Durham County Council

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

and

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

Inspection date: 22 February 2016–18 March 2016

Report published: 16 May 2016

Children's services in Durham 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		Requires improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and 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 Durham require improvement to be good. The consistently high quality of services identified at the last inspection in 2011 has not been maintained. Some services and a number of outcomes have improved, for example through the development of early help services, for children and young people at risk of sexual exploitation, for care leavers and for children whose plan is for adoption. However, assessments and plans for children in need of help and protection and children looked after are of variable quality and require improvement.

During the past two years, there have been significant changes to children's services. The reorganisation of children's services in June 2014 was followed by the establishment of a Multi-Agency Safeguarding Hub (MASH) in March 2015. As part of the wider transformation programme, the local authority is co-locating early help and social work teams. These changes have had a substantial impact on service delivery in Durham. There is some positive impact across early help services, but some other frontline services have not received sufficient attention.

Performance information is extensive and has resulted in some improved outcomes. However, some reports provided to senior managers and elected members are not sufficiently analytical, and do not assist in scrutinising frontline services. Some issues concerning the quality of social work practice and recording remain, and reports on the quality of case file audits are not routinely provided to elected members.

The early help offer is good and offers wide-ranging services to all children and young people aged 0 to 19 years and their families. Key strategic policies align closely with multi-agency working, especially within early help and in responses to child sexual exploitation. Services to address issues of drug and alcohol misuse, domestic abuse and mental health are in place and well established.

Information sharing on referrals is not always detailed enough to progress concerns about children and young people and there are delays when workers have to obtain additional information and consents from parents. Systems for case recording currently require the use of both electronic and paper systems. The local authority has plans in place to improve these arrangements.

As a result of recent staff shortages, two out of the three child protection teams have been unable to accept any new children's cases. Consequently, caseloads in Families First teams have increased. This has resulted in delays in assessment and the provision of services for some children with lower levels of need and risk. The reorganisation of services and staff shortages mean that some children and young people have had too many changes of social worker. Managers have identified these issues and have plans in place to improve workforce stability.

The quality of assessments for children is not consistently good. Analysis is of variable quality and does not sufficiently inform care planning. In addition, care planning is not always robust. Many plans are not sufficiently outcome focused, do not have clear timescales for actions to be completed and do not assist in improving outcomes for children. The quality of strategy discussions and child protection

enquiries is inconsistent.

Recording of management oversight on children's files is not always present and lacks sufficient detail to demonstrate the reasons for decisions or to progress planning. This results in drift and delay for some children. For children looked after, this means that children's cases do not always progress through to the pre-proceedings phase of the Public Law Outline (PLO) or to special guardianship order (SGO) arrangements as quickly as they should.

The arrangements for children and young people who go missing and those at risk of child sexual exploitation are good. The local authority is working effectively with partners to implement strategies and raise awareness through the Educate and Raise Awareness of Sexual Exploitation (ERASE) team. As a result, the number of children and young people who go missing has decreased. However, more work is needed to use the analysis from return home interviews to further strengthen practice.

Political and senior leaders as corporate parents demonstrate passion and commitment to children and young people. Placements for children are of good or better quality and meet children's needs. Out-of-area placements are rarely used. When used, outcomes for those children, who often have very complex needs, are good.

A well-resourced and effectively managed Looked After Children Education Support (LACES) team ensures that every young person is seen regularly by their LACES key worker, to actively promote their education and provide ongoing emotional support. However, more work is required to improve attainment across all key stages.

The adoption service is a strength within the authority. Work is child focused to ensure that a lifelong placement for children and young people is at the heart of all practice. Children's progress through care proceedings and planning is effectively tracked to avoid unnecessary delay. However, further work is needed to ensure that the recruitment of adopters is informed by a clear analysis of need.

The majority of care leavers develop trusting and long-standing relationships with their personal advisers or their social worker. Commissioning of accommodation for care leavers is also good. The local authority provides a good range of emergency accommodation for young people who present as homeless.

The number of children privately fostered is low and social work practice in respect of private fostering does not currently meet standards set out in regulations and guidance. Children and young people are not visited as often as they should be and private foster carers are not subject to sufficiently robust assessments.

Consultation with children and young people to inform service development is well embedded and effective. A national community interest company is commissioned to deliver a wide range of opportunities for children and young people to share their views and influence how services are provided. The local authority works well with partners and has shared priorities based on a good understanding of local need.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates 10 children's homes, including one secure unit. All were judged to be good or outstanding in their most recent Ofsted inspections.
- The previous inspection of the local authority's safeguarding arrangements/arrangements for the protection of children was in December 2011. The local authority was judged to be outstanding.
- The previous inspection of the local authority's services for children looked after was in December 2011. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since August 2012.
- The DCS is also responsible for adult services.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since October 2014.

Children living in this area

- Approximately 100,300 children and young people under the age of 18 years live in Durham. This is 19.4% of the total population in the area.
- Approximately 21.5% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 19.9% (the national average is 15.6%)
  - in secondary schools is 16.4% (the national average is 13.9%).
- Children and young people from minority ethnic groups account for 2.5% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are mixed and Asian or Asian British.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 2.3% (the national average is 19.4%)
  - in secondary schools is 1.6% (the national average is 15%).
- Durham County Council has the highest population of all local authorities in the North East region, with 517,800 residents in 2014. The population is projected to

[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.

increase by a further 2.8% by 2021. The county covers a mix of large rural areas and small urban centres, with several experiencing high levels of deprivation.

Child protection in this area

- At 22 February 2016, 3,351 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,745 at 31 March 2015.
- At 22 February 2016, 373 children and young people were the subject of a child protection plan. This is a reduction from 377 at 31 March 2015.
- At 1 March 2016, eight children lived in a privately arranged fostering placement. This is an increase from four at 31 March 2015.
- Since the last inspection, 10 serious incident notifications have been submitted to Ofsted and six serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 22 February 2016, 665 children were being looked after by the local authority (a rate of 66 per 10,000 children). This is an increase from 620 (62 per 10,000 children) at 31 March 2015. Of this number:
  - 148 (or 22%) live outside the local authority area
  - 41 live in residential children's homes (including residential special schools that are dual registered as children's homes), of whom 17% live outside the authority area
  - two live in residential special schools[3] (excluding dual registered children's homes), both of which are outside the authority area
  - 536 live with foster families, of whom 22% live outside the authority area
  - 33 live with parents, of whom 9% live outside the authority area
  - one is an unaccompanied asylum-seeking child.
- In the last 12 months:
  - there have been 30 adoptions
  - 50 children became the subject of special guardianship orders
  - 244 children ceased to be looked after, of whom 6% subsequently returned to be looked after
  - 19 children and young people ceased to be looked after and moved on to independent living

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

- no children or young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Continue with existing plans to ensure that there is sufficient capacity and stability in social work teams so that caseloads are manageable and workers are able to fully support children and young people.

2. Review existing arrangements to ensure that political and senior leaders have access to improved quantitative and qualitative performance information that enables them to have an accurate picture of the current practice delivered to children, so that they can develop strategies to maintain and improve the quality of frontline practice.

3. Continue with the plan to review existing recording systems to ensure that children's case records are organised in such a way that they present a coherent, accurate and easily accessible picture of a child's journey.

4. Improve the quality of social work assessments for all children, young people and care leavers by ensuring that they consistently contain comprehensive and rigorous analysis of all relevant information.

5. Improve the quality of planning for all children, young people and care leavers so that plans are clear about intended outcomes and timescales, and about who is responsible for actions. Ensure that families receive a copy of their plan. Ensure that key agencies participate in strategy discussions and meetings, or provide information to them, to comply with statutory guidance.

6. Ensure that consent is sought from parents when enquiries are undertaken for all cases of children and young people in need.

7. Improve private fostering arrangements to comply with statutory guidance through effective awareness raising, visits to children and completion of assessments.

8. Improve case file auditing to ensure robust and independent evaluation of the quality of practice to promote learning and improvement.

