York City 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 Board¹

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<table>
<thead>
<tr>
<th>Children’s services in York are good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Children who need help and protection</td>
</tr>
<tr>
<td>2. Children looked after and achieving permanence</td>
</tr>
<tr>
<td>2.1 Adoption performance</td>
</tr>
<tr>
<td>2.2 Experiences and progress of care leavers</td>
</tr>
<tr>
<td>3. Leadership, management and governance</td>
</tr>
</tbody>
</table>

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

Overall, children’s services in York are good. The chief executive, director of children’s services (DCS), senior leaders and elected members ensure that there are robust governance arrangements and set clear priorities and aspirations to improve outcomes for children in York. They share a well-articulated vision of continuous improvement and progress for all children. A wholesale restructuring of children’s social care was completed in September 2016.

The restructuring of children’s social care is supported by a new electronic recording system introduced in March 2016 and further structural changes in September 2016. This is beginning to evidence clear improvements in outcomes for most children across the service. However, it is not complete, so the full impact cannot be seen for all children, particularly those in need of help and protection. Services to children who need help and protection require improvement. A recently developed system to integrate multi-agency information into a child’s single assessment has been implemented. However, this is not yet improving the quality or timeliness of children’s assessments or the resulting plans. Overall, assessments lack focus on all risks within families and do not consider parents’ histories well enough. They do not take enough account of the uniqueness of families, their culture or heritage. It is, however, a particular strength that the local authority has prioritised capturing in assessments the voice of the child.

There is clear evidence that reduced caseloads are giving social workers the opportunity to undertake direct work with children. Workforce planning is effective. Staff are supported through a wide range of training opportunities. Senior managers are visible and approachable. Staff with whom inspectors spoke said that they feel valued, safe and supported. This has resulted in high retention rates and a reduction in the use of agency workers. While staff receive regular supervision, their records do not show how they are helped to reflect on practice or supported to develop. Some frontline managers across the service do not always identify when delay is occurring in progressing children’s assessments. While senior managers receive regular performance information on frontline operational practice through a revised comprehensive quality assurance framework, this is not yet providing managers with a clear understanding of the experience and progress of all children.

There are highly effective links to the YorOK Children’s Trust Board, the Health and Wellbeing Board (HWB) and the City of York Safeguarding Children Board (CYSCB). The voice of children is integral to strategic and operational activity. The promotion of children’s views and ways in which these influence service developments are highly effective and embedded in the foundations of the local authority and partnership culture. There is a clearly articulated approach to the application of thresholds for access to children’s social care, which is understood and applied across the partnership. A wide range of effective services are in place to help children and their families to access help and protection when they need it. A comprehensive, multi-agency strategy is in place for responding to domestic abuse. There has been an innovative parent-led development to accessing short breaks for
children who have a disability and about whom there is no safeguarding concern. This has led to more timely and positive outcomes for children and their families. A dedicated children in need team coordinates services for children and their families, providing lower-level and intensive, time-limited interventions and effective edge-of-care support. This has safely reduced the number of children who become looked after or subject to a child protection plan and has sustained the lower numbers over several years. When children return home from care, outcome-focused assessments, planning and support ensure that the decisions are safe and in the child’s best interests.

There are highly effective mechanisms in place to respond to and safeguard children who go missing from home or education, or who are at risk of being sexually exploited. Outstanding work by the council and its partners, driven by the CYSCB, has developed effective referral and assessment processes when children are at risk or have been victims of child sexual exploitation. Extensive training and awareness raising through the council’s ‘It’s not OK’ campaign have delivered many positive outcomes, increasing the awareness of risk indicators and raising confidence among professionals and the general public in responding to those risks. Most importantly, it has encouraged children to speak out about their worries and concerns.

The services for children looked after are good. The majority of children looked after are cared for by local foster carers. The number of children placed out of the city continues to fall. Independent reviewing officers (IROs) are an emerging strength. Evidence of their scrutiny and challenge can be seen on the majority of children’s records and plans, although the impact of their challenge is not well evidenced. Plans for children who are looked after to achieve permanency are progressed in a timely way. A full range of permanent placement options are considered at the earliest possible stage. York has a good success rate in securing ‘foster to adopt’ and ‘staying put’ arrangements, and provides children with good foster homes through the selective recruitment of capable, caring and resilient foster carers, although foster carers do not receive good enough support out of hours. Legal permanence is secured promptly, and the quality of care applications before the court is good. However, letters before proceedings do not make clear enough to parents what they need to do to achieve positive and sustained change, or when care proceedings will be issued if change is not achieved. When adoption is the agreed plan for the child, there is a relentless focus on securing the right placement at the right time. Children are well prepared and supported, and adopters are positive about their experiences, including their post-adoption support.

