, led effectively by the director of people, together with elected members, is appropriately focused on transformational, long-term change and improving children's outcomes. There is strong political support to steer a realistic course through this process, and effective challenge and oversight through scrutiny arrangements. The lead member for children is highly committed and ensures that senior leaders are held to account and can evidence improvements in children's outcomes.

75. In 2015, the director of people restructured the senior management team. Weak management oversight and a lack of challenge regarding the quality of social work practice and performance shortfalls were resulting in children receiving inconsistent services. Some children were experiencing delay in their needs being assessed, and managers had not responded quickly enough to address them.

76. Leaders and managers now understand the strengths and weakness of their services well and have a commitment to improving children's outcomes. A much stronger focus on performance management has demonstrated sustained improvement in meeting the council's target for securing compliance across the service. Very few areas of improvement were identified that were not already known by senior managers and where action plans were not already in place. However, inspectors found that not all action plans are leading consistently to improved practice. For example, a recent independent review of contact, referral and assessment arrangements, in January 2017, identified a number of practice weaknesses: in particular, poor-quality screening of information to inform the response to contacts to social care. The review found a lack of robust management oversight, with particular regard to

recording the rationale for the decision made. Despite a comprehensive action plan to address these issues, and training taking place at the time of the inspection, some of these weaknesses in practice were still evident at the time of the inspection, as it was too soon to see the full impact of this action.

77. The quality assurance framework has been strengthened, and compliance with statutory requirements is firmly established across the service. Clear plans linked to training are being implemented to improve the quality of social work practice. Senior managers and frontline staff have access to good-quality, robust and timely performance management information. A strong focus on performance management has enabled sustained and continuous improvement in meeting targets for securing compliance across the service.

78. Regular supervision takes place at all levels. Group supervision delivered by consultant social workers is provided in addition to formal supervision in the social work units. Despite this good performance, records of supervision do not show well enough how social workers are being supported to reflect on their practice. Supervision records at all levels do not show what happens during supervision, what difference it makes for practitioners and how effective it is in relation to achieving better outcomes for children and their families. Similarly, while IRO scrutiny of children's plans is in evidence, the impact of IRO challenge is not consistently seen in plans for all children.

79. The recent development of a number of performance panels is providing senior managers with better oversight of decisions and of the allocation and need for resources. While this is evidence of progress, it is not yet leading to improvement in the quality and timeliness of decisions for all children, as these processes are not yet fully embedded, particularly around planning for early permanence and pre-proceedings work.

80. Long-term coherent, strategic planning and financial commitment are ensuring sustainability in service provision and maintaining a focus on improving a shared ambition for children across the city. Effective and accountable arrangements for the oversight of the NSCB mean that partners work together very effectively to safeguard children and young people. The political commitment to ensure that this is a priority across key partner agencies is demonstrated through the leader of the council chairing the Well-being for Life Board. This is ensuring that the Newcastle future needs assessment (NFNA) is focused on the needs of local children and their families and is aligned with the overall council plan.

81. Workforce planning is highly effective. The principal social worker adds value by driving forward a workforce strategy that is inextricably seen as the key element in improving outcomes for children and their families. Consequently, there has been a high level of investment and a strong focus on learning and development for staff at all levels. This has resulted in high retention rates and a reduction in the use of agency social workers, which has been sustained in recent years. Vacancies and sickness rates are among the lowest in the

region. There is a commitment to providing high-quality placements for social work students through traditional routes, Step Up and Frontline. Highly effective partnerships with regional local authorities and universities have resulted in 27 social workers securing permanent positions following their student placement and assessed year in employment (ASYE) in the past two years. Staff at all levels are highly committed to their work, and those spoken to during the inspection told inspectors that they are proud to work in Newcastle.

82. There is a well-coordinated and easily accessible early help offer. Early years and preventative services have been aligned to better target efforts on the most vulnerable families in the city. A continued effort to strengthen this offer through aligning public health services has recently been achieved. The launch of a new model of early help assessment and planning has seen a 16% increase in the number of children being supported through early help plans in the last six months, with 64% of children achieving improved outcomes. In early years, Newcastle is now above the national average for good level of development. Children who are looked after do well at school and attend regularly, and their educational achievements and progress are effectively supported by the virtual school.

83. A well-informed commissioning strategy uses a broad range of information to identify the needs of children, young people and families across the city. Senior managers recognise that there are insufficient placements available locally for children who have more complex needs, and work is under way to develop more provision locally, but this is not yet in place. Good commissioning arrangements are underpinned by strong partnership arrangements and good consultation with stakeholders, providers and voluntary organisations. All contracts meet stringent safeguarding standards and they are subject to ongoing scrutiny to ensure that high-quality services are provided. However, care leavers and children looked after have insufficient access to specialist emotional and mental health services, and so far the council has been too slow to respond. (Recommendation)

84. There is some very early evidence that children are experiencing more timely and targeted interventions. However, it is clear that there are high number of long-standing cases where some children have remained on child in need and child protection plans due to parents' inability to achieve and sustain change. This has meant that earlier interventions have not improved the circumstances of some children, and a small number of children continue to become looked after in an emergency due to crisis. Not only has this impacted negatively on children's experiences, but it has placed increasing pressure on the council's ability to provide a range of suitable local placements in an emergency.

85. Outstanding work by the council and its partners, in particular Northumbria police, to identify and respond to sexual exploitation and human trafficking has resulted in a high number of convictions of perpetrators. Highly effective intelligence-led disruption and prevention strategies are making children,

young people and vulnerable adults in the city safer. Considerable emphasis has been placed on the collection and sharing of information with partner agencies, resulting in a sophisticated understanding of the extent of sexual exploitation in Newcastle and the surrounding areas.

86. Well-planned training and awareness-raising programmes across a range of partners constantly take place. Knowledge about how to identify risk and respond to protect children is comprehensively disseminated across all agencies, including the voluntary sector. Awareness raising with the business community is impressive and has been a vital element in tackling sexual exploitation, and many children have been safeguarded through this approach. Extensive assertive outreach is taking place to identify vulnerable children and undertake preventative work. Targeted awareness raising and positive engagement with minority ethnic communities on the issues of sexual exploitation is ensuring a focus on under-reporting in these communities and raising awareness. Wrap-around services provided by a high number of agencies to assist children to recover and move forward with their lives are outstanding. At the core of this practice is targeted work to promote children's self-esteem and self-confidence in order to reduce future risk and support recovery.

87. Newcastle children have experienced sustained long-term placement stability for a number of years. The council has well-established effective relationships with the local family justice board and Cafcass, and this is ensuring that children benefit from efficient and effective progression through legal proceedings, with court timescales currently standing at 27 weeks. This is among the best performance locally. Once a plan for adoption is agreed and a placement order granted, the majority of children do not wait to be matched with adopters. Services for care leavers are good. Strong multi-agency partnerships have significantly improved outcomes in education, employment and training. The range of accommodation available to care leavers is very good.

88. The corporate parenting advisory committee is chaired by an experienced and committed lead member who takes a keen interest in the experiences of children looked after and care leavers. While the panel is able to evidence where it has championed the needs and rights of children looked after and care leavers, it has not been sufficiently curious or challenging in relation to the time that children and young people wait to access support for their emotional and mental health needs or young people's transitions into adult services.

89. Service planning and delivery take account of the views of children, their parents and carers. Children who are looked after are regularly involved in the recruitment of staff and the training of foster carers and elected members. Corporately, SCRs and complaints are managed well and senior leaders are keen to use learning to improve services to children. However, operationally the voices of children are not heard as well as they could be. While an

advocacy offer is available, children are not supported well enough by their social workers or by their IROs to access this service.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

Newcastle Safeguarding Children Board (NSCB) functions effectively and meets its statutory requirements. It is supported by constructive working relationships between senior partnership managers, a clear alignment of strategic priorities and effective political overview.

Strong governance arrangements and efficient board processes support productive multi-agency challenge, oversight and effective delivery of the Board's priorities and business plan.

The analysis and evaluation of performance through a thorough and focused multi-agency data set and multi- and single-agency social care auditing is a particular strength. This offers a broad oversight of the quality of practice across all areas of safeguarding responsibility, and effectively identifies and supports areas for improvement. The Board has been highly influential in the development and oversight of effective multi-agency practice. The responses to sexual exploitation and human trafficking are particularly impressive, and the identification of neglect as a Board priority has ensured consistent focus and practice development in this work. The Board has played a key role in developing partnership working in relation to female genital mutilation and violent extremism. These developments have been supported effectively by the voluntary sector.

The Board has ensured multi-agency engagement in the ongoing oversight and development of consistent application of thresholds, and there are firm plans in place to continue to embed this across partner agencies.

The Board is a learning organisation, effectively identifying and disseminating learning from case reviews. The multi-agency training programme is delivered in line with board priorities and is responsive to emerging needs. Wider learning is constructively disseminated to frontline practitioners through a range of methods.

The Board uses existing forums and processes to ensure that the views of children inform discrete areas of work, although these do not inform all areas of Board activity. The recent working agreement between the NSCB and the youth council further develops this, but is not yet sufficiently embedded to evidence impact.

Recommendations

- Ensure that the views of children consistently and effectively inform Board activity and developments.

Inspection findings – the Local Safeguarding Children Board

90. Strong governance arrangements ensure that NSCB is effectively meeting its statutory responsibilities. The Board's business plan has clear priorities identified through effective performance monitoring and self-evaluation. The delivery of the business plan is well supported by clear, prioritised and monitored action planning.

91. Constructive working relationships between senior partnership managers, and the clear alignment of strategic boards and priorities, with the addition of a committed political overview, ensure that there is effective strategic prioritisation and multi-agency ownership of safeguarding work in Newcastle.

92. Effective board functioning is supported by efficient Board processes, and multi-agency commitment to Board activity is evident. The independent chair has been instrumental in developing focus and challenge by the Board. Timely monitoring of areas of challenge is well supported by a challenge log. The chairs of the Board committees are from a range of partner agencies, further enhancing the multi-agency contribution to safeguarding work. Lay members have played a key part in the Board's work, particularly informing about and linking with local communities.

93. Engagement with schools has been constructively developed and utilised. Strong relationships with the voluntary sector have ensured both challenge and the use of specialist knowledge to support safeguarding practice developments. The Board does use existing forums and engagement processes with children to inform some discrete areas of development, and has recently engaged in a working agreement with the Newcastle youth council. However, these are not sufficiently comprehensive or developed to ensure that the views of children are central to all key areas of Board activity. (Recommendation)

94. The effective use and analysis of a thorough and evolving multi-agency data set, to ensure oversight and prioritisation of safeguarding activity, is impressive. This is a particular strength for the Board. Areas for more detailed and qualitative investigation are identified, and this effectively supports subsequent practice improvement.

95. Thorough multi-agency auditing with a well-developed methodology and clear dissemination of learning focus on key points in the child's journey, and responds to Board priorities and emerging needs. Allied to learning from single

agency social care audits, this ensures that the Board has a qualitative oversight of frontline practice, with a focus on, and driving areas for, practice improvement.

96. Neglect has been identified as a Board priority and has been key in driving partnership focus and development in this area. The neglect strategy and progress of the action plan are subject to regular Board review, including the impact of specific projects to address neglect. Bespoke training and best practice events have disseminated learning to frontline practitioners, and thematic auditing ensures an ongoing focus on the quality of frontline practice.

97. The Board has ensured that there is active multi-agency involvement in improving the consistent application and understanding of thresholds. Plans are in place to embed this further. There was multi-agency engagement in the revision and dissemination of the thresholds guidance and continuum of help and support framework, and the weekly social care audits of thresholds are supported by monthly multi-agency auditing. Specific targeted work arising from this auditing has included improving the quality of written referrals.

98. Section 11 and section 175 audits provide an appropriate overview of multi-agency safeguarding. The current audit process is expanding the breadth and depth of practice. The previous audits in 2015 assured the safeguarding practice of the required agencies and schools. Learning from that audit process has resulted in the current use of an online tool with a much wider range of agencies and greater depth of scrutiny with specific amendments for schools. The current audit is being viewed as an ongoing process by the NSCB, and sampling of current audit returns to date has evidenced immediate Board responses to support improvement of safeguarding practice in a responding agency.

99. Clear and detailed reports are presented to the Board to supplement performance data analysis and auditing where appropriate or where those areas are not covered by performance activity. This ensures that the Board is fully sighted on, and can assure itself of, all areas for which it has safeguarding responsibility. These include the management of allegations against professionals, private fostering and children in custody.

100. Cases from which there may be learning and which may meet the criteria for SCR are identified effectively, and timely decisions are made in line with statutory requirements. Reviewing methods, using creative approaches, are clearly considered to maximise learning specific to the case, including immediate learning where possible. Subsequent learning is effectively disseminated through a variety of methods. Clear actions arising from reviews are regularly monitored to ensure timely progress. A recently introduced impact assessment thoroughly evaluates effectiveness at the point that completion of the case review action plan is signed off by the Board.

101. The multi-agency training programme is delivered in line with Board priorities and is responsive to emerging needs. A range of methods are used to deliver and evaluate training. Learning from practice events is also utilised to gain frontline practitioner views of and suggestions for the Board in that practice area. There are effective links with other Board committees, ensuring that training is delivered and amended in line with case review and audit findings. There are specific examples where the impact of training on frontline practice has been evaluated through audit.

102. The child death overview panel (CDOP) benefits from an independent chair and demonstrates a learning approach to improving its function and effectiveness. Information and data is used effectively to identify and act on areas for learning and development. Priorities identified from the annual report are being progressed, and examples of positive impact include reduction in maternal smoking rates, following targeted intervention, and increased awareness of safe sleeping.

103. Coordinated approaches between the NSCB and the adult safeguarding board (NSAB) have effectively supported and overseen the development of outstanding multi-agency practice in responding to sexual exploitation and human trafficking.

104. Responding to female genital mutilation has been identified as a Board priority and the female genital mutilation strategy and action plan has underpinned effective awareness raising, the development and implementation of clear pathways, timely responses to potential risk and ongoing refinement of those service responses. The development of the work has been enhanced by the effective engagement with local voluntary groups.

105. The multi-agency 'Prevent' duty group has overseen the effective development of understanding risk from and responses to violent extremism. External funding has been agreed to further enhance links with and understanding of the needs of local communities, and the work has also benefited from coordination with voluntary groups.

106. Policies and procedures are regularly updated to reflect local and national developments, and are in line with current statutory requirements. The accessible online procedures also contain practice guidance, all of which are known to and used by frontline staff.

107. NSCB is a learning organisation that reflects on its effectiveness and evolves its approaches to discharging its functions. The annual report, in conjunction with the annual learning from practice report, effectively evidences the range of Board activity with a focus on priority areas and analyses the effectiveness of key areas of safeguarding practice and learning.

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

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

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

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

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

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