9. Improve the oversight of casework where children are in voluntary care arrangements, including those under the PLO process, so that plans for these children progress without delay and within their timescales.

10. For children moving to live with parents under care orders, review practice in respect of reports prepared under 'The Care Planning, Placement and Case Review (England) Regulations 2010' to make sure that these cover all relevant information and are signed off at a suitably senior level.

11. Review the use of, and eligibility criteria for, the independent visitor scheme so that the full range of children who would benefit from the scheme are able to do so.

12. Ensure that all care leavers in foster care are aware of the opportunity to 'stay put' in their placements after the age of 18 years, should they so wish.

13. Ensure that the adoption recruitment strategy is based on the analysis of data, so that there is a targeted approach to ensure that sufficient carers are recruited to meet the needs of children in Durham.

14. Improve how information from return home interviews is used to support risk assessments for children who go missing and/or are at risk of child sexual exploitation.

Summary for children and young people

- When children and families need help in Durham, there is a good range of early help services available to them. This means that most children and families do not have to wait too long to be helped.
- When things become unsafe for children, social workers, police and health professionals work together well to make sure that children are protected.
- Some social workers have too many children and families to work with. This means that they do not always have enough time to visit children and get to know them.
- Some children have had too many different social workers. This makes it difficult to make good relationships and fully understand how they and their families can best be helped.
- When children go missing, all professionals work together to understand why and help children to learn about the dangers of child sexual exploitation.
- Sometimes, social workers delay making decisions about children's futures and children remain in voluntary care arrangements for too long.
- For a small number of children looked after by the local authority, social workers do not act quickly enough to investigate allegations made by children, though these children have not been left at risk as a result.
- When it has been decided that a child needs an adoptive family, work is done quickly to find a family. Children waiting for a family are prioritised and, when adopted, get very good support.
- Children who are looked after get good support to attend school. Some children are doing well in school, but more needs to be done by senior managers to improve achievement for all children and young people looked after.
- Some good work has recently been done to help care leavers start apprenticeships so that they have good career opportunities for the future.
- Senior managers, social workers and political leaders are good at listening to children when they need help and consult with children on how services in Durham should be changed to help them more.

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

Summary

The service for children needing help and protection in Durham requires improvement. Although some services are resulting in positive outcomes for children, other services are not sufficiently strong. This is evident, for example, by the variable quality of plans and assessments.

Early help services are effective and well established. The 'think family' approach is embedded and there is good multi-agency involvement in the planning and delivery of early support to families, leading to them receiving the right help at the right time.

The Durham MASH, established in March 2015, brings together professionals from children's services, health, education and the police. While overall this service is working well, there are not sufficient health and police resources in the teams to fully support and progress work.

Staff shortages have resulted in high caseloads for some teams. This potentially increases risks as there are delays in progressing work with children and young people. Managers have put arrangements in place to manage risk, although plans to recruit additional staff had yet to have an impact at the time of the inspection.

The quality of referrals into the First Contact service is variable and, where insufficient information is provided, time is spent chasing information, leading to delays in families receiving support. Managers have taken appropriate action to tackle this through the LSCB. Where concerns about children do not meet the threshold for risk of significant harm, consent is not routinely sought or clearly recorded prior to multi-agency information gathering and sharing. The quality of strategy discussions and child protection enquiries is inconsistent.

The quality of assessments requires improvement. Most do not provide a comprehensive analysis of a child's circumstances, taking into account their family history, although they do contain the views of children, family members and significant males. The majority of children's plans are not sufficiently outcome focused and do not have clear timescales for actions to be completed.

The local authority's response to children who go missing, including those missing education and those at risk of child sexual exploitation, is good and protects children and young people. Return home interviews are conducted routinely, although analysis of underlying issues is not completed.

Services for children and young people with disabilities are well managed and the quality of work, including assessment planning and arrangements for the transition to adult services, are good.

Inspection findings

15. The local authority has prioritised early help and prevention through its Innovation Programme, aiming to increase the number of families receiving support at an early stage and as a consequence, decrease those requiring statutory intervention. This is part of a five-year transformation programme up to 2020.

16. There is a good range of early help services provided by One Point and partner agencies for all children and young people aged 0 to 19 years and their families. Multi-agency working is embedded in practice, with a range of partner agencies routinely attending weekly allocation meetings. Services to address drug and alcohol misuse, domestic abuse and mental health issues are well established. There is a 'think family' approach adopted by staff who use tools to assess and plan appropriate direct work, for example, alcohol assessments. The number of children registered with children's centres is high. Centres are aligned with One Point services and provide a wide range of preventative and targeted services.

17. The number of early help assessments completed is increasing. However, there is no electronic system for recording the date of completed assessments. The authority relies on notifications from partner agencies with regard to assessments that have been undertaken. This means that the authority does not know the actual number of assessments completed by partner agencies or the quality of them. A tracking tool is in place to monitor the progress of completed assessments. Early help assessments seen by inspectors were all good, resulting in appropriate support being offered to families.

18. As part of the wider transformation programme, the authority is co-locating early help and social work teams. The final phase of this co-location occurred during the inspection. All staff are positive about this change and welcome the emphasis on intervening early with families. While it was too soon to see the long-term impact, inspectors saw evidence of prompt information sharing and appropriate escalation and de-escalation of children's cases between the One Point and Families First teams. The ability to share information, in particular when children's cases are stepped up to Families First teams, is impeded by lack of a common case recording system, although the local authority is developing its social care recording system to include early help services.

19. The overall performance management and quality assurance of early help work are underdeveloped and limited by the lack of a joint information technology system within social care. The introduction of an outcomes framework tool to demonstrate impact is not yet used across all early help services, although staff are being trained to use it, and plans are in place for this to be embedded across One Point and partner agencies. The impact of early help is currently evidenced on a case-by-case basis, alongside performance scorecards and an electronic tracking system. However, this is limited by the lack of electronic case management.

20. The Troubled Families programme in Durham is known as 'Stronger Families', and is integrated into the children's services management structure. Children's cases are worked at a statutory level when there is an assessed need. The local authority reports that it has achieved all of the specified outcomes for all identified families during phase one of the project.

21. Thresholds at all stages are appropriate, well understood and applied. The local threshold document has recently been reviewed and refreshed to align with the restructure of service delivery. Professionals are able to access advice and guidance from social workers within the First Contact service.

22. Children and young people who are at risk, or in need of social work intervention, are identified and referred appropriately to the First Contact service by a range of partner agencies. In most children's cases seen, referrals were appropriate and timely and, where there was a need for social work intervention, children's and young people's cases were promptly allocated. However, the quality of referral information was variable, ranging from inadequate to good. This means that further information often needs to be obtained prior to a decision being made about the most appropriate response. This results in delays for some children receiving the right help at the right time. The local authority has made efforts to address this issue through the LSCB and through the provision of support and guidance for referrers.

23. Parental consent is not routinely sought or clearly recorded prior to multi-agency information gathering in respect of children where concerns do not meet the threshold for risk of significant harm. Agencies within the MASH are not clear about how consent is obtained or where this is recorded in children's files. For example, there is an assumption that police have obtained consent but it is unclear if parents understand that this is for the purpose of further information gathering (Recommendation).

24. Decision making following contacts is appropriate and is made by suitably qualified and experienced staff and managers. However, in the records of most children's cases seen, the rationale for decision making where these are progressed to early help or Families First for assessment is not clear. Poor record keeping hampers the progress of assessments and inspectors observed duty social workers within Families First teams repeating information gathering, therefore causing a delay for some families receiving a service.

25. Where children are at risk of significant harm, immediate action is taken to reduce risks and safeguard their welfare. Strategy discussions and section 47 enquiries are routinely undertaken where risk of significant harm is identified. The quality of recorded discussion is variable and does not always involve health partners. Although some records detail clear actions to progress the investigation, too many contain limited information, sometimes only including those who contributed, with no recorded information about the risks and needs of children and young people (Recommendation).

26. Assessments undertaken to complete section 47 enquiries demonstrate appropriate information gathering and all contain an analysis of risk. The quality of the analysis is variable and in the majority of children's cases, requires improvement to be good. Recording of the outcome of section 47 enquiries is also limited, with little analysis or rationale evident for decision making. Managers have recently taken action to improve the consistency of the recording of section 47 enquiries, but it is too early to evidence impact.

27. Decision making to progress to initial child protection conference (ICPC) was appropriate in all children's cases seen, but conferences are not consistently held within timescales. Timeliness of ICPCs was below that of the authority's target of 75% for the previous quarter. High caseloads in some Families First teams and recent structural change as part of the transformation programme have impacted on this. In the large majority of instances, child protection core groups demonstrate effective coordination between agencies (Recommendation).

28. A specialist team works with children and young people with disabilities and provides appropriate child-focused work from skilled practitioners who are supported well by managers. The team manages child protection concerns for children's cases already open and receives referrals via the MASH. The overwhelming majority of assessments considered within this team were good and included the views of children and the wider family with appropriate multi-agency input. As a result, plans for children and young people were focused and clear.

29. The quality of assessments is not consistently good. The majority do not provide a comprehensive analysis of a child's circumstances that takes into account their family history. This means that emerging patterns are not always recorded, considered and understood sufficiently. Most assessments were detailed and contained evidence of consideration of the views of children, parents and significant males within families. However, in some instances, there was insufficient analysis to inform plans. Chronologies are not developed or used consistently to inform assessments and planning for children (Recommendation).

30. The local authority does not have a preferred social work model of practice, but has drawn on various models in developing assessment and practice guidance. Several practice tools are available for social workers to assist their engagement with children and young people. Social workers spoke of tools that they used for direct work with families, although their use and impact was not always evident within case recording.

31. Plans require improvement to be good. They are not sufficiently outcome focused and are generalised, lacking clear timescales for actions to be completed and clarity as to who will undertake required actions. Parents and children are not routinely given a copy of their plan. In some children's cases, a written agreement with a parent was put in place to clarify an expectation and supplement the plan. Where plans are good, they are comprehensive, regularly

reviewed and updated and identify how risks will be managed and reduced. The local authority recognises that plans need to be improved and is developing a new 'family plan', to be introduced in summer 2016 (Recommendation).

32. The number of children on a child protection plan under the category of neglect has not reduced significantly over the past year, although this is a key aim for the local authority. At the time of inspection, 67% of the 373 children on a child protection plan were under the category of neglect. This figure is down from 69% in March 2015. The local authority recognises that more needs to be done and revised its early help and neglect strategy in December 2015. Strategies to identify the early signs of neglect include implementation of the home conditions checklist across One Point and partner agencies. Further practice guidance for staff is also planned.

33. The emergency duty team provides an effective service for children and families at evenings and weekends. The team has access to the local authority database. However, not all information is currently able to be accessed due to some information being stored on paper files. This means that decision making to safeguard children outside office hours may not be fully informed. The local authority is planning to replace the current systems for record keeping.

34. With a good range of partner agencies, including children's social care, multi-agency risk assessment conferences (MARAC) are effective in sharing information, identifying risks and developing appropriate responses to protect children affected by domestic abuse. Multi-agency public protection arrangements work effectively to keep children safe.

35. The local authority and its partners have developed and implemented an effective approach at strategic and operational levels to safeguard children and young people at risk of sexual exploitation. A strategic multi-agency group oversees the delivery of the 'County Durham child sexual exploitation strategy 2014–17' and supporting action plan. Progress against the plan is good. A child sexual exploitation risk matrix tool is well understood by social care staff across all tiers. Where the assessed risk is medium or high, regular reviews are carried out at fortnightly multi-agency meetings. In all children's cases, inspectors saw good quality work being undertaken that resulted in risks being demonstrably reduced or managed for children and young people who were at risk of sexual exploitation. However, although all children who go missing from home are offered return home interviews, there is no analysis of the underlying issues that led to the missing episode to strengthen responses to risk (Recommendation).

36. The local authority takes a proactive and robust approach to tracking children who are missing from education. Schools promptly report children through an online central tracking database and appropriate enquiries are made with a wide range of agencies. As a result of these effective systems, at the time of the inspection, the authority had located the vast majority of children missing from education. There is good information sharing with the ERASE panel,

ensuring that swift action is taken for children at additional risk of sexual exploitation.

37. Effective arrangements are in place for young people aged 16 to 17 years who become homeless. Young people who present as homeless are offered accommodation in specifically commissioned emergency placements. A robust protocol ensures multi-agency planning between the Holistic Temporary Accommodation and Support Service, housing, health, education and the youth offending service, as appropriate. Plans for young people are reviewed regularly, meaning that young people receive timely and appropriate support to return home or move on to lodgings.

38. The management of allegations against professionals who work with children is good. The designated officer has recently increased awareness and developed the role with partners and this is resulting in an increase in referrals. Appropriate systems are in place to manage and monitor the progress of children's cases, meaning that investigations are being progressed within suitable and prescribed timescales.

39. The local authority's arrangements to respond to the needs of privately fostered children and young people are poor. At the time of the inspection, there were eight children and young people known to be living in private fostering arrangements. Activities to raise awareness of private fostering have had limited impact. The authority needs to do more to improve the quality of practice and raise awareness of requirements in this area. Practice does not currently meet standards set out in regulations and guidance, meaning that children are not visited as often as they should be and private foster carers are not subject to sufficiently robust assessments (Recommendation).

40. Consideration and impact of diversity are not well considered in most children's cases seen, with a lack of analysis on how issues children were experiencing impacted on their identity. Inspectors saw good use of interpreters and translation services in some casework.

41. Plans are in place to introduce an advocacy service for children subject to child protection plans from April 2016, but this is not currently offered, which means that children and young people have not had timely access to an advocate when they need one.

42. The local authority is implementing the 'Prevent' guidance well. Two hundred and sixty headteachers and school safeguarding leads completed a 'Workshop to Raise Awareness of Prevent' (WRAP) and 2,230 school staff have completed online training. Schools use a toolkit that helps them to identify behaviour that is concerning and appropriately share this information. About 80% of childcare providers have also received WRAP training. Plans are in place to offer a series of 'Prevent' seminars through the Safer Durham Partnership in May 2016.

43. Guidance has recently been developed in relation to female genital mutilation, although, at the time of inspection, this was not on the Durham Local

Safeguarding Children Board (DLSCB) website. Strategic overview of female genital mutilation and honour-based violence sits within a subgroup of the Safer Durham Partnership. Inspectors saw appropriate responses, with good use of advice and research informing planning to protect children.

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

Summary

In most circumstances, children and young people become looked after appropriately. Placements with friends and family members are used to provide a safe place for children and young people to live. However, delays in completing assessments of friends and family members as foster carers mean that children are not always deemed to be looked after as quickly as they should be. There are also delays for some children within the pre-proceedings phase of the Public Law Outline (PLO) and where the plan is for a special guardianship order. This means that they remain looked after under voluntary arrangements for longer than they should.

Placements are of good quality and meet children's needs. There is a good range of placements available for children. This means that most live near home, and brothers and sisters can live together. Social workers visit children regularly and take account of their wishes and feelings, though some children have had too many changes of social worker.

The virtual school, through the LACES team, provides good-quality support for the education of children looked after. All children looked after have a Personal Education Plan (PEP), although these are of variable quality. Plans appropriately include behavioural and personal, as well as academic, goals.

Children looked after have their health needs considered effectively in most cases. There have been recent improvements in the timeliness of health assessments when children first become looked after, though there is more work to do on this. The Full Circle service provides timely and effective support for children's and young people's emotional and mental health needs.

Children's care plans are regularly reviewed. Where there is concern that these are not progressing in good time, independent reviewing officers (IROs) make use of the dispute resolution process, though this is not always effective in ensuring that managers make improvements within timescales for children and young people.

The adoption service is child focused. Children are identified early and are found appropriate placements without undue delay. Support is offered throughout the process, which promotes adoption stability.

Care leavers are well supported to achieve independence and the vast majority engage very well with leaving care services. The majority of care leavers are in suitable accommodation. Further improvements are needed in updating written pathway assessments to include specific targets and fully consider and collate health histories.

Inspection findings

44. For some children on the edge of care, the Community Support Team offers intensive work, which helps them to remain with their families. Other children and young people become looked after appropriately, in response to immediate concerns about their welfare. However, sometimes, children do not become looked after immediately, but move to live in family arrangements supported by the local authority before a suitable assessment of this has been undertaken. No instances were seen by inspectors in which children had suffered harm while in these arrangements. The local authority has recognised that this practice is not appropriate and has revised its procedures.

45. Risk is identified, responded to and reduced well for the large majority of children looked after. However, in a small number of cases, there were delays in recognising the full significance of their experiences, leading to risk not being fully considered and reduced as soon as it could have been. A small number of children's cases were seen where the local authority had not responded quickly enough to investigate allegations made by children, though these children were not left in danger as a result.

46. At 31 March 2015, 620 children were looked after by Durham children's services. This represents a rate of 62 children per 10,000 of the population. This was lower than the most recently published figures for similar local authorities, and slightly above the figure for England overall. At the time of the inspection, there were 665 children looked after, an increase of 7% on the previous year.

47. Some children remain in voluntary care arrangements for too long. This can be because the plans to achieve permanence through an SGO with a family member are not progressed quickly enough. There are also weaknesses in the practice and oversight of the pre-proceedings phase of the PLO, although some examples were seen where pre-proceedings work had resulted in plans moving forward for children in good time. Overall, the process does not give sufficient oversight to ensure timely planning. This means that some children remain in care for longer than necessary without achieving permanence as quickly as they should (Recommendation).

48. When the local authority presents children's cases to the courts, the Children and Family Court Advisory and Support Service (Cafcass) reports that these are not always as well prepared as they should be. The local authority is receptive to feedback about this and takes remedial action quickly. The large majority of proceedings conclude within the 26-week national target timescale. In the first three quarters of 2015–16, Cafcass figures show 71% of children's cases concluding within the timescale, and the average duration of proceedings is reducing over time.

49. When children return home from care in a planned manner, assessments are undertaken to support these decisions. Once they have returned home, ongoing plans are not always of good enough quality to identify their needs

and how these will be met. However, very few become looked after again, with only seven of the children in care at the time of the inspection having been looked after on a previous occasion during the last year (Recommendation).

50. In cases seen by inspectors, decision making was effective and timely for only a minority of children looked after. A lack of management oversight leads to drift and delay on some children's cases. Decision making is not consistently well recorded, including gaps in supervision records and superficial recording of supervision discussions and decisions. In better examples, there is regular recording of management oversight, and evidence that this helps to progress children's cases.

51. Assessments are poor in a majority of children's cases seen. They can contain a good range of information, particularly information about parents' histories, but the analysis of this is weak. In some, not all important issues are adequately considered to produce a rounded assessment. In others, there are delays in completing assessments, or assessments are not appropriately updated to reflect current circumstances. When children are placed with parents under care orders, the assessments undertaken by the local authority to support this decision are not consistently of good enough quality. They do not contain all the information that they should, and not all are signed off at a senior enough level (Recommendation).

52. In most instances, social workers visit children regularly, though some children have experienced a number of changes of social worker. Children are seen alone and their views obtained. In the best examples, this includes the use of alternative forms of communication, and the recording of observations of very young children to gather their wishes and feelings. In weaker instances, there is a lack of recording of an appropriate range of discussions with young people, or it is not clear how discussions relate to the plan.

53. Children and young people have access to an advocacy service. This is well publicised and used by appropriate numbers of children. Advocates have skills in alternative methods of communication, ensuring that children with disabilities are able to access the service. An independent visitor service is also available. However, the current eligibility criteria for the service are narrower than the requirements set out in statutory guidance. As a result, take-up of this service has been very low, with only six young people receiving a service at the time of the inspection and two more young people waiting (Recommendation).

54. The vast majority of pupils are attending good or better schools. Attendance is carefully monitored and current attendance for children looked after is good, at 96.6%. This is in line with statistical neighbours. A small number of children (39 children) experienced school moves in 2014–15, which was a significant reduction (43.5%) from the previous year.

55. Where it is clear that children are not making expected levels of progress, the Looked After Children Education Support (LACES) worker identifies and agrees support strategies and interventions to ensure that children get back on track.

As a result, the vast majority of children looked after are making expected levels of progress and a very small minority are exceeding expectations. No child has been permanently excluded from education for the last three years. This is because LACES workers use a range of timely interventions. However, despite this good work, fixed-period exclusions remain too high for children looked after. The pupil premium is used well to enhance the education experience and opportunities for children looked after. The vast majority of the pupil premium is used to fund one-to-one academic support and provides opportunities for pupils to work in small groups.

56. Attainment for children looked after has fluctuated over time and key stages. Pupils' attainment at key stage 1 improved well in 2015, following a fall in 2014. This improvement has not been consistent across the other key stages. For example, at key stage 2, the proportion of pupils gaining level 4 or above in mathematics and reading has been above that of similar pupils nationally for the last three years and the gap between their achievements and their peers has narrowed well. However, the proportion of pupils who are looked after gaining level 4 or above in grammar and punctuation has been below that of similar pupils nationally for two of the past three years and gaps between these pupils and their peers were much wider than the national gap in 2015.

57. The attainment of pupils who are looked after at key stage 4 has been too variable over the past three years. The proportion of pupils gaining five GCSEs at grades A* to C, including English and mathematics, was above that of similar pupils nationally in 2013 but fell to well below that of similar groups in 2014. The overall progress that pupils who are looked after made from their starting points on entry into secondary school has been below that of similar groups of pupils for the past two years, falling further in 2015. Gaps between pupils who are looked after and their peers were wider than those found nationally for similar groups. The quality of PEPs of tracked and sampled children's cases is not consistently good. Most plans demonstrated that the views of young people are listened to and recorded. A small number of plans lack sufficient detail and do not state how targets will be monitored or reviewed. In addition, some young people are not fully engaged in the process and, as a consequence, their progress is being hampered (Recommendation).

58. Children looked after, including those placed outside of the local authority, have their health needs met appropriately in most cases. The latest figures for 2015–16 show that 86% had had a health assessment, which is deterioration from the 93% rate in 2014–15. Performance is below that of statistical neighbours, at 96%, and the England level of 90%.

59. Work between health providers and the local authority has led to recent improvements in the timely completion of initial health assessments. Sixty three per cent were completed within the target timescale in 2015–16, compared with 8% at the same point in 2014–15. The local authority and partner agencies recognise that there is more to do in this area. Initial health assessments are carried out by paediatricians, who offer dedicated clinics for

children looked after. The Full Circle service provides swift, effective support for the emotional and mental health needs of children looked after. Looked after reviews regularly consider children's health needs to ensure that these are being addressed effectively.

60. The Youth Offending Service is well integrated with children's services, being part of the same management structure. There are close working relationships between youth offending workers and children's social workers. This leads to effective work around restorative justice and discharge from custody. At the time of the inspection, the offending rate for children who have been looked after for a year or more stood at 2.5% for 2015–16, an improving picture over the 2014–15 figure of 4%. This is better than 2014–15 rates for England, 5%, and statistical neighbours, 8%, and a significant improvement from 2012 when Durham rates were 11.4%.

61. Children's leisure interests are regularly considered as part of looked after reviews, and they are encouraged to pursue a range of extra-curricular activities. Contact arrangements help children to stay in touch with the people who are important to them.

62. Most children live in good-quality placements that are meeting their needs effectively, including placements that have been sustained over long periods of time. Good communications between residential placements and social workers help to support children remaining in placements. At the time of the inspection, few children (5.6%) were reported as having had three or more placements in the previous year. This figure has been improving over time as a result of targeted improvement action, and is better than the most recently available figures for both similar local authorities and England overall.

63. A large majority (77%) of children looked after are placed within the local authority. Of those placed outside the local authority, most (92%) are placed in a neighbouring local authority. This promotes children's identity and ongoing contact with their wider family. A very large majority of children (90%) are placed with families. Thirty three children (5%) are placed with their own parents, a figure in line with the most recently published national figures.

64. The fostering service has clear priorities and a determination to achieve permanence for children and young people. There is a clear strategy to recruit carers for permanence, as well as for teenagers and for groups of brothers and sisters. The number of children placed with Durham foster carers has increased over time, from 336 in March 2013 to 436 in March 2015. The fostering panel plays a key role in the quality assurance of the service. This has meant that the quality of matching, reports and life story work has improved.

65. The recruitment of foster carers is robust, with all relevant checks and interviews undertaken. Foster carers receive good-quality training to support them in caring for children and young people. They particularly welcomed the training delivered by the Full Circle service regarding attachment and the difference it has made to their approach in handling and managing children's

and young people's behaviours to minimise risk. Foster carers receive good support with regular visits from their supervising social worker, and say that workers are responsive to their requests for information and advice.

66. The majority of plans for children are not comprehensive enough, lack clear, focused outcomes and timescales and are not updated to reflect changes in circumstances. This means that plans do not always effectively help to progress outcomes for children. In most cases, IROs review plans regularly, with local authority figures showing 96% of reviews are carried out on time. Where plans for children are not progressing, IROs make appropriate use of the dispute resolution process in most cases. However, for some children, the oversight of IROs does not always succeed in preventing drift and delay (Recommendation).

67. IROs have developed positive relationships with children's guardians. They attend joint development events, and there is effective handover between guardians and IROs at the end of care proceedings.

68. The Children in Care Council (CiCC) has undertaken a range of valuable work with the local authority. This includes being involved in the design of the DLSCB website and delivering training for foster carers and other professionals.

69. Issues of diversity are considered well. Children are placed in culturally appropriate placements that maintain their connections with their roots. There is appropriate recognition and consideration of needs arising from disability, including those of parents and other family members, and of needs arising from ethnicity and religious choice.

The graded judgement for adoption performance is that it is good

70. The adoption service in Durham is very child focused. Achieving a lifelong placement for children is at the heart of all practice. The adoption service is stable, experienced and well led. A dedicated senior practitioner effectively monitors and tracks the individual progress of children. Plans for children are discussed weekly at team meetings and at fortnightly link meetings. This ensures that children awaiting placement are known to the managers and the team, keeping them at the forefront of the process. Progress of prospective adopters is also tracked at the fortnightly link meetings. Since November 2015, this new system has had a positive impact in reducing the time between placement order and being matched. This is currently at 179 days, against a set target of 230 days.

71. All children who require an adoptive placement have a child permanence report completed by the permanence team. This team has been in place since April 2014. The agency decision maker (ADM) and panel chair report that the quality

of reports has improved over the past year. Permanence reports sampled by the inspectors were mainly good, with child-focused and reflective assessments. All permanence reports are robustly quality assured by the ADM. On occasion, the reports are not updated to include information requested by the ADM or refreshed to include the child's most recent information. This does not delay the overall processes but does mean that adopters do not always have the up-to-date picture of a child. If no match for children can be achieved within the adoption service, other avenues are actively explored.

72. Children are well prepared for adoption. All have personalised child-friendly timetables and information booklets to ensure that they are fully informed and involved in their plans. The adoption service has an established letter-box system, to coordinate indirect contact. This is sensitive to all and thorough in its processes. The later life letters seen are written in a clear and candid way that give a summary of the child's history. Life story work is child centred and includes all the people involved in a child's journey. There is a designated worker to support professionals and carers involved in a child's life to help them contribute to life story work. Although there is a backlog following the recent appointment of the specialist life story worker, inspectors saw good examples that were sensitive, informative and well presented. The service is committed to ensuring that children receive these by the time that the Adoption Order is made, and recognise this is as an area for improvement.

73. Children's needs are very well supported and assessed by the Full Circle service. This is a therapeutic service that is offered to all children looked after. This service is highly commended by all professionals and adopters who spoke with inspectors. To ensure that the right placements are requested for brothers and sisters, Full Circle workers complete a thorough assessment of each child's needs. All placement requests for brothers and sisters to stay together have been achieved in the past year. The Full Circle service is also involved in the training of prospective adopters. In addition, a clinical psychologist meets with all adopters before matching takes place. The needs of each child are holistically and realistically presented to the potential matched carers. This is supported by the work of the adoption team and has resulted in only one disruption in the past 12 months. The panel and the service reflected on this disruption to capture learning and consider any changes to improve services.

74. The national adoption scorecard measures the average length of time between children becoming looked after and being placed for adoption. Performance against this indicator is an improving picture. For 2014–15, a sizeable reduction of 102 days was achieved from the previous year, at 449 days. The latest information for this year shows a further positive reduction to 421 days, which is again below the national target.

75. The local authority's recruitment strategy for adopters is not based on an analysis of predicted numbers, needs and profiles of children, which is an omission. However, the service attracts a large number of enquiries, and a broad range of recruitment activity is employed. Adopters are prepared and

trained to a good standard. This training is currently being refreshed to ensure that it is inclusive to all potential adoptive families, reflects current practices and presents a realistic and balanced perspective on both positive and challenging aspects of adoption. Inspectors saw evidence of good-quality assessment practice. Adopters confirmed to inspectors that they are positive about the communication they had received following their initial enquiry, subsequent assessment visits, and training and support (Recommendation).

76. The adoption service promotes the adoption register for adopters who have been approved by the panel if they are unable to be considered for a match immediately. There have been no fostering-to-adopt placements made, with only one placement available currently. This aspect of the service is in the early stages of development and is recognised by the authority as an area for further development.

77. The quality of post-adoption support is good. The Full Circle service provides an accessible, timely and comprehensive range of therapeutic techniques to support children and families. Families are also informed of the other support organisations available. Post-adoption training updates and other relevant information are regularly sent out by the service.

78. The adoption support panel is well managed and appropriately constituted. Feedback from adopters who have attended the panel is positive. It demonstrates effective oversight of adoption decisions and the approval of adopters. The chair of the panel and the agency decision maker, along with other key professionals, meet quarterly to discuss issues and challenges that have occurred. This ensures that the practice of the panel and service is informed by research and evidence-based practice. The adoption panel plays a key role in quality assurance, providing appropriate challenge and clear decision making.

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

79. Care leavers are a priority for Durham children's services and there has been a clear focus on improving their outcomes and opportunities. Care leavers are well consulted on service developments that are important for them, for example, the quality of their accommodation, health passports, planning a discrete annual event to celebrate their achievements and supporting events to encourage fellow care leavers to engage in education, employment and learning. Care leavers are celebrated through care leavers' week and specific events, such as a recent celebration for 30 care leavers' achievements in education, employment and training.

80. Care leavers who spoke with inspectors reported positively about the support that they receive. They are knowledgeable about their rights and entitlements and are in receipt of their important personal documents. The local authority is successful in engaging and keeping in touch with the vast majority of care leavers. Workers are persistent in their attempts to keep track of those very few young people who choose not to be in touch with the service. As a result, the majority of care leavers develop trusting and long-standing relationships with their personal advisers or their social workers. Care leavers are well known within the 16-plus teams due to the stability of workers. This helps ensure that they receive advice, support and guidance across a team of workers who know them well.

81. Young people's safety and welfare are a priority. As workers know the young people very well, they are attuned to changes in young people's presentation, emotional well-being or their known behaviour. This alerts them to when things are not going well or there are potential risks. Workers are prompt to take any necessary action to protect and support care leavers. For example, where risks of child sexual exploitation are identified, there are effective and timely arrangements for joint working with partner agencies to investigate concerns and provide support for young people. Young people's needs are clearly risk assessed to support their plans and multi-agency meetings are convened to monitor risks and target support effectively.

82. Care leavers' needs are assessed when they are first allocated to the 16-plus team and the pathway planning process is used to update young people's ongoing assessment and needs. This means that some assessments have been completed three or four years ago and the updating of pathway plans is based on the workers' ongoing knowledge. Although their knowledge of individual young people is thorough, this practice does not consistently ensure that all current information is considered, analysed and reflected on. This is particularly relevant for those young people presenting with challenges and chaotic routines (Recommendation).

83. The majority of young people are engaged in updating their pathway plans. Those care leavers spoken with described how their workers support them to update their plans and they describe their plans as meaningful to them. One care leaver said, 'We go out and have a proper talk, then change it.'

84. Pathway plans contain the relevant information for all young people, and some very good detailed plans were seen. Others were too brief and lacked clarity on specific timescales. In particular, pathway plans lack clear education targets to understand how all care leavers will achieve their goals to engage in education, training or secure employment. Plans do not reflect the actual good-quality work undertaken with care leavers (Recommendation).

85. There is effective and good quality pathway planning for care leavers with disabilities, resulting in care leavers successfully making the transition to adult social care services for seamless, ongoing support and services.

86. Care leavers report that they are well supported with their health needs and know how to access health services. Care leavers have their health needs assessed annually, but some choose to opt out and independently visit their general practitioner. Examples were seen of young people confidently accessing services independently. Some good examples were seen of care leavers supported to reduce drug use, manage eating disorders, receive bereavement support, explore gender identity and follow a healthy eating and exercise plan.

87. Care leavers do not currently receive their health histories and progress to rectify this is slow. A pilot scheme is currently underway to provide 20 current care leavers with their health passports. These meet all necessary requirements to inform and support care leavers to meet their own health needs independently. However, there is not enough urgency through the consultation process to avoid the potential for delay.

88. The majority of care leavers are well supported through a range of options to increase their independence skills, for example, during direct work with social workers, advisers and youth workers. In addition, there is a range of structured independence programmes provided by housing and supported lodgings providers, as well as floating support options, all offering differing levels of support. Care leavers who become parents are well supported through family nurse partnership interventions or by family support workers. In addition, there are accommodation options tailored to parents.

89. The local authority and partners have specifically focused on improving the number, quality and range of accommodation options for care leavers. Concerted efforts to do this have resulted in 94% of young people now living in suitable accommodation. This is an increase of 20% since 2014. There are no young people living in multi-occupancy homes. Those 14 young people at university are well supported to avoid excessive debts and have a consistent place to stay during holiday periods. There are currently 11 young people in 'staying put' arrangements with previous foster carers, which is relatively low, despite the local authority policy to offer 'staying put' to all care leavers (Recommendation).

90. The local authority has increased the availability of emergency accommodation options, known as 'crash pads', across the area to support care leavers at times of crisis. Therefore, the use of hotels or guest houses is low, with these used on two occasions for care leavers since April 2015. A protocol developed in the last six months to reduce the risk of evictions for the most challenging young people, although relatively new, recognises well the need to support those care leavers presenting challenges. Workers are persistent in finding solutions and offering support. Care leavers spoken with report that they feel safe where they are living, although not all are happy with their accommodation location and would prefer more choice.

91. Care leavers are supported to gain skills and employment through an initiative with the local authority's adult education services. All care leavers are offered a

six-month traineeship within the local authority's services. They are then supported to progress to an apprenticeship in their chosen field, for example, the local authority offers mechanical maintenance, care work and administration. Currently, six young people over 19 years old and formerly not in education, employment or training (NEET) are being supported to progress through this route. Care leavers were very positive about this programme, with one stating, 'I got so much from the programme. I am now going to grasp the opportunities it has offered with both hands.'

92. Care leavers are identified as a priority group through the Youth Employment Initiative, with secured funding of £17 million over the next three years to support them into employment. Positively, 30 apprenticeships are allocated for care leavers. This will significantly increase the current figure of six care leavers who have completed apprenticeships over the last three years. This, potentially, will have a dramatic impact on the high numbers of care leavers aged 19 years and over who are NEET, which is 49%. The NEET figures for the 15- to 17-year-old care leavers are much lower, at 16%, which is in line with national and regional rates.

Leadership, management and governance	Requires improvement

Summary

Children's services in Durham require improvement to be good. The consistently high quality of services identified at the last inspection in 2011 has not been maintained. Work undertaken with children requiring adoption and care leavers continues to be good. Early help services are developing well and the response to children at risk of child sexual exploitation is good. However, other important services require improvement. The quality of plans, assessments and case recording is too variable and it is too soon to see the impact of the Innovation Programme on raising the quality of social work practice.

The recent significant restructure of children's services, funded through the government Innovation Programme, introduced the Families First service. The last of the Families First teams became operational in February 2016. This service aims to work intensively with families at an early stage to prevent re-referrals and escalation of concerns. There have been early benefits in improving joint work with early help services, but it is too soon to see the full impact of the restructure.

The local authority demonstrates a commitment to ensuring an effective workforce and provides good support and training for newly qualified staff. The response to address staff shortages in some teams has not yet had impact. This currently prevents the authority from delivering a consistent, timely or good-quality service.

There are clear and effective governance arrangements across strategic partnerships. The local authority works well with partners and has shared priorities based on a good understanding of local need, which inform the commissioning of services. Consultation with children and young people to inform service development is well embedded. This is demonstrated through the work of the Health and Well-being Board's commissioning of strong preventative emotional well-being services based on young people's feedback.

The local authority works well with partners at a strategic level to address and develop services to meet the needs of children at risk of sexual exploitation and those who go missing.

Performance information and quality assurance information are not analysed effectively to consistently improve practice in all areas of service. Arrangements for scrutiny by political and senior leaders are not sufficiently robust. The quality of frontline practice is not routinely reported, and this aspect requires improvement.

Systems for case recording do not ensure that children's files are consistent and complete. Management oversight and decision making are not easily identified on children's records. Evidence of analysis and the rationale for decisions are not sufficiently demonstrated.

Inspection findings

93. Since 2014, significant changes have been made to how early help and social work services are provided in Durham, with the intention to offer increased capacity and support for children. The introduction of the Families First model, with financial support from the government Innovation Programme, has created social work-led teams with a mixed skill base of staff who work closely with community based third sector organisations. The changes are appropriately targeted to reduce the numbers of children requiring statutory intervention and improve capacity for ongoing family support.

94. The focus of political and senior leaders on this integrated community approach as a long-term solution to delivering good-quality services to children has supported the progress and development of early help services for children at lower levels of need. Ten One Point teams are now based in locations across the county. Impact is evident, with an increase in the take-up of early help, reductions in re-referrals to social care and support for children and families more appropriately provided according to their different levels of need. The last of the Families First teams became operational in February 2016. These teams are co-located with One Point services to deliver child in need and child protection work. This is part of an integrated locality provision, with the aim of meeting the future needs of children and families in the most cost-effective way.

95. The local authority focus on working with partners to improve early help and more fully integrate services is sustained by the strong alignment of priorities across key strategic organisations such as the Health and Well-being Board, the DLSCB and the Strategic Partnership Boards. These organisations work closely with the 14 Area Action Partnerships to ensure community involvement in a range of consultation and planning regarding service delivery. This supports strategic objectives, including the continued development of awareness of child sexual exploitation.

96. The Joint Strategic Needs Assessment (JSNA), which offers a comprehensive overview and analysis of relevant data, has effectively informed strategic themes and priorities. These translate into shared strategies, targets and coordinated action plans demonstrating a coherent approach to key issues, such as emotional health and well-being and childhood obesity. The strong and well-resourced Health and Well-being Board demonstrates clear governance arrangements to the DLSCB and the Children, Young People and Families Plan. The latter demonstrates that children and young people were consulted and their views considered to inform planning.

97. There are clear and effective governance arrangements across the strategic partnerships, with political and senior leaders having clear lines of accountability and responsibilities. The new chief executive, in post since January 2016, has taken immediate steps to familiarise himself with children's services, ensuring the continuation of effective monitoring arrangements with

the director of children's services (DCS) and close links with the lead member for children's services, the leader of the council and other elected members.

98. A comprehensive data set is provided to senior managers to develop action plans to address performance deficits. This has resulted in improvements in some areas of practice such as placement stability for children looked after and the percentage of return home interviews completed following a child or young person going missing. However, performance reports presented to senior and political leaders lack analysis and explanation to provide sufficient understanding or scrutiny of frontline practice and lack information on casework quality and audits (Recommendation).

99. The analysis of children's case auditing by senior managers is not robust or sufficiently self-critical and does not drive improvement. Actions taken by managers to improve the rigour and consistency of auditing have had inconsistent impact across the service, and efforts to improve case file recording have not resulted in consistently good practice. The quality of practice has not substantially improved and, in some teams, has remained static or deteriorated. The recent appointment of a dedicated improvement manager is intended to facilitate development in the quality of auditing and practice (Recommendation).

100. Senior leaders and managers have not taken timely action to ensure that work with children is recorded effectively. The location of case records on electronic or paper systems is inconsistent, resulting in children's case records not always demonstrating a coherent picture of the child's journey. This results in staff working in First Contact, MASH or emergency duty teams not having access to the entirety of a child's record to inform decisions to address and manage risk. A review of the current database is planned for September 2016, as part of a longer term development plan to enable the creation of a single children's electronic record (Recommendation).

101. Managers have taken action to increase staff capacity but this has not yet had a positive impact. As a result of recent staff shortages, two out of the three child protection teams have been unable to accept any new children's cases. Consequently, caseloads in Families First teams have increased. This has resulted in delays in assessment and provision of services for some children with lower levels of need and risk. Furthermore, the reorganisation of services and staff sickness and changes mean that some children have had too many changes of social worker. This means that children have not been able to develop enduring relationships with social workers. Managers are actively monitoring caseloads and medium and longer term plans are in place to reduce the pressures on teams (Recommendation).

102. The local authority has prioritised action to ensure that it has a strong workforce and effective workforce development and overall has improved staff turnover and vacancy rates in addition to reducing reliance on agency staff. The retention of staff is enhanced by good support in the assessed and supported year in employment (ASYE) and comprehensive training in addition

to opportunities for career development. Social workers describe managers as supportive and accessible, but evidence of management oversight on children's files is not always present and does not demonstrate sufficient analysis or the reasons for decisions.

103. Effective and robust commissioning is undertaken in relation to key areas of need identified in the JSNA, particularly in relation to health needs of children and young people, education of pupils excluded and parenting programmes. Significant work has been undertaken to ensure that the recommission of health provision is fit for purpose and feedback from young people has informed the priority being given to emotional health and well-being. This has led to the commission of a range of services designed to deliver effective prevention and early intervention for children and young people. Sufficiency of placements for children looked after is supported by the local authority being part of an effective regional joint commissioning framework that includes suitable arrangements to monitor the quality of providers, including visits to provision and detailed annual reviews.

104. An effective strategic approach has ensured coordination of strategic and operational services across the partnership to children who are at risk of or subject to child sexual exploitation and those who go missing.

105. Elected members in Durham demonstrate passion and commitment to improve the lives of young people through the work of the dedicated scrutiny committee which meets regularly to review and challenge aspects of service delivery. The committee selects its own work programme which has included scrutiny of services for children at risk of sexual exploitation and those at risk of self-harm. It has regular oversight and challenge of performance information and has sought to increase the participation of young people by holding a recent committee meeting in a local school.

106. The local authority is a committed corporate parent with elected members demonstrating a good knowledge of corporate parenting issues. Elected members attend CiCC meetings and regularly attend corporate parenting panel meetings to discuss a range of topics including feedback from the CiCC about service provision. Feedback is used to make changes in some areas of practice but elected members do not have enough performance information about some key areas of the quality of frontline practice, such as inefficient management oversight resulting in delays to the PLO process and SGO arrangements. This limits their ability to challenge and influence improvement.

107. The local authority has strong systems in place to collate learning from a range of sources, including serious case reviews, complaints and feedback from children and young people. There are clear examples of change taking place as a result of this learning, for example, the training on completion of assessments has recently been amended, and social workers are increasingly aware of the importance of considering fathers and other males in assessments. However, the impact of this learning is not embedded or always evident in current practice.

108. The local authority has been the subject of peer and independent reviews, including of child sexual exploitation and health and well-being, which have informed and improved current practice. Complaints are well coordinated and managed, with learning regularly identified and fed back to inform future practice.

109. Consultation with children and young people to inform service development is well embedded in Durham children's services. A national community interest company is commissioned to deliver a wide range of opportunities for children and young people in the community to share their views. This has been effective in influencing aspects of service delivery.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

Durham Local Safeguarding Children Board (DLSCB) is an ambitious and reflective board whose effectiveness and functioning has significantly improved since the peer review of October 2014. There is clear multi-agency ownership of board activity, which is sighted on key issues with focused priorities. The voice and experience of children and young people are at the heart of the board's work. There is a culture of openness and challenge and the chair of the board has been instrumental in leading and facilitating the developments.

DLSCB has clear governance arrangements with partner boards, with whom there are aligned priorities. These successfully support senior management coordination and oversight of strategic safeguarding work.

An appropriately resourced and well-managed business unit provides good support to the board. Efficient processes underpinning board activity have been developed, ensuring that work is coordinated, timely and in line with board priorities.

A timely and thorough section 11 audit and challenge process ensures that safeguarding is a priority for partner agencies in Durham and that identified improvements are implemented.

DLSCB leads on aspects of key strategic work, including early help and neglect and responses to child sexual exploitation and missing children. The early help offer is well resourced and embedded, with clear strategic direction. Responses to child sexual exploitation are well coordinated at both a strategic and operational level.

Effective processes are in place for reviewing and disseminating learning from serious, child death and other case reviews. Learning events have been particularly well received and future evaluation will be required to assess whether there have been embedded practice improvements.

Quality assurance processes have improved significantly over the last year and give oversight for the board to challenge and assure itself of the quality of work, but in some areas, the reporting and oversight is not yet sufficiently developed.

The board has effective systems for the planning, monitoring and oversight of training activity, clearly linked to board priorities, and training requirements arising from serious case reviews. The board delivers a well-regarded programme of training and e-learning opportunities.

Recommendations

110. Ensure that quality assurance and performance management processes are further developed to offer a detailed and comprehensive picture of the quality and impact of frontline practice in all service areas to underpin strategic understanding, challenge and development.

111. Ensure that quality assurance and audit work contribute to understanding the impact of training and the embedding of lessons learned from case reviews.

112. Develop more effective feedback processes from children, young people and families who have received child protection services to support ongoing service improvement.

113. Ensure that the annual report provides a rigorous assessment of the performance and effectiveness of local services.

Inspection findings – the Local Safeguarding Children Board

114. DLSCB has made significant improvements in its effectiveness and functioning since the commissioning of the peer review by the corporate director of children's and adult services in 2014. Good arrangements are now in place to fulfil its statutory functions.

115. Strong governance arrangements and constructive work at a senior level between the board, key partnership boards and senior officers are clearly evident in ensuring that there is coordinated oversight of safeguarding children work. These arrangements are underpinned by the safeguarding framework, which details joint working arrangements and responsibilities with a clear alignment to strategic priorities. A Chief Officer's Safeguarding Group ensures that all senior officers are sighted on safeguarding practice.

116. The board is constituted in line with statutory requirements. Development work with, and by, the board has ensured that there is committed multi-agency ownership of board activity, with clear shared priorities supported by an appropriately detailed business plan. The engagement of education leaders since the peer review has been significant in involving schools more effectively with the work of the board and in developing more coordinated safeguarding work in the sector. The chairing of the sub-groups by officers with sufficient seniority from across the partnership has been important in embedding shared ownership and progressing subgroup work in a timely way.

117. The independent chair of the board also chairs the Safeguarding Adults Board (SAB) and has been in post since October 2014. She has been instrumental in steering the board developments, setting a culture of openness and challenge and developing constructive working relationships across the partnership. The chief executive has established appropriate links with the chair through which

she is held accountable and there are regular meetings with the corporate director of children and adults services. The lead member is actively involved, regularly briefed on children's service information and attends the DLSCB meetings as an observer.

118. An appropriately resourced and well-managed business unit provides good support to the board. Efficient processes underpinning activity have been developed, ensuring that work is coordinated, timely and in line with board priorities.

119. The voice of children and young people is central to the board and engagement work is supported by a national community interest company. The DLSCB chair chairs the children's and young people's reference group, which has given presentations to the board. The young people who attend the board are well prepared and supported. There are clear efforts to engage a wide range of young people, with board members going to meet young people in their local areas on a Friday night. There have been visits to lesbian, gay, bisexual and transgender (LGBT) young people and their views have informed school responses to homophobic bullying. Young people have also been involved in website development, ensuring that it is more engaging for young people and that information is accessible. There is a coordinated strategic approach across the partnership to engagement with children and young people, ensuring that key messages can be shared without subjecting children and young people to repeated requests.

120. DLSCB has ensured that safeguarding is a priority for all partner agencies. The recent section 11 process was undertaken 18 months after the previous audit in April 2014 and engaged the full range of partners, including individual schools. Bespoke questionnaires aligned to board priorities and amended to support effective school engagement were completed in a timely way. Subsequent challenge clinics have ensured that the board has a clear picture of agency safeguarding practice and an action plan is in place to achieve improvements. Prompt responses to identified gaps were evident and there was appropriate and effective escalation to board level where responses or actions were not completed in a timely way.

121. The performance information and quality assurance processes have significantly improved and are sufficient to ensure that the board has oversight of the range of safeguarding work in Durham children's services. A culture of openness and challenge is evident in board activity and this is supported by the use of a challenge log to ensure timely monitoring and resolution of challenge. The board is appropriately supported in its oversight of key threshold and core child protection activity through specific reports, performance information and audit activity. The application of thresholds is supported by specific training and dissemination of the 0 to 19 years needs document, which has been recently revised. Current processes to gain feedback from children, young people and families who have received child protection services do not give sufficient information to inform service improvement (Recommendation).

122. The performance scorecard has been subject to ongoing revision and development and provides key data and analysis linked to board priorities. Minutes of the DLSCB meetings evidence discussion and challenge arising from that data. The scorecard does not yet include robust trend analysis or the narrative behind the data. A programme of multi-agency audits linked to board priorities is in place and audit findings are reported to the board in a clear and timely way. While the multi-agency audits provide recommendations for change, further auditing of the identified issues has not yet been undertaken to enable the DLSCB to know whether practice has actually changed or improved as a result. The multi-agency audit processes are evaluated to support ongoing improvement, but learning from single-agency audits is not yet included to support the board's oversight and evaluation of practice (Recommendation).

123. The board receives reports in relation to specific areas of safeguarding work, providing challenge where necessary. A comprehensive and analytical report in relation to restraint at the local secure children's home evidenced effective DLSCB oversight of, and links with, the secure children's home in line with the requirements of 'Working together to safeguard children' (Department for Education, 2015). The recent annual private fostering report identified issues in relation to low numbers and practice adherence to procedural requirements. A board task and finish group was set up to ensure a comprehensive response.

124. DLSCB has led the development, implementation and oversight of the early help and neglect strategy. The early help offer is well resourced, coordinated and embedded, covering the 0 to 19 years age range, and further developments are evidenced by the recently revised and updated strategy, which has a clear action plan. Basic performance reporting has evidenced some impact, but overall performance management and quality assurance of early help work are underdeveloped, partly due to the lack of an effective IT system to date, and do not yet give a sufficiently detailed picture to measure impact or identify gaps. A draft early help scorecard has been developed and is about to be implemented and auditing of early help case work is undertaken within children's services but has not been reported to the board. The embedding of the outcomes framework across all early help practice is taking place, with plans to support this with an IT system later on in 2016 (Recommendation).

125. DLSCB has led the strategic development and oversight of effective responses to children at risk of sexual exploitation and children who go missing. The missing and exploited subgroup of the board (MEG) has driven timely implementation of the child sexual exploitation strategy and the Educate and Raise Awareness of Sexual Exploitation (ERASE) team provides effective direct work and support for young people at risk of child sexual exploitation. The number of children who go missing has decreased and child sexual exploitation training developments, including taxi driver training, have underpinned increased intelligence to identify and support vulnerable young people. The MEG has identified a cohort of vulnerable young people placed by other local authorities in Durham and has instigated a robust process to ensure that appropriate information is shared to support safety planning.

126. Current policies and procedures, including links to practice tools, are utilised and accessed by staff, but there is insufficient capacity in the business unit to ensure consistently timely updates. Some procedures still have track changes evident and the level of usage in the current system cannot be audited. At the DLSCB meeting in February 2016, a decision in principle was made to explore the purchase of online procedures.

127. DLSCB has a learning and improvement framework that describes a range of methods for learning from case reviews and clearly details the process for serious case review (SCR) consideration. Suitable links to quality assurance activity and training and development are evident in the framework. The board has managed a significant number of SCRs and good processes are in place for identifying learning from these and other case reviews. The reviews have been completed in a timely way and where there are delays, the reasons are understood and appropriate. The learning is disseminated primarily through well-attended learning events as well as by email, newsletter and other single-agency briefings. The recent learning events received very positive feedback from multi-agency participants and future events are planned along similar themed lines. Inspectors found frontline staff awareness of key lessons, although not with all staff seen. There is evidence of impact of learning from serious case reviews on some, but not all, current casework practice. Future auditing activity to support impact evaluation is planned (Recommendation).

128. DLSCB evaluation of the SCR processes has identified areas for further improvement, particularly the need to support staff in preparing for and going through SCRs. A thematic action plan underpins the progress monitoring of plans arising from reviews and there are examples of effective escalation to the full board where agency actions have not been completed.

129. Learning from child deaths is clearly identified through thorough processes and thematic reviews with appropriate actions and challenge. In one example, the intervention of the child death overview panel (CDOP) instigated a Care Quality Commission (CQC) external review in relation to consultant cover in tertiary services (the findings of which have not yet been completed). The CDOP has contributed learning to inform and support a number of regional awareness-raising programmes, including smoking (Baby Clear), co-sleeping, alcohol and risks around water and rivers. Factors that have negatively impacted on the timeliness of child death reviews are well understood and changes have underpinned reported improvements in timeliness. The annual report is not sufficiently detailed to accurately reflect the range and impact of work undertaken by CDOP.

130. The child death rapid response arrangements in Durham are a particular strength, with a dedicated 24-hour nursing service providing timely and effective support to parents through the whole child death review process. The service also supports appropriate partner agency responses and, in one example, has instigated procedural change by police to ensure a more measured response where the child death is expected.

131. The training, development and communication (TDC) subgroup ensures good planning, monitoring and oversight of training activity, clearly linked to board priorities, and includes training requirements arising from serious case reviews. The board delivers a well-regarded programme of training and e-learning opportunities. Scrutiny of attendance ensures an ongoing multi-agency commitment to participation in training. Practitioners and managers spoken to across a range of agencies, including education, reported that training was usually of a high standard and positively impacted on their practice. Impact evaluation has been primarily around immediate and subsequent participant feedback and work to obtain managerial overview. Links to the quality and performance subgroup to commission audit work to support impact evaluation of training are not yet in place (Recommendation).

132. The DLSCB annual report for 2014–15 describes the range of board activity, demonstrating that it is sighted on key national and local drivers. The challenge and development evidenced in the report influences positive strategic developments, such as early help and responses to child sexual exploitation. In light of the significant improvements in board functioning in the current year, the annual report for 2015–16 should provide a more rigorous assessment of the performance and effectiveness of local services than was evident in the 2014–15 report (Recommendation).

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 nine of Her Majesty's Inspectors (HMI) from Ofsted and one associate inspector.

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