The local authority has high aspirations for their care leavers. A high percentage are in employment and training. There is a range of suitable and safe accommodation options for care leavers. York has a strong track record in supporting care leavers to remain with their foster carers after their 18th birthdays. Good pathway planning supports preparation for independence, when it is safe and appropriate to do so.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>2</td>
</tr>
<tr>
<td><strong>The local authority</strong></td>
<td>5</td>
</tr>
<tr>
<td>Information about this local authority area</td>
<td>5</td>
</tr>
<tr>
<td>Recommendations</td>
<td>8</td>
</tr>
<tr>
<td>Summary for children and young people</td>
<td>9</td>
</tr>
<tr>
<td>The experiences and progress of children who need help and protection</td>
<td>10</td>
</tr>
<tr>
<td>The experiences and progress of children looked after and achieving permanence</td>
<td>17</td>
</tr>
<tr>
<td>Leadership, management and governance</td>
<td>30</td>
</tr>
<tr>
<td><strong>The Local Safeguarding Children Board (LSCB)</strong></td>
<td>37</td>
</tr>
<tr>
<td>Executive summary</td>
<td>37</td>
</tr>
<tr>
<td>Inspection findings – the Local Safeguarding Children Board</td>
<td>38</td>
</tr>
<tr>
<td><strong>Information about this inspection</strong></td>
<td>43</td>
</tr>
</tbody>
</table>
The local authority

Information about this local authority area

Previous Ofsted inspections

- The local authority operates one children’s home, which was judged to be good in its most recent Ofsted inspection.
- The last inspection of the local authority’s safeguarding arrangements/arrangements for the protection of children was in May 2012. The local authority was judged to be good.
- The last inspection of the local authority’s services for children looked after was in May 2012. The local authority was judged to be good.

Local leadership

- The DCS has been in post since March 2014.
- The DCS is also responsible for community services and skills.
- The chair of the CYSCB has been in post since January 2014.

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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.
**Children living in this area**

- Approximately 36,699 children and young people under the age of 18 years live in York. This is 18% of the total population in the area.
- Approximately 11% of the local authority’s children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 9% (the national average is 17%)
  - in secondary schools is 8% (the national average is 15%).
- Children and young people from minority ethnic groups account for 8% 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 Asian/Asian British (3%) and Mixed ethnicity (3%).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 7.6% (the national average is 20.1%)
  - in secondary schools is 4.7% (the national average is 15.7%).

**Child protection in this area**

- At 30 September 2016, 1,095 children had been identified through assessment as being formally in need of a specialist children’s service. This is an increase from 986 at 31 March 2016.
- At 30 September 2016, 143 children and young people were the subject of a child protection plan. This is an increase from 135 at 31 March 2016.
- At 30 September 2016, two children lived in a privately arranged fostering placement. This is a decrease from four at 31 March 2016.
- Since the last inspection, two serious incident notifications have been submitted to Ofsted and one serious case review has been completed.

**Children looked after in this area**

- At 30 September 2016, 190 children were being looked after by the local authority (a rate of 52 per 10,000 children). This is the same as 190 as at 31 March 2016 (a rate of 52 per 10,000 children). Of this number:
  - 72 (or 38%) live outside the local authority area
  - 16 live in residential children’s homes, of whom seven (44%) live out of the authority area
  - one lives in a residential special school out of the authority area
  - 150, of whom 53 (35%) live out of the authority area, live with foster families
  - nine, of whom two (22%) live out of the authority area, live with parents
- two children have been unaccompanied asylum-seeking children in the past 12 months.

In the past 12 months:
- there have been three adoptions
- seven children became subject of special guardianship orders
- 82 children ceased to be looked after, of whom four (5%) subsequently returned to be looked after
- seven young people ceased to be looked after and moved onto independent living
- no young people who ceased to be looked after are living in houses in multiple occupation.

The local authority operates a small number of theoretical models to support social work practice.
Recommendations

1. Improve the timeliness and quality of assessments for all children to ensure that their needs are fully understood. In particular, ensure that robust risk assessments, which explore whole family histories are undertaken to inform plans fully, and that the additional vulnerabilities of children who have a disability are recognised and understood.

2. Ensure that assessments consider the impact of a child’s uniqueness arising from their family culture and ethnicity.

3. Ensure that plans are updated when children’s needs change or when significant events occur in their lives.

4. Ensure that children and their carers have access to effective out-of-hours support and that robust agency checks take place and are clearly recorded to inform decisions and actions to be taken.

5. Ensure that initial and review health assessments are completed in a timely manner for children who are looked after.

6. Improve the quality of letters before care proceedings, ensuring that they stipulate clearly what is expected of parents and professionals, contain timescales for change to be achieved and are clear about what action will be taken if children’s circumstances do not improve.

7. Ensure that child protection chairs and IROs monitor actions between children’s reviews and demonstrate evidence of the impact of any challenge that they make when progress is not being made against the child’s plan.

8. Ensure that care leavers are supported to understand their health histories and that they and professionals are clear about the pathways to access support for their emotional and mental health needs.

9. Improve the quality of frontline management oversight and direction across all teams, and ensure that social workers receive good-quality supervision that supports and challenges practice and promotes professional development.

10. Ensure that managers have access to accurate audit tools and performance data that lead to specific areas for practice improvements.
Summary for children and young people

- When children, young people and their families begin to have problems, they have access to a wide range of help and good-quality services. When children need a higher level of support, sometimes it takes too long for assessments to be completed. Children’s needs are not always well understood, and this means that plans to help them are not always focused on the right things and that it can take too long to get the support for some children when they need it.

- Senior managers, councillors and social workers work very hard to make sure that children and young people take part in the decisions affecting their lives and about the support that they get. They come to know children and young people very well, listen carefully to what they have to say and, if they need to, do things differently to make services better.

- The Children in Care Council (CiCC)’s ‘Show me that I matter’ group works extremely hard to influence how children in care and care leavers are understood and supported and have the best possible chances to be safe, healthy and happy, and to achieve. Children and young people talk to senior managers and councillors about how the council and services are best organised to support families. The council also provides training for adults to help them better to understand children’s lives, and it won a national award for helping children in care to see that they can have happy and fulfilling lives.

- Social workers, teachers, doctors, nurses, health visitors and the police act together quickly to help to keep children and young people safe. Senior managers make sure that everyone understands the problems faced by children and young people, and that different agencies work together well to protect children and young people. The ‘It’s not OK’ campaign has helped children, young people and adults to understand more about the risk of sexual abuse and exploitation, and what to do if they are worried about it.

- When children and young people are unable to live with their parents, social workers find them a good home with caring adults. Social workers always try to keep brothers and sisters together, and enable children to see people who are important to them. If it is safe for children to return home, social workers make sure that families continue to get the help that they need for as long as necessary. Social workers make every effort to find the best possible adoptive families for children at the right time. When children and young people cannot return home to live with their parents, social workers and support workers help them to understand the reasons why this needed to happen, and to have information about their background.

- Young people have good help and support when it is time for them to leave care. Their health needs are well met, but they do not always understand how to get help with their emotional needs. They are helped to find a safe place to live that is right for them, and some continue to live with foster carers after their 18th birthdays. They have the practical support that they need to live independently, to stay in education or to find a job.
<table>
<thead>
<tr>
<th>The experiences and progress of children who need help and protection</th>
<th>Requires improvement</th>
</tr>
</thead>
</table>

**Summary**

When children are referred to children’s social care, their immediate safety needs are identified and responded to effectively. Professionals and families have easy access to social workers to discuss safeguarding concerns, receive advice and guidance and be signposted to early help support. Thresholds are understood and applied across the partnership. When children are in need of protection, multi-agency strategy discussions take place promptly and are well attended by agency partners.

A recently developed system to integrate multi-agency information into a child’s single assessment has been implemented. However, this is not yet improving the quality or timeliness of all children’s assessments or the resulting plans. Overall, assessments lack focus on all risks within families and do not consider parents’ histories well enough. As a result, some children’s plans are not focused on all risks. The needs of children who have a disability and require a statutory service are not always well understood. Contingency plans are largely absent from children’s records. Assessments do not take enough account of the uniqueness of families, their culture or heritage. Although management oversight is in evidence, it does not always identify when delay is occurring or consistently challenge the quality of social work practice. Social workers know children well, and senior managers are aware of individual children for whom there is a high degree of risk or complexity.

A collaborative multi-agency approach identifies the needs of individual children who may benefit from early help. Support is available from a wide range of effective services across the city. The number of family early help assessments (FEHAs) are increasing, although some lack a robust analysis and are unclear about the actions to be taken and services to be provided. Innovative parent-led developments to access short breaks for children who have a disability have led to more timely and positive outcomes for children. There is a proactive multi-agency response to children who are exposed to domestic abuse, parental substance misuse and parental mental health issues.

Children who are at risk of sexual exploitation and/or go missing from home receive an effective, well-coordinated range of services to address their assessed needs. When children aged 16 to 17 present as homeless, they receive a sensitive response to provide them with support and, if appropriate, accommodation.

A neighbouring authority provides out-of-hours support. While this service responds to immediate risks, the rationale for decisions is poorly recorded, and decisions are not underpinned by robust agency checks.
Inspection findings

11. A mature multi-agency partnership works effectively to identify children who may benefit from early help services. While early help services are well coordinated, senior leaders have recognised the need to improve the delivery of early help interventions in order to improve the way that families are supported. Firm plans are in place to establish three multi-agency local area teams from January 2017.

12. Currently, the main route to access early help is through the children’s advice team (CAT). Professionals and the general public receive good-quality information, advice and guidance from the CAT advisers, who use a comprehensive directory of local services to ensure that children are directed to the appropriate provision. The CAT advisers also coordinate the allocation of FEHAs and all arrangements when children’s needs step down to early help, or step up to statutory services.

13. Although the numbers of FEHAs are slowly increasing, inspectors found inconsistent practice in their quality. Although multi-agency information is included, there are weaknesses in the analysis, which limit the identification of children’s holistic needs. The voice of the child comes through strongly in statutory assessments, but this was less evident at the early help stage. In addition, it was difficult to see how managers across the partnership measure the impact of early help, as currently there is no evaluation of children’s progress or the quality of FEHAs undertaken. (Recommendation)

14. The referral and assessment service restructured in September 2014 provides an effective first point for contact with children’s social care. Professionals and families have easy access to social workers to discuss safeguarding concerns, receive advice and guidance and be signposted to early help support. Thresholds for access to children’s social care are well understood and applied across the partnership. The co-location of agency partners means that multi-agency information is readily available and is used effectively to inform decision-making. Parental consent is understood and applied, as appropriate.

15. Referrals out of hours are responded to through an arrangement with a neighbouring authority. Inspectors identified in all five children’s cases sampled that the rationale for decisions is poorly recorded. In two of the five children’s cases reviewed by inspectors, agency checks were not completed, which meant that decisions to take no further action were based on insufficient information. In addition, foster carers reported to inspectors that they have no confidence in the service, and choose to seek support from within the fostering network. (Recommendation)

16. When children are in need of protection, multi-agency strategy discussions take place promptly and are well attended by agency partners. Enquiries and
investigations are undertaken by experienced social workers, although the records of discussions to inform safety plans often lack detail and do not always contain the timescales within which actions are to be achieved.

17. Initial child protection conferences are held within statutory timescales. All initial and review child protection conferences are well chaired and attended by a wide range of agencies. This results in well-informed multi-agency decision-making. While some progress is being made in supporting children to attend their conferences when appropriate, the numbers doing so are very low. An action plan is in place to address this, and children have access to effective and advocacy support.

18. A dedicated children in need team coordinates services to children and their families. This service provides lower-level, intensive time-limited interventions and effective edge-of-care support. Positive impact can be seen in the safe reduction in the number of children who are re-referred to children’s social care. A strong emphasis is placed on ensuring that parents have demonstrated sustained change before children’s cases are closed or stepped down to early help, and underpins this positive performance. This means that children are receiving the right help for as long as it is needed.

19. Despite this positive performance, at the time of the inspection, there were delays in the completion of single assessments for 49% of children. The local authority’s data showed that 140 children had waited between for 51 and 100 days for their assessment to be completed and signed off by a manager. The local authority’s self-assessment recognised that some children were waiting too long for services to be provided while single assessments were ongoing. Senior managers explained to inspectors that some children had experienced delays in their assessments being completed in recent months, in part due to the restructuring of children’s services and a difficulty in recruiting to social work vacancies during this time. They had also identified weaknesses in the performance of some managers at different levels of the organisation, which were impacting adversely on the oversight and grip of children’s assessments and plans. A successful recruitment campaign and the restructuring of children’s services has begun to positively address these issues. In September 2016, the local authority created the immediate response team, with the intention to provide support during children’s assessments. Senior managers recognise that this is a short-term solution for any child who may require this support.

20. In order to improve assessment quality, together with the CYSCB, the local authority has recently developed a system to integrate multi-agency information into a child’s single assessment and introduced a graded care profile within single assessments in order to identify neglect better. Inspectors have seen very recent evidence of social workers beginning to consider neglect not as a static, single event but as a cumulative process that occurs over time. However, overall assessments lack focus on all risks within families
and do not consider parents’ histories well enough. In nine of 10 children’s cases tracked during the inspection, overall the assessment quality was poor. Chronologies are not used to help social workers to make sense of the life events which have been important to a child and their family or to assist with decision-making. Although multi-agency information is contained in most assessments, the analysis of risk and need is not well developed. The impact of culture and diversity is not recognised sufficiently. The needs of brothers and sisters are not considered separately, and only three of 10 children’s assessments tracked by inspectors had evidence of robust management oversight. When this was in evidence, it was poorly recorded.

(Recommendation)

21. It is a particular strength that the local authority has prioritised capturing in assessments the voice of the child. There is clear evidence that reduced caseloads and the recent restructuring of children’s services are giving social workers an opportunity to undertake direct work with children. Social workers know children well, and senior managers are aware of individual children for whom there is a high degree of risk or complexity. It was clear to inspectors that more direct work is undertaken with children than is evidenced in case recording.

22. When appropriate, most assessments undertaken lead to a child’s plan. However, as the analysis of need in most assessments seen by inspectors was weak, children’s holistic needs are not well understood. Children’s plans are not always focused on the right things or the outcomes to be achieved. Overall, plans do not stipulate what actions are to be undertaken or by whom. Timescales for progress are not routinely recorded. Contingency plans are rarely included, which makes it unclear to parents what is expected of them and what action will be taken if change is not achieved and within what timescale. This is mirrored in letters before proceedings for children subject to child protection planning. It is also unclear whether parents and children have agreed to or understood the plan. (Recommendation)

23. Children’s plans are regularly reviewed across the service. Statutory reviews are held within timescales and are well attended by a range of agencies. Child protection chairs challenge social workers and their managers when there are gaps in children’s plans or when drift is occurring. However, children’s records do not show whether this challenge has made any positive difference. When a child in need plan is in place, this is reviewed by an IRO. This is a positive development, which is beginning to improve the quality of the child’s plan after the first review.

24. Children who are at risk of sexual exploitation and those who go missing from home and school receive an effective, well-coordinated range of services to assess and respond to their needs. Children who go missing from home are visited by a social worker and, if appropriate, a return home interview is undertaken. All risk factors are considered, including the risk of sexual
exploitation. All outcomes are shared with a dedicated child exploitation and missing coordinator. When children are identified to be at risk of exploitation or this is suspected, robust wrap-around services intervene to assess risk and safeguard the child. Bespoke multi-agency services are tailored to the needs of individual children. All staff spoken to by inspectors had a high level of awareness of child sexual exploitation, risk assessment processes and referral pathways.

25. The coordinator oversees all missing children, including children looked after, care leavers and those children looked after who are placed in York by other local authorities. The coordinator has impressive and detailed knowledge of individual children. Close links with education professionals enable the cross-fertilisation of information and the identification of individual children, or groups of children, at risk. Patterns and trends of risks and concerns are gathered and analysed to inform children’s individual safety plans, wider risk prevention and disruption activities, through strategic forums and close links with the CYSCB.

26. The incidence of female genital mutilation in York is extremely low. However, staff and partners spoken to during the inspection were very knowledgeable about the issue. Similarly, the identification of the risk of radicalisation is embedded within established local early help practice and arrangements. Referral pathways are clear, and risks are well understood across the partnership.

27. There is a well-considered response to special educational needs and disability, delivered by a mature and well-managed partnership. There is clear evidence that children, parents and their carers have influenced many service developments. The impact can be seen, for example, in the refreshed short-breaks offer. When there are no safeguarding concerns, parents can self-refer through an online portal. A recent evaluation of this service shows that outcomes are good, with the vast majority of children, parents and carers all reporting the value of the service and how this has improved children’s experiences, family life and parents’ relationships with their children.

28. Frontline managers in the health and disability service within children’s social care are not robustly tracking the progress of allocated work or statutory assessments and are not ensuring, through supervision, that there is sufficient focus on risk and children’s changing needs. Inspectors found that when referrals for short breaks are made through this service, there is evidence of drift and delay in assessments being undertaken and the provision of services. Similarly, in the small number of children’s cases sampled, when a child protection response is needed, risk assessment is not robust. Senior managers responded swiftly when inspectors referred one child’s case back to the DCS for urgent review, when the risks to a child who has disability had not been fully identified or his holistic needs understood. In this child’s case, inspectors found limited evidence that safeguarding social workers are working in
partnership with the children’s health and disability service in order to understand children’s holistic needs. (Recommendation)

29. Multi-agency partnerships are a particular strength in York, especially when domestic abuse is a risk factor. Domestic abuse is the main reason why children are referred to children’s social care. Consequently, domestic abuse is a high priority across the partnership, driven by the CYSCB. Multi-agency risk assessment conferences are well established and have a committed, consistent membership, which supports effective safety planning to reduce risk. A wide range of domestic abuse services are commissioned, including a women’s refuge and urban outreach service, which offers support for victims to develop independence and can be provided for up to two years. Two perpetrator programmes, ‘Positive steps’ and ‘Making safe’, are always available and there is no waiting list.

30. Some individual services to children are not timely, as both the independent domestic abuse services (IDAS) and the respect and advocacy service currently have a waiting list. Senior managers have responded effectively to this shortfall, employing an early intervention worker to work within IDAS to target and support cases of domestic abuse classed as ‘standard’ risk, to intervene at the earliest opportunity, to prevent escalation and to provide direct support to children.

31. Effective multi-agency working is also evidenced in a recently piloted model based on the family drug and alcohol court. It is too soon to see any discernible impact. However, the early indications are positive, with evidence seen of a child’s case resulting in achieving permanency very quickly through the making of a special guardianship order.

32. Arrangements for the assessment and accommodation of children aged 16 to 17 years who are homeless are well structured and organised through the youth homeless scheme. Risk assessments are undertaken in a timely way, and a good range of accommodation is available. Importantly, the youth homeless scheme works to mediate for children returning home. Similar pathways are available for homeless 16- to 17-year-olds who are pregnant or have children, and they can be supported in specialised placements.

33. Children who are in private fostering arrangements do not benefit from individual assessments separate from those of their carers. Neither does the manager have oversight of all arrangements nor, until recently, has performance information been accessible through data recording systems. This has reduced effective management oversight of private fostering arrangements. Senior managers have responded positively to findings during the inspection and amended their procedures in respect of both issues, and they plan to transfer responsibility for the completion of private fostering assessments to a dedicated staff team.
34. Arrangements for managing allegations against staff, carers and volunteers who work with children is commissioned from North Yorkshire County Council. During this inspection, measures were taken to strengthen local oversight, recording arrangements and increased capacity for information sharing between the designated officer and local authority, as these were identified by inspectors as weaknesses.
The experiences and progress of children looked after and achieving permanence  |  Good

**Summary**

When children become looked after, the decisions taken by social workers and their managers are appropriate. Children are placed with their extended families when it is safe to do so and is in their best interests. The local authority has recently reviewed all children’s cases with a section 20 status to ensure that this is the most appropriate legal option for those children. The majority of children looked after are cared for by local foster carers who are well trained. When children return home, they do so on the basis of clear risk assessments and with good support.

Children do not always receive a reassessment of their needs when their circumstances change or when a significant event occurs. Evidence of the scrutiny and challenge of children’s plans by IROs can be seen on the majority of children’s records, but these do not show how this challenge has made a difference.

Plans for children who are looked after to achieve permanency are progressed in a timely way. Legal permanence is secured promptly, and the quality of care applications before the court is very good. However, letters before proceedings do not make it clear enough to parents what they need to do to achieve positive and sustained change or the action that will take place if change is not achieved within their child’s timescale. When adoption is the agreed plan for the child, there is a relentless focus on securing the right placement. Children are well prepared and supported, and adopters are positive about their experiences, including post-adoption support.

Children looked after are well supported at school. Some children of primary school age do not make expected progress. Outcomes for children at key stage 4 are above the national average. Personal education plans (PEPs) are mostly up to date and of a good quality. Health assessments are not routinely completed in a timely manner. Strengths and difficulties questionnaires are not being used to inform health assessments or to identify children’s emotional health needs.

Children looked after who go missing or are at risk of sexual exploitation receive effective help and support to reduce risks and keep them safe. The ‘Show me I matter’ and the ‘Show me I still matter’ groups are highly effective in representing the views and interests of children looked after. Advocacy support for children is strong. Most care leavers are placed in suitable accommodation. Care leavers are prepared well to live independently when it is right for them. Pathway workers are in touch with all young people, and most care leavers spoke positively about the support that they receive.
Inspection findings

35. Concerted efforts are made to ensure that children remain with their families when appropriate. An effective edge-of-care service provided by the children in need teams has safely and consistently reduced the number of children who become looked after over the past two years. Children are well supported with a variety of service provisions designed to improve their circumstances and prevent the need for them to become looked after. Inspectors saw no cases in which children were looked after unnecessarily, and decisions were made within a timescale that met their needs.

36. In a very small minority of cases, although children’s safety needs had been addressed, there was a delay in children’s looked after status being recognised when they are placed with connected persons. This was due to social workers and managers not recognising that such arrangements meant that these children were looked after.

37. When the plan is for children to return home, assessments are undertaken to ensure that it is safe do so and that it is in their best interests. Children have appropriate support plans to meet their needs, with risks clearly understood and minimised. Plans to discharge care orders are not made until changes in children’s circumstances have been sustained.

38. There are very effective strategic and operational relationships with the Children and Family Court Advisory Service (Cafcass) and the family proceedings courts. The local authority has a good reputation and produces good written and oral evidence to support care applications. These are accepted by the courts and children’s guardians, in most cases without the need for additional or independent assessments. This results in legal permanence being secured in a timely way. Care proceedings are completed within an average period of 25 weeks. This is below the national threshold of 26 weeks. The local authority has recently reviewed all children’s cases with a section 20 status to reassure itself that this is the most appropriate legal option for those children. This has ensured that timely decisions are made when children require legal permanence.

39. While children’s cases progress swiftly though the Public Law Outline (PLO), in a small number of cases when letters before proceedings were issued these were not routinely reviewed. The letters do not always make it clear enough to parents what they need to do to achieve positive and sustained change, or what action will take place if the required change is not achieved within their child’s timescale. (Recommendation)

40. There is a strong sense that permanence must be sought and can be achieved for all children. A full range of permanent placement options are considered at the earliest possible stage. Viability assessments of potential extended family carers are undertaken swiftly. Assessments are of a good quality. Family
group conferences to identify family carers and explore potential care arrangements for children are routinely undertaken, which means that children have the opportunity to be placed within their family network at the earliest opportunity.

41. The local authority considers the permanent placement of children within the wider family appropriately, and has encouraged and enabled the use of special guardianship orders and child arrangement orders for family members and foster carers. Financial and practical support plans are considered on an individual basis, according to the child’s and family’s needs and circumstances. Over the past year, five children have benefited from leaving care through their foster families applying for special guardianship orders. At the time of the inspection, 31 children looked after benefited from living with connected carers.

42. Risks to children looked after who go missing from care and those at risk of child sexual exploitation are promptly recognised and assessed. Strategy meetings are held when risks are identified. Information sharing between partner agencies is robust and well established, contributing to effective planning that targets and reduces risks. Child sexual exploitation risk assessments are completed when children are deemed to be at risk and regularly reviewed to reflect children’s changing circumstances. Oversight of all children at risk is undertaken by a dedicated missing and child sexual exploitation coordinator, who analyses all risk assessments and return home interviews. Information is shared and discussed with police on a daily basis, and safe care strategies and wider safety planning are informed by these discussions. Children’s care plans are not always updated following risk assessments, but there is clear evidence from the records that protective actions have taken place.

43. Children looked after do not always receive a timely health assessment. A lack of comprehensive data and a vigorous quality assurance framework mean that senior managers are not able to monitor health provision effectively for the children whom they care for. At the time of the inspection, only half of initial health assessments were completed within 20 working days, meaning that children’s health needs are not understood and carers do not have all relevant health information. Strengths and difficulties questionnaires are not completed for some children. They are not routinely used in planning for children. For example, they are not shared with health partners to inform health assessments. Senior managers recognise these gaps and have a health improvement plan with health partners, but its impact is currently limited. (Recommendation)

44. There is a wide range of provision available for the emotional health support of children looked after. Specialist psychological support is used to support individual children as required, although pathways to access services are unclear. Despite this lack of clarity, the local authority ensures that no child
who is looked after waits for a response to their needs, and individual support is provided as required. In addition, despite a lengthy waiting list for children in York to access child and adolescent mental health services (CAMHS), no child looked after is awaiting assessment or treatment.

45. The educational needs of children looked are well met. Most pupils attend good or outstanding schools (89%). A small minority of children attend schools outside the city. In such cases, the virtual school works closely with other local authorities to ensure that appropriate education is identified and that children receive services that meet their needs. Attainment at key stage 2 is not yet good enough, with just under a third of all children looked after achieving the expected levels of attainment in reading, writing and mathematics. Pupil premium is rightly focused on improving attainment in these areas.

46. The majority of PEPs seen were good. They provide a clear insight into children’s learning and development needs, and how these will be met. The proportion of children looked after who have an up-to-date PEP is too low, at 86% at the time of the inspection and below the high expectations that the local authority has set for itself.

47. Attendance of children at school in all age groups is good, and above the national average. The virtual school headteacher carefully monitors the attendance of all children and ensures that prompt action is taken by schools to ensure that the reasons for any decline in attendance are fully explored. Appropriate interventions are quickly put into place to ensure that children are well supported in returning to the classroom. A small number of children experienced a fixed-term exclusion in the past year, ranging from half a day to eight days. A range of carefully considered interventions are quickly put into place to support children in such circumstances, including the provision of alternative education. There have been no permanent exclusions in the past year.

48. At the time of the inspection, 12 children were receiving a timetable of fewer than 25 hours a week, for a variety of reasons. Each child’s individual circumstances are tracked and closely monitored by the virtual headteacher, and each has an individual action plan. Children benefit from a range of activities, which are tailored to meet their individual needs, and to engage and motivate them to learn and achieve. A number have made progress across many areas, including improved attendance.

49. Assessments of children looked after are not regularly updated to reflect significant changes in a child’s circumstances. In a small number of cases, placement plans for children had insufficient detail relating to needs and how these would be met. Updated information is reflected in social workers’ reports for looked after reviews, but there is no clear, specific assessment to redefine children’s needs to help to inform care planning. This is particularly
relevant for some children whose circumstances have changed significantly since their last review. (Recommendation)

50. Social workers visit children frequently, at least within minimum timescales, and see them alone when appropriate. In the majority of cases, the purpose of visits to children is clearly recorded, with children’s voice being evident. Inspectors viewed positive examples of direct work with children, helping them to understand their journeys to becoming and being looked after. Social workers know children well, prepare them sensitively for placement changes and help them to understand the reasons why they became looked after and the plans for their futures.

51. Children looked after reviews are mostly held within statutory timescales and, in the vast majority, the needs of children are well considered, with carefully thought-through changes to children’s care plans. However, the local authority’s own information identifies that IROs are not consistently seeing children prior to their looked after reviews. There is evidence on the majority of children’s records of IROs scrutinising children’s plans, yet the impact of their challenge is not well evidenced. Neither are they robustly capturing data relating to partner agency attendance at reviews to ensure that all relevant information is available to facilitate planning for children. (Recommendation)

52. Children are carefully matched to carers, and their wishes and feelings are considered well. Children are prepared with information about their carers and, when possible, introductory visits are made. Brothers and sisters are consistently placed together, unless their plans identify that this would not be in their best interests. When this is not the case, arrangements for contact are considered well to ensure that brothers and sisters retain appropriate and meaningful contact with each other. Arrangements for children looked after to engage in contact with members of their extended families and those people important to them are given appropriate attention and priority at looked after reviews.

53. The large majority of children looked after benefit from stable, positive placements, and there have been only three disruptions of long-term foster placements in the past 12 months. Stability meetings are held when difficulