Sunderland City Council

Re-inspection of services for children in need of help and protection, children looked after and care leavers

Inspection date: 23 April–18 May 2018

Report published: 25 July 2018

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

Executive summary

Children in Sunderland are better served today than they were three years ago. Solid improvements have been made for children in care, children with a plan for adoption and care leavers. However, there has not been sufficient progress made to ensure that the experiences of children who need help and protection have improved. For too many children, risk is not recognised, or appropriately responded to. The scale of some of the weaknesses in practice found during this inspection were not well understood by managers and leaders.

The multi-agency improvement board led by a Department for Education commissioner was established to oversee expected improvements in services for children. An alternative delivery model for children's social care, 'Together for Children' (TfC), was created. Due to the complexities involved in establishing the company, it did not start to deliver services until April 2017. Several changes in director of children's services (DCS) have impeded the pace of change. Governance arrangements between the council and TfC has not provided sufficient challenge and scrutiny. The current interim DCS, employed by the council, works closely with the chief executive of TfC. This arrangement, which has been in place since November 2017, has begun to improve some services.

Actions taken following monitoring visits have not been sufficiently effective in improving social work practice. Senior managers and leaders do not have a good enough understanding of the quality of services being provided in some areas. Performance management systems have improved, but too much emphasis is placed on data compliance and whether performance targets are met. Quality assurance systems are not informing senior managers about the quality of children's and young people's experiences of services. Audits of the cases of children in need of help and protection are overly optimistic. A consequence of this is that managers are not well informed about the quality of services.

The thresholds for accessing children's social care are too high. Risk is not recognised or responded to soon enough. Screening of contacts in the Integrated Contact and Referral Team (ICRT) is ineffective. Statutory guidance is not followed, resulting in delays in protective action being taken. Children who go missing and those at risk of child sexual exploitation do not receive a coordinated response to protect them. Children aged 16 and 17 who present as homeless are not informed of their right to be accommodated. Private fostering arrangements are not appropriately understood or assessed.

Safeguarding and promoting the well-being of children with a disability remains poor, as many children have not had their needs re-assessed. Overall, most children's assessments are weak. Key information is often missing, thus limiting the assessment of risk and need. Managers and independent reviewing officers (IROs) are not always challenging the quality of assessments or children's plans.

Sunderland has made progress in creating and rebuilding the foundations needed to deliver improved services from a low base. This includes: developing services that did not previously exist; improved workforce stability and effectively reduced workloads;

strengthened partnership working; and enhancing the voice and influence of children. These are beginning to improve experiences and outcomes for some children. As a result, this inspection found improvements in services for children looked after. Most children enter care when it is in their interests. Children benefit from living with their families when appropriate.

Significant progress has been made in adoption services. This is now good. Adoption as a permanence option is considered early for children for whom care proceedings are being initiated. Children move into adoptive placements more quickly than previously. Children are effectively matched and placed with adoptive parents, who receive good training and support. Children in care and care leavers receive good support to improve their physical health, but delays in access to specialist mental health provision is impeding some children's emotional well-being.

Not all children benefit from achieving permanence at the earliest opportunity. A combination of factors in pre-proceedings work is resulting in some delay when progressing court applications. The quality of care applications is not yet consistently good. A strong emphasis is placed on children living with extended family and friends if it is safe to do. There are currently insufficient placements to meet the complex needs of Sunderland's children in care, and a lack of proactive matching is impacting on the number of moves that children experience in the first 12 months of coming into care. Managers and IROs are not scrutinising effectively the quality of plans or challenging when actions from reviews are not completed. Children in foster care are not routinely helped to understand their life history, nor do they receive help to understand their future.

The support and planning for children's education has improved, including better attendance. The rate of their progress, however, remains an important challenge.

The experiences of care leavers has improved from a low base. Staff pay close attention to young people's personal life experiences. There is a strong focus on their needs and living arrangements. However, too many care leavers aged 18 to 21 are not in education, employment or training. Clear transition pathways are lacking for those care leavers who do not have an education health and care plan (EHCP).

Contents

The local authority

Information about this local authority area[1]

Previous Ofsted inspections

- The local authority operates four children's homes (through Together for Children – Sunderland)
- The last inspection report for the local authority's children's services was published in July 2015. The judgements for the local authority were:
  - Overall effectiveness: Inadequate
  - Children who need help and protection: Inadequate
  - Children looked after and achieving permanence: Inadequate
    - Adoption performance: Inadequate
    - Experiences and progress of care leavers: Inadequate
  - Leadership, management and governance: Inadequate

Local leadership

- The interim DCS has been in post since November 2017.
- The interim DCS is also responsible for adult services.
- The interim chief executive of TfC has been in post since November 2017.
- A director of children's services and chief executive has been appointed under a 'single' post and will commence in post in July 2018.
- The chief executive has been in post since April 2016.
- The chair of the Sunderland Safeguarding Children Board (SSCB) has been in post since May 2017.

[1] 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.

In consultation with the Department for Education (DfE) and while under direction, the council took the decision to set up a company limited by guarantee, TfC, to deliver children's services on an arms-length basis. The company, established in April 2017, is owned by the council but has day-to-day operational independence under the management of the TfC Board (with the chair appointed by the DfE). The company delivers all services for children in need, children in need of protection, children in care and care leavers, education, including the virtual school and early help under a service delivery contract with the council. The company arrangements were established by a formal direction with the Secretary of State. The council acts as the local commissioner with responsibility for contract management. The statutory functions of the DCS and the lead member are retained within the council.

Children living in this area

- Approximately 54,260 children and young people under the age of 18 years live in Sunderland. This is 20% of the total population in the area.
- Approximately 26% of the local authority's children aged under 16 years are living in low income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 20% (the national average is 14%)
  - in secondary schools is 21% (the national average is 13%).
- Children and young people from minority ethnic groups account for 6% of all children living in the area, compared with 21% in the country.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 6% (the national average is 21%)
  - in secondary schools is 5% (the national average is 16%).

Child protection in this area

- At 23 April 2018, 2,929 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,704 at 31 March 2017.
- At 23 April 2018, 532 children and young people were the subject of a child protection plan (a rate of 98 per 10,000 children). This is an increase from 423 (78 per 10,000 children) at 31 March 2017.
- At 23 April 2018, three children lived in a privately arranged fostering placement. This is an increase from zero at 31 March 2017.

- In the two years before inspection, four serious incident notifications had been submitted to Ofsted and four serious case reviews have been completed.
- There was one serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 23 April 2018, 592 children are being looked after by the local authority (a rate of 109 per 10,000 children). This is an increase from 540 (100 per 10,000 children) at 31 March 2017.
- Of this number, 188 (or 32%) live outside the local authority area.
- 32 live in residential children's homes, of whom 22% live outside the authority area.
- None live in residential special schools.
- 456 live with foster families, of whom 27% live outside the authority area.
- 20 live with parents, of whom none live outside the authority area.
- Four children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 49 adoptions
  - 56 children became subject of special guardianship orders
  - 299 children ceased to be looked after, of whom 3% subsequently returned to be looked after
  - 58 children and young people ceased to be looked after and moved on to independent living.

Recommendations

1. Urgently review ICRT and take action to ensure that risks to children are identified, that thresholds are applied appropriately to support effective decision-making, and that actions taken are timely and compliant with statutory guidance.

2. Ensure that children at risk of child sexual exploitation and those that go missing have an up-to-date assessment of risks that informs a comprehensive response to keep them safe.

3. Ensure that governance and scrutiny arrangements are rigorous and challenging and that there is an accurate understanding of the quality of practice, to enable the council to hold TfC to account and to ensure that progress is made, that children are protected, and that their experiences improve.

4. Improve the training and development offer for social workers and managers to ensure that all staff have the right skills and knowledge for their role.

5. Ensure that managers provide reflective and directive supervision for all workers, with additional challenge from IROs and conference chairs, in order to improve the quality of practice and planning for all children.

6. Improve the timeliness of services to children and families, including the early help response, and the access to services to support victims and perpetrators of domestic abuse.

7. Ensure that children's records are kept up to date and contain clear child-focused information so that children's histories and progress can be clearly evaluated to inform decisions.

8. Ensure that all assessments are appropriately updated, that they evaluate individual risk, need and the experience of children, and that the resultant plans are outcome-focused, are meaningful to children and families, and are regularly reviewed.

9. Ensure that applications to court are timely and of good quality, and that no children are left in situations of ongoing risk due to delay.

10. Ensure that children who present as homeless fully understand their rights to become looked after under Section 20 of the Children Act 1989, and the benefits this brings.

11. Ensure that practice for children who are subject to private fostering arrangements meets statutory requirements.

12. When children come into care or need an alternative home, ensure that they are provided with a placement that meet their needs and offers stability through more proactive matching.

13. Ensure the timely completion of life-story work for all children looked after so that they can understand their life history.

14. Improve timely access to appropriate mental health services for children looked after and care leavers and develop a clear transition pathway for those care leavers who do not have an EHCP.

15. Improve access to vocational, training and employment opportunities for care leavers and particularly for those who have been not in education, employment or training (NEET) for long periods.

Summary for children and young people

- When Ofsted last inspected Sunderland Children's Services, inspectors said that children and young people were not getting the help they needed quickly enough. Some improvements have been made, but these have been too slow. Senior managers have not yet done enough to put things right.
- When social workers first hear about children who need help and protection, they do not always find out everything they need to know to make children safe. This means that children do not always get the right help at the right time.
- The managers need to make sure that people who work with children understand children's lives and their families better, so they can provide help and support when it is needed.
- Managers also need to check that children have a say in what is happening to them and are helped to understand their plan.
- When children come into care, they go to live in safe homes even if these are not always in Sunderland. Social workers try hard to find the right home as soon as possible.
- Children in care get lots of help to improve their health and help them do well at school, but not all children get the right help when they have worries and need extra support.
- If possible and safe, some children go back to live with their parents or other family members. Social workers stay in touch and make sure that children get extra support if they need it.
- When children cannot return home to their parents, sometimes they need to be adopted by another family. This happens quickly, and children get a lot of help to get to know the family and settle into their new home.
- When some young people leave care, they get much better support to live in a safe home and find a job than they used to do, but this is not the case for all care leavers. The council needs to make sure that all care leavers get the same level of support when they need it.

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

Summary

Services for children who need help and protection are inadequate. Early help provision is relatively new and is not coordinated well enough to achieve positive impact where it is needed. Some children and families experience delay in accessing services. Early help planning is not of good enough quality to make a difference to children and their families. Thresholds to access children's social care are too high, which means some children are not receiving help and protection when they need it. Screening of contacts in ICRT is ineffective and leaves some children and young people in situations of continued risk. Repeat contacts and some referrals do not always result in children receiving a service at the correct level of need.

When risk is identified, timely action is not always taken. Information sharing between professionals in ICRT does not consistently lead to appropriate decision-making. Informal information sharing and visits to families prior to strategy meetings taking place is not in line with statutory guidance. This delays both strategy meetings and coordinated safeguarding action. Interim safety planning while child protection enquiries are ongoing is limited. For some families who experience domestic abuse, services are delayed.

From a very low starting point, TfC has made progress in some areas. Children receive a swift and appropriate response to concerns outside of normal office hours through a newly created emergency duty team. Significantly more children and families now access early help provision with improved partnership commitment. A more stable workforce and lower caseloads are leading to better social work practice in some child protection work, but this is often to the detriment of children in need who are not afforded the same priority.

The quality of most children's assessments is weak. Many assessments are too focused on the adults in the household, and this limits the understanding of the specific needs and experiences of individual children. Chronologies are not used effectively to understand family history. Key information is missing, which limits the analysis of risk and need. Managers are not consistently scrutinising or challenging the quality of social work practice. However, when children's cases move to locality teams following assessment, inspectors identified some improved practice, particularly where children are subject to child protection plans.

Children who go missing from home and care and those at risk of child sexual exploitation do not receive a coordinated response to keep them safe. Children aged 16 and 17 who present as homeless are not informed of their right to be accommodated by the local authority. Private fostering regulations are not understood. Many disabled children have not had their needs reassessed.

Inspection findings

16. Children in need of help and protection are not adequately protected. They do not receive services that meet their needs at the right time.

17. While an increasing number of families access early help, early help responses are delayed for some families. Early help planning is not of good enough quality. Too much emphasis is placed on the adult rather than the child's needs and experience. Reviews are inconsistent. Senior leaders recognise that the quality of practice still needs further improvement. This was an area identified through an Ofsted monitoring visit. (Recommendation)

18. Some children and their families experience delay in accessing services to support victims of domestic abuse. The strategic response across the partnerships has improved since the new early help strategy was launched in April 2017. Schools and the police are more engaged. However, there continues to be a disconnect between strategic planning and the accessibility of services. Given the high number of children exposed to domestic abuse, the level of demand for services is greater than the resources available. This means that some children and their families experience delay in getting help when they need it most. (Recommendation)

19. Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC) identify risks to children effectively. Information is not consistently used by social workers to inform safety planning for children. At a previous monitoring visit, inspectors raised the issue of inappropriately using written agreements as part of the plan to keep children safe because of the over-reliance on the adult victim as the primary protector in keeping children safe. Senior managers responded by training staff in safety planning. However, the plans seen by inspectors were still written agreements renamed as 'safety plans'. This demonstrates a lack of effective impact and understanding about what is needed to improve services that will safeguard children.

20. A recent restructure of the ICRT has co-located police, health and education professionals with a dedicated social work assessment team. Despite these changes, too many children who need help and protection are not identified soon enough.

21. Screening of contacts in ICRT is ineffective. This leaves some children and young people in situations of continued risk and need. The published threshold document does not assist professionals to understand and apply the criteria to access help and support for children. Inspectors raised the number of repeat referrals on two separate occasions during monitoring visits with senior managers. During this inspection, inspectors found over 1300 children in the last six months who had repeated contacts. Some of these contacts were from professionals reporting child protection concerns. TfC has now

commissioned an independent review of these children's circumstances, but this again demonstrates that senior managers have not taken effective remedial action to address deficits in practice. (Recommendation)

22. There is an inconsistent approach to identifying risk in ICRT. While there has been some improvement in multi-agency information sharing, this is not always leading to good analysis of the material collected. There is weakness in the ability of professionals to consistently synthesise and analyse the information and to understand what it means for the child. This is further hindered by poor recording practices.

23. Inspectors identified a small but significant number of children who were not identified by social workers as needing protection, which means that some children were left at risk of significant harm. In some instances, police and social workers visit children and their families to seek further information before holding a strategy meeting. This does not inform the planning of child protection enquiries, limits the full analysis of risk and does not follow statutory guidance. Little evidence exists of interim safety planning while safeguarding enquiries are taking place. Families are often not aware that this process could simultaneously lead to a child protection conference. The practice of visiting children and families prior to a strategy meeting has continued despite being raised by inspectors in a monitoring visit. (Recommendation)

24. Children in need assessments are undertaken by a dedicated assessment team. Most assessments are too long, and lack analysis, a clear sense of purpose or the use of evidence-based approaches. Children's individual identities are not explored or understood, particularly when the children and parents are not of White British heritage. Although the use of chronologies is now standardised, most do not identify key past events in children's lives. Patterns of risk are not well considered. This leads to children's needs and the impact of their experiences being overlooked. (Recommendation)

25. Children's cases remain with the assessment team until a child protection or a child in need plan is required. At this point, they transfer to a locality social worker. A stable workforce and manageable caseloads in this part of the service are enabling some practice improvement. Social workers have more time to spend with children and young people and get to know children well. However, children's views, wishes and feelings are not always reflected in case recording. Weaknesses in recording permeates practice across the whole of the service. (Recommendation)

26. Thresholds are appropriately applied when children need to become subject to a child protection plan. The timeliness of conferences and reviews has improved since the last inspection. Core group meetings are well attended by relevant professionals. Parents are mostly engaged in the process. However, the recording of these meetings is variable in quality and, in some cases, does not reflect the discussion or actions needed to safeguard children. Conference

chairs are beginning to evidence improved scrutiny and challenge, although this is not improving the quality of children's plans. (Recommendation)

27. When children's circumstances do not improve within agreed timescales, legal planning meetings are quickly convened. This is also an improvement since the last inspection. A small number of children continue to experience delays in care proceedings being issued where this is needed. Assessments are not always timely and there are delays in the legal team progressing court applications. (Recommendation)

28. Safeguarding and promoting the well-being of disabled children remains an area for improvement. Social workers know their children well. Records are clear and detail the views of children. However, many children have not had their needs reassessed, some for several years. The heightened vulnerability of these children has not been recognised. Managers and staff cannot assure themselves that children are safe or that parents are supported to meet children's additional needs. A new team manager recently identified the scale of this problem. Senior managers acted to review all children's needs in this service. However, at the time of this inspection, the needs of 40 children still had not been re-assessed. (Recommendation)

29. Children who go missing from home or care and those who are at risk from child sexual exploitation are not adequately safeguarded. They do not receive a well-coordinated multi-agency response in order to reduce risk and keep them safe. Risk assessments are not thorough, and they are not updated when children's circumstances change. Safety plans are not routine. The TfC identified its most 'at risk' children to inspectors. Despite these children being considered the most vulnerable, inspectors identified weaknesses in practice in all children's cases sampled. Deficits in safeguarding children at risk of sexual exploitation were identified and raised through an Ofsted monitoring visit.

30. Return home interviews are timely. Information is fed into a strategic meeting to inform a wider understanding of trends and push and pull factors. The strategic response is much improved. Monthly meetings for children who are missing, children who are sexually exploited and children who are trafficked provide a multi-agency forum for sharing information. This informs disruption and prevention activities. However, these actions are not improving the operational response to keep children safe. (Recommendation)

31. Identification, monitoring and tracking of children missing education have become more rigorous. Clear policy and procedures ensure that reporting by schools is timely and relevant. Concerns regarding individuals are escalated appropriately. Strategic communication and liaison regarding elective home education are effective.

32. Private fostering procedures are not well understood. Children living in these arrangements have not had their needs fully assessed. Children are not seen alone by social workers to ensure that they are safe. (Recommendation)

33. Better practice is seen in cases where there are other contextual safeguarding concerns, for example risks of female genital mutilation, risk of radicalisation and risk of gang association. The number of children identified as being at risk are low. However, multi-agency understanding and partnership working are effective. Responses to children at risk are well managed. Similarly, where there are concerns about professionals who work, or come into contact, with children, the response is strong.

34. Since the last inspection, a newly designed service has been created with a team of full-time out-of-hours staff. Responses to contacts received outside of normal office hours are timely and effective. Access to children's recording systems enables history checks to be completed and effectively informs decision-making. This is utilised to provide a clear handover of information to day-time services. Outcomes of such interventions are clearly recorded. This means that the service can effectively respond to safeguarding concerns and keep children safe.

35. Children aged 16 and 17 who present as homeless are not routinely informed of their right to be accommodated or helped to understand how they could benefit from this. For those children who are informed, their decision is not always formally recorded. Where children are assessed as homeless, they can access appropriate emergency accommodation. For those who cannot return home, pathways to secure more permanent accommodation are clear and well used. However, none of these young people receive support as a child looked after, irrespective of their family circumstances. (Recommendation)

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

Summary

Not all children benefit from achieving permanence at the earliest opportunity. There is an improved understanding and use of the Public Law Outline (PLO). However, a small number of children continue to experience delays in achieving legal permanence. Delays in pre-proceedings work is impacting on the progression of court applications. The quality of care applications is not consistently good.

Lower caseloads and improved workforce stability is enabling children and young people to develop more meaningful relationships with their social workers. A stronger emphasis is placed on children living with extended family and friends if it is safe to do. Special Guardianship Orders (SGOs) are promoted, and well supported with connected carers and foster carers. Children return to birth parents' care where it is appropriate and safe.

There are insufficient placements to meet the complex needs of children. Limited placement choice and lack of proactive matching is impacting on the number of moves that children experience in the first 12 months of coming into care. Brothers and sisters are often placed together without a full understanding and assessment of their individual needs. Children with a plan for adoption now receive a good service. Children are identified quickly and live with families who are supported to effectively meet their needs

Managers and IROs are not effectively scrutinising the quality of plans or challenging when actions from reviews are not completed. Children living in foster care are not routinely helped to understand their life history or receive help to understand their future plans. The children in care council, Change Council, is well established, and is beginning to raise the profile of children in care and influence some service development.

Children in care and care leavers receive good support to improve their physical health. Not enough priority is given to their emotional well-being. There are delays in accessing specialist mental health provision. Most young people leaving care are well supported. However, too many care leavers aged 18 to 21 are not in education, employment or training. There is a lack of clear transition pathways for those care leavers who do not have an EHCP.

Support and planning for children's education have improved. Resources are targeted to raise the educational attainment of children in care. The rate of progress is not rapid enough to close the gap between peers. Low attainment of children looked after continues to be a cause for concern. Attendance has improved.

Inspection findings

36. Most children now enter care when it is in their best interests. Consequently, the number of children in care has appropriately increased. There is improved compliance with the PLO. Decisions to progress to PLO are now determined through a panel. Senior managers monitor progress through a tracker. The panel ensures that drift in decision-making is minimised. While improvement can be seen, inspectors did find some drift and delay at the pre-proceedings stage. A lack of assertive action at the pre-proceedings stage and delays in applications being filed at court have left a very small number of children at home for too long in situations of chronic neglect. (Recommendation)

37. TfC are beginning to take a more proactive approach in securing legal permanence for children. All children subject to section 20 accommodation have been reviewed and, where appropriate, are subject to legal orders. This is a significant improvement since the last inspection. While the PLO panel monitors care applications, the quality of court work is not consistently good. At 34 weeks, the timeliness of court proceedings in Sunderland is in line with other local authorities within the region. Delays in complying with PLO timescales when proceedings are issued is in part due to family court listing delays. TfC recognises that the quality of care applications need to improve. Senior managers are now working effectively with the Children and Family Court Advisory and Support Service (Cafcass) and the court to improve practice and enhance working relationships.

38. Not all children are achieving permanence at the earliest opportunity, although this is improving. IROs monitor children and young people's progress against plans through midway reviews. The process for resolving professionals' disputes about children's cases is now established. However, IROs are not effectively challenging the quality of children's plans or whether actions are completed following reviews. Ofsted have raised this at two monitoring visits. There is little evidence of improvement. Children's plans are not always linked to updated assessments or the specific needs of the child. The goals are often too general to target interventions and ensure good outcomes in the child's timeframe. Brothers and sisters are often placed together without a full understanding and assessment of their individual needs. The Mind of My Own (MOMO) app captures children's views and wishes as part of the review process. However, children's views are not always influencing care planning. (Recommendation)

39. Children transfer to looked after permanence teams when the permanence decision is agreed. Improved workforce stability in these teams enables social workers to build meaningful relationships with children and young people. Social workers see children regularly and get to know them well. Some good examples of direct work were seen by inspectors. Social workers can describe the work that they are undertaking with children. However, this is not always

well reflected in case recording, nor does it capture children's wishes, views and experiences. Not all children in care are assisted to understand their family histories through life-story work. (Recommendation)

40. Children return to the care of their parents when it is safe to do so. Risk is assessed before decisions are made and approved by senior managers. Appropriate support and monitoring is provided. Children live with their family wherever possible. Extended family members are identified at an early opportunity. Connected carers' assessments are thorough. Connected carers receive the same level of support as foster carers. This ensures that children are living with adults who are known to them. This enables children to maintain contact and a sense of identity with their birth family. Permanence with connected carers and current foster carers is actively pursued with a high number of children exiting care on SGOs.

41. Ensuring that there are sufficient numbers of local carers available to meet the full range of children and young people's needs continues to be a challenge. Senior managers are taking appropriate action. This includes commissioning an intensive family support team and refreshing the sufficiency and fostering recruitment strategy. The intention is to increase the availability of residential and fostering placements for children with more complex needs. These developments are too recent to evaluate their effectiveness or to have made any significant impact on placement sufficiency.

42. Limited placement choice and a lack of early proactive matching is impacting on the number of moves that children experience in the first 12 months of coming into care. The complexity of the needs of some children and young people's is having an impact on short-term placement stability. The ability to match children and young people to appropriate carers is impacted on by the quality of assessments. Assessments do not sufficiently identify children's needs to inform matching at the earliest opportunity. Most often children and young people are matched when they have been in placement for some time rather than the type of home needed being sought early in the process. Matching is ratified by the permanence-monitoring group usually some time after children are initially placed. This means that decisions are focused on stability rather than children's initial needs and good matching decisions. (Recommendation)

43. To improve placement stability, there has been a strong focus on the support offered to foster carers. Recruitment activity has improved. Assessments are thorough and foster carers' support and training needs are carefully considered. Foster carers spoke positively about the recruitment process and the training they receive to support children in their care. The majority of children in long-term foster placements are secure and their placements are confirmed as permanent.

44. Children access an effective advocacy service that meets their needs. Children are supported to complain and express their views. The timeliness of the

response has improved, and the learning is beginning to inform practice and service developments. Themes from complaints are collated in performance meetings and have recently informed social worker training.

45. Children in care have their physical health needs well met. Assessments and reviews are timely and inform care planning. Wherever possible, the children looked after health team will respond to health issues directly rather than refer children and young people to specialists. This reduces delay and the number of professionals that a child must see. As a result, children and young people's health outcomes are improving.

46. Children's emotional and mental health needs are not well met. Not all children in care receive a timely strength and difficulties questionnaire. When these are undertaken, they do not always identify and result in timely additional support. Children and young people experience delay in accessing specialist services when they are needed. Senior managers have responded by commissioning clinical psychologist consultation for residential staff and foster carers. This is making a difference to the care provided. Foster carers receive training on how to identify and better support children's emotional needs. Recent and improved partnerships with schools to develop mental health and well-being groups are beginning to improve the awareness of the needs of children in care. (Recommendation)

47. There has been significant improvement in the management, support and training offered by the virtual school for children looked after during the last 12 months. This means that children are receiving better support and more targeted interventions to address their learning needs. Attendance has improved. The virtual school addresses any concerns about attendance or punctuality swiftly, regardless of where the child is placed. Visits to out-of-area placements are prioritised. This ensures that those children furthest away are receiving equitable levels of support to those living in the city.

48. Support and planning for children's education has improved. Resources are targeted to raise the educational attainment of children in care. The quality of personal education plans (PEPs) has improved significantly. The clear majority are now completed within appropriate timescales, but the quality remains inconsistent. Not all PEPs have sufficiently targeted actions to improve specific learning needs and facilitate progress. The virtual school headteacher now tightly monitors pupil premium funding and holds the school to account for the spend. This ensures that children receive the additional learning resources that they are entitled to.

49. Senior managers know the rate of progress for children looked after is not rapid enough to close the gap between peers. Low attainment of children looked after continues to be a major cause for concern. Better progress made in early years and at key stage 1 and 2 is not sustained when children move on to secondary education.

50. The children in care council, Change Council, is well established, and works to improve services for children in care. For example, they have developed leaflets for care leavers to ensure that they understand their rights and entitlements. They have influenced the increase in the care leavers' grant. Through their influence, senior leaders have ensured that care leavers are now exempt from paying council tax and children in care have worked with health professionals to improve the experience of children at their medicals. Children and young people attend the corporate parenting board and their agenda items are prioritised. This ensures that the voices of children and young people are heard. The Change Council has noted improvements in the support to children looked after over the last year. They consider that there is better communication with senior managers and social workers. More permanent staff means that relationships have been able to develop. Children and young people report that children in care and care leavers are now more aware and are informed of their rights and entitlements.

The graded judgement for adoption performance is that it is good

51. Since the last inspection, there has been substantial progress in services for children whose plan for permanence is through adoption. Children now receive a more responsive and focused service. In 2017/18, 12 early permanence placements were made through foster-to-adopt arrangements. This was a significant improvement from 2015/16, when there was just one. Concurrent and parallel planning are also carefully considered in order to promote early permanence. The recent allocation of adoption social work 'champions' to locality social work teams enhances communication and promotes early identification of children whose permanence plan could be through adoption. Recent adoption performance data indicates better performance overall. Timeliness for children becoming looked after to being placed for adoption has continued to improve. Children are moving into adoptive placements more quickly than previously.

52. Children and adopters receive a good service because of the effective leadership of the adoption agency and a very committed and stable team. A comprehensive and child-centred service plan underpins service developments. Quality assurance processes are effective and continue to be strengthened through analysis of data and outcomes. Management oversight of the adoption service is complemented by the work of the adoption panels. Knowledgeable and experienced panel members are determined not to lose sight of the child's needs, however complex these may be.

53. Prospective adopters develop skills to appropriately support children. They now receive a responsive and sensitive service. Introductory meetings and preparation training is timely. Prospective adopters are well supported by their social workers. Training is comprehensive so that adopters have a good range of skills to support their children effectively. As part of the training,

adopters meet with a foster carer, approved adopter and an adopted child. Prospective adopters particularly welcome this element of their preparation training. They told inspectors that this gives them good insight into the processes and challenges of being an adoptive parent. Training also includes theraplay, attachment training, foster-to-adopt and life-story work.

54. Child-centred, tenacious work in family finding and matching ensures that children live with families who can offer good appropriate support. A family-finding tracker monitors children's progress well from a very early stage, prior to placement orders being granted. 'Opening minds' events are held regularly to promote adoption of children who are harder to place. This includes children with disabilities, older children and brothers and sisters. Weekly adoption team meetings to discuss family finding ensure that this area of work has a high priority. Where necessary, information about children is shared with independent family finding agencies. Referrals are appropriately made to the Adoption Register England.

55. Overall, the quality of matching reports, prospective adopters' reports (PARs) and support plans is good. The quality of child permanence reports (CPRs) is improving and action has been taken to address shortfalls. PARs and CPRs are timely and detailed, and they provide the key information to make sure that children are well placed and that disruptions are minimised. The number of disruptions of adoptive placements is low. When disruptions happen, they are handled sensitively. Independent social work reviews are used to good effect. When appropriate, they highlight any learning to improve the agency's effectiveness.

56. The adoption panel chair is highly experienced and is well supported by knowledgeable and well-trained panel members. The adoption panels provide an additional layer of scrutiny when considering not only approval of potential adoptive parents but also the 'matching' between children and approved adopters. The panels make sure that robust adoption support plans are in place before recommending adoptive placements. Where sometimes there are areas of work that could be better, panels report these back to the social worker and their manager. Work is being undertaken to collate learning from these reports to further improve social work practice.

57. Adopters spoke very positively of their experiences of training, assessment, matching and support from TfC. Adopters report that the process of assessment through to matching is appropriately challenging. They told inspectors that the adoption social workers are sensitive and go 'above and beyond' to offer guidance and help. Adopters particularly welcomed the adoption support. This, coupled with comprehensive training, equips them well to parent their adopted children. Adopters also welcomed the informal support they receive from 'buddies', who are allocated to them by the panel when adopters' approval is confirmed.

58. Children receive very good support to meet their assessed needs. Adoption support is wide ranging and a key strength of the service. Innovative work is undertaken. This includes using arts and crafts in developing problem-solving skills, and the use of therapeutic life-story work. In addition, social workers within the team provide theraplay for children. Social workers have trained prospective adopters and adopters in theraplay techniques to support them in caring for children. Adopters access counselling services and benefit from access to a consultant clinical psychologist. The adoption service is especially good at assessing and making applications to the adoption support fund (ASF). There have been 61 successful applications to the ASF during 2017/18.

59. Birth families receive assessments and support from a commissioned service. The service also undertakes innovative life-story work with birth families, for example creating DVDs for adopted children of birth parents talking about the child's early life and grandparents reading stories to the adopted child. However, feedback from birth families using this service is limited and not routinely collated to identify themes to inform service improvements.

60. Children are helped to understand their lives through life-story work. The importance of this is recognised as a priority within the adoption team. The quality of life-story work has improved. Formats are now more accessible to children, and this includes information being available in digital formats. Therapeutic life-story work is also available as part of the adoption support offer. Children are helped to understand their early life through sensitively written later-life letters. Later-life letters and life-story work are given high priority and provided to adopters at the earliest opportunity and prior to the submission of reports for the final adoption application.

The graded judgement about the experience and progress of care leavers is that it requires improvement to be good

61. Since the last inspection, experiences for care leavers have improved. Staff pay close attention to young people's personal life experiences. There is a strong focus on their needs and living arrangements. This means that they are better supported and, for the large majority, are safe. The quality of contact between social workers, personal advisers and young people has been enhanced through the relocation of the next steps team into the city centre. Moving towards independence is now a prime focus of the work. In most cases, this is appropriately paced for each young person's individual circumstances.

62. Management oversight and scrutiny is now more effective and is helping to improve outcomes. Progress has accelerated in the last 18 months. Managers understand that more work is still required to embed good practice. Staff are using data more efficiently to monitor and track young people's accommodation, education and training placements. Personal advisers and social workers know their young people well. The relocation of a dedicated

next steps team in the city centre means that they are accessible. This is enabling improved support to young people when they need it. This is a significant improvement from the last inspection. At that time, young people were unable to enter the building to visit their workers. Young people said that they now feel welcomed and 'part of a big family'. The percentage of care leavers who stay in touch with the service has increased significantly from 30% in 2015 to 78% at this inspection. The local authority is aware that there is more to do to engage with all care leavers.

63. Pathway plans are still too inconsistent, although this has improved since the last inspection. Most pathway plans are now completed within appropriate timescales. In the best examples, the process was being used effectively to hold detailed conversations with young people. Consequently, their needs are better understood, and the right support is identified. Better attention is given to key issues about living independently, for example on managing their finances, claiming benefits and help accessing specialist services. Young people told inspectors how this process had helped them to organise themselves and to think about their lives and plans for the future. In one example, a young man facing multiple challenges told inspectors how his personal adviser had helped him stay calm and plan positively, as well as think about potential problems that might arise.

64. Where risk assessments are undertaken with agency partners, these are much improved. Risk is accurately assessed, and action plans are realistic, with set objectives. For example, where young people are at risk of sexual exploitation, risk assessments are timely and robust. Key actions are identified to keep young people safe. This includes, if appropriate, securing alternative accommodation, therapeutic input and intensive support. Weaker plans are overly descriptive and too long. Many were incomplete. Contingency planning is not always considered and, when it is, it is too generic. Managers recognise that more work is required to bring all plans up to a consistently good standard. Risk is now more accurately assessed. Action plans are specific and set to realistic timescales. Some young people's plans are overly long and too descriptive. Key events are lost in the detail, and some information was incomplete. Action plans lacked information about who was to do what, by when and how. Managers were aware that more work is required to bring all plans up to a consistently good standard. (Recommendation)

65. Young people know about and have ready access to services to support their physical health needs. Young people said they were confident to use these independently, and when necessary, with the support of their personal adviser. For those living out of area, services are usually identified through pathway planning. However, pathway plans do not always reflect this detail. Most young people have their birth certificates and are registered with a local doctor. Health passports are issued for 18-year-olds by the designated nurse for children looked after. New arrangements have been made to send copies of these for all new care leavers to the next steps team. This enables personal advisers to check and discuss the details with their young people.

66. Young people wait too long to have their mental health needs met. The current waiting list to receive specialist mental health services is approximately 12 weeks. Personal advisers have successfully fast-tracked individual cases to services when crises emerge. This approach is ad hoc and not sustainable to ensure that young people receive ongoing targeted support. A weekly counselling service is now operating from next steps. This bridges the gap. The small number of young people making regular use of it indicates that it is a helpful intervention for them.

67. Transition arrangements to adult services for care leavers who have an EHCP are effective. These young people receive bespoke packages of care and they are making progress relative to their assessed needs. For the increasing numbers who also have complex emotional health needs and may already have been identified with special educational needs in their schooling do not have an EHCP. Concern was expressed by staff that these young people may not always receive timely access to appropriate services. (Recommendation)

68. Too many care leavers (aged 18 to 21 years) are NEET. Of 173 care leavers, 72 (42%) are NEET and 30 of these young people are currently unable to access training or employment because of medical reasons or parenthood. There are too few apprenticeships identified for these young people. Only six are currently available in the city. Four are provided by a voluntary-aided school and two are long-standing within city council departments. The recently formed engage in education, employment and training team within next steps is making some headway in identifying alternative career pathways. In addition, improved relationships with the local further education college is beginning to open some opportunities for those leaving care and the older NEET group who are more difficult to place. It is positive that 17 care leavers are currently in higher education and this figure has increased year-on-year. However, there has been insufficient strategic drive and focus by the council since the last inspection to help improve opportunities in training and employment. (Recommendation)

69. The picture is more encouraging for those 16- and 17-year-olds preparing to leave care. Good collaboration between social workers, personal advisers and the virtual school post-16 coordinator is improving outcomes for these young people. Of 78 in this cohort, 69 (82%) are in education, training or employment. The remaining 18% are receiving intensive support to find appropriate placements. This is better than the national average.

70. The majority of young people leaving care live in suitable accommodation. At 82%, this demonstrates sound improvement since the last inspection, when it was only 44%. The quality of accommodation has also improved. Regular audits and inspections ensure good standards are maintained of commissioned placements. TfC and partners providers work well together through weekly allocations and pathways panel and the external placement panel. This ensures that young people's housing needs are met. The panel

reviews all referrals and potential moves. It considers the type of housing, location and support needed to ensure the best fit for young people. Young people can now stay with their carers after the age of 18. 'Staying put' arrangements have increased. Currently, 25 young people have chosen to stay with their existing foster carers.

71. Flexible support packages are routinely available to help young people move towards independent living. All supported accommodation offers appropriate preparation for independence. Programmes include managing a home, personal well-being, budgeting and learning to cook. In addition, three providers also arrange bespoke basic skills and employability training. Young people were very complimentary about the supported lodgings provision. One young woman commented that she felt 'broken' by her previous experiences as a child looked after, but said she was now 'fixed' and studying at university. This was because of the 'amazing care' and support she had received from her carers and PA.

72. Young people told inspectors that they are now much better informed about their rights and entitlement to services. The advocacy service has been used by a small and increasing number of care leavers. Young people said that they knew how to complain if they had grievances about their support and access to services. All young people receive an information pack containing a range of information. This has been devised with input from the Change Council. Information on benefits and financial support, careers and job vacancies, options for housing and staying put information, as well as details about citywide services and emergency contacts, were readily available for young people at the next steps building. The improved financial offer, particularly for those who choose to remain in education and training, has good take-up. Christmas and birthday allowances are now provided for all care leavers. Each year, their achievements and experiences are celebrated at an annual awards event.

Leadership, management and governance	Inadequate

Summary

Leadership, management and governance are inadequate. Senior managers have not ensured the safety of the most vulnerable children. The governance arrangements between the council and TfC are not ensuring effective challenge and scrutiny to improve children's experiences. Since the last inspection, the new governance arrangements and service delivery model have not achieved sufficient change of the scale needed to ensure that risks to children are consistently identified and appropriately responded to. Discontinuity arising from several changes in DCS has slowed the pace of change, particularly for children in need of help and protection. The current interim DCS is employed by the council and works closely with the chief executive of TfC. This arrangement has recently increased the pace of change.

Senior managers and leaders do not have a good enough understanding of some of the weaknesses in practice or the quality of the services being provided. The scale of weaknesses in practice found during this inspection was not well understood by senior managers and leaders. The areas for improvement and the recurring themes relating to poor practice, fed back through Ofsted's monitoring visits, have not resulted in the council taking action to sufficiently improve practice.

While performance management systems have improved, too much emphasis is placed on data compliance, and whether performance targets have been met. Audits of practice seen during this inspection are overly optimistic. Quality assurance by managers is not sufficiently improving social work practice to deliver positive outcomes for children. Management 'grip' on some front-line practice, particularly for children who go missing and those at risk of child sexual exploitation is insufficient. Not all managers and IROs adequately challenge the quality of social work practice when it is poor. When concerns about children escalate, managers do not always recognise or respond appropriately.

Sunderland has made some progress in creating and rebuilding the foundations needed to deliver improved services from a low base. This includes developing services that did not previously exist, improved workforce stability and effectively reduced workloads. This is now strengthening relationships between social workers, children and their families, enhanced partnership working, and has amplified the voice and influence of children. These changes are beginning to improve experiences and outcomes, particularly for children looked after and care leavers. Children with a permanence plan for adoption now receive a good service.

Inspection findings

73. In response to the 2015 inspection, the council prioritised the need to improve services for children, with significant financial investment. A multi-agency improvement board, led by the Department for Education commissioner, was established to oversee improvement. The council took the decision to set up a company limited by guarantee, TfC, to deliver, from April 2017, early help, social care and education services for children. The improvement board ended in March 2018. The TfC board manages service delivery and the quality function is undertaken by SSCB. The decision to relinquish the improvement board's oversight is premature given the continued fragility of the service.

74. Governance arrangements have not affected sufficient change of the magnitude needed to ensure that risks to children are consistently identified and appropriately responded to. While the council has begun to challenge TfC through scrutiny and corporate parenting boards, to date this has not been effective in changing practice. The corporate parenting board has not secured service improvements, for example training, education and employment opportunities for care leavers. Care leavers and children in care continue to experience delay in accessing mental health services.

75. Other governance structures, such as the operational commissioning group and the chief executive's (of the council) performance clinic, interrogate data and request further information to understand performance. There has also been a need to give attention to issues such as staffing and budget pressure, which has diluted the focus on quality and improving service delivery for all children.

76. Senior managers and leaders do not have a good enough understanding of some weaknesses in practice, particularly for children who need help and protection. The scale of practice weakness found during this inspection was not well understood by senior managers and leaders. Some actions taken following monitoring visits have not been sufficiently effective in improving social work practice. A number of recurring themes identified during these monitoring visits have not translated into improved practice. A number of areas requiring improvement identified by inspectors through monitoring visits are still evident in current practice. Senior managers did not recognise the significance of visiting children prior to strategy meetings, which was raised by inspectors at a previous monitoring visit. Consequently, no corrective action was taken.

77. There have been four changes of director of children's services since the last inspection. This has impacted on the momentum of improvement. At the time of this inspection, interim DCS arrangements remain in place until the newly appointed DCS takes up post in July 2018. The interim DCS who is employed by the council works closely with the chief executive of TfC. This arrangement

has recently begun to make progress in rebuilding and creating some of the structures needed to deliver improved services. However, the pace of change has been too slow for too long, particularly for children in need of help and protection.

78. The new early help service has taken almost two years to set up. The joint relocation of ICRT with the dedicated assessment team was only completed in November 2017. During this inspection, senior managers acknowledged that improvements around thresholds and the identification of risk had not progressed sufficiently in ICRT. Managers have not ensured that children who go missing from home or care and those vulnerable to child sexual exploitation are adequately protected. Managers cannot assure themselves that disabled children are safe. Senior managers have been responsive to the concerns identified during this inspection. Improvement actions have been proposed, including commissioning an independent review of repeat contacts. (Recommendation)

79. There is insufficient management 'grip' on the front line for vulnerable children, including children who go missing and those who are at risk of child sexual exploitation. Front line managers and IROs do not adequately scrutinise or challenge the quality of social work practice, children's assessments or plans. When children's circumstances change, and concerns escalate, this is not always recognised or responded to in a timely way. While supervision is now taking place regularly, it is not of consistently good quality. This means that opportunities for social workers to learn and improve their practice is often missed. Inspectors found weaknesses in recording on children's case files in too many cases. Some records are incomplete, missing or not good enough to understand and follow children's experiences. This hinders social workers and managers in fully understanding children's experiences in order to help situations to improve. (Recommendation)

80. Senior managers have created a whole performance framework since the last inspection. At an operational level, managers receive information to enable them to monitor and address compliance measure. Performance data now demonstrates improvements in meeting compliance measures as set out in the TfC contract with the city council. Data has been used to good effect and action is taken to improve performance. For example, senior managers engaged a project team in August 2017 to complete new assessments over a 13-week period. This enabled the assessment team to better manage their workloads and complete outstanding work.

81. While performance management systems have improved, too much emphasis is placed on data compliance and whether performance targets have been met. Audits seen during this inspection undertaken by managers in help and protection services are overly optimistic. The new quality assurance framework is not supporting managers to sufficiently improve the quality of social work practice to deliver positive outcomes for children. (Recommendation)

82. Since the last inspection, Sunderland has made some progress in rebuilding services that were seriously broken. Improvements have been made in: redesigning the service; developing services that did not previously exist; creating a structure of governance and accountability, including performance and quality assurance; strengthening partnership working; improving workforce stability and effectively reduced workloads; introducing practice standards; and enhancing the voice and influence of children. In some areas, senior managers and leaders are taking appropriate action to improve services. This is seen, for example, in working in partnership with the court and Cafcass to improve the quality and timeliness of court applications and in targeted education work for children in care and sufficiency of foster care placements, particularly for children with complex needs. However, in some instances actions are still in their infancy and impact has not yet been seen.

83. Through ongoing monitoring visits, TfC has demonstrated more effective actions in tackling weaknesses in practice identified by inspectors. There have been improvements to services for children looked after, although the quality of services remains variable. There are skill gaps in social workers conducting analytical assessments as a basis for planning for a child's future. Permanence planning is not embedded at the earliest opportunity and managers are not scrutinising or challenging children's plans.

84. Senior leaders and managers recognise that there are insufficient placements to meet the needs of children in care and the increasing numbers of children entering care, particularly those with complex needs. A refreshed commissioning strategy recognises these shortfalls. The profile of need is well understood. A strong focus on connected family placements is enabling children to remain within their family network where it is safe to do so.

85. Short-term placement stability is starting to show some decline. Some children on the edge of care and those in pre-proceedings are experiencing delay in their needs being identified and plans to enter care progressing. Senior managers recognise that they have to invest time and energy in improving the quality of care applications and gaining the confidence of the local judiciary and Cafcass in the quality of social work evidence. They have not effectively tackled delays in care proceedings being issued when completed due to insufficient legal capacity within TfC. This is impacting on progress.

86. Solid progress has been made in supporting care leavers. There is evidence that children leaving care are increasingly feeling supported. They have better access to good-quality housing. However, not enough is being done to improve their education, training and employment opportunities to set them on the road to success. Adoption work is now good. More children are achieving permanence through adoption. The effective adoption service has demonstrated that it now offers timely, child sensitive and supportive interventions for adoptive families as well as for birth families.

87. Dedication to implementing a strong recruitment and retention strategy in conjunction with the workforce strategy has increased workforce stability. Staff turnover is now less than the national and regional average. In 2015, nearly half of management and social worker posts were filled by agency staff. This has reduced to 28% for social workers and 17% for managers. Improving workforce stability is beginning to strengthen relationships between social workers, children and their families in some, but not all, parts of the service.

88. There are still challenges in recruiting specialist children's social workers for the children with disabilities team. The heavy reliance on agency staff in the children with disability team, together with a previous lack of management oversight, has resulted in the current needs of many children being unassessed.

89. Child and family social work is challenged by the continued heavy reliance on agency staff. The demand for permanent staff in Sunderland and neighbouring authorities outstrips supply. Senior managers are working hard to attract 'trainees' and newly qualified staff. The framework for the assisted and support year in employment (ASYE) is ensuring that newly qualified staff receive the support and training that they need.

90. The training and development offer for all children's service staff is not comprehensive. It does not ensure that staff have the skills and knowledge to fulfil their role. For example, social workers have not yet received training in the risks around child sexual exploitation, despite this being identified as a practice area needing improvement. (Recommendation)

91. Complaints are dealt with in an increasingly timely way. Since TfC took over service delivery, there is now a dedicated complaints service for children's services. A few legacy issues remain, which affect timely completion. Accessibility to the complaints process has improved. Learning from complaints is now identified and tracked. However, it is too soon to see how this is routinely making a difference to children and families.

92. Senior managers and leaders have strengthened the voice of children and young people. They have created opportunities to better understand what it's like working for and receiving children's services in Sunderland. The elected members, DCS, lead member and chief executive of TfC regularly meet with staff, foster carers, and young people to hear and understand their views. The corporate parenting board now engages with children and young people. Children are now having their say about the agenda and structure of the corporate parenting board. TfC has invested in the MOMO app to better understand individual children's views, wishes and feelings. Children and young people spoken to as part of this inspection described some of the positive changes in having their views heard.

Information about this inspection

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

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

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

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

The inspection team

Lead inspector: Lisa Summers

Deputy lead inspector: Rachel Holden

Team inspectors: Ian Young, Matt Reed, Stella Butler, Fiona Millns, Neil Penswick

Senior data analyst: Clare Atkinson

Quality assurance manager: Sarah Urding

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.he Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 1231, or email enquiries@ofsted.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: http://eepurl.com/iTrDn.

Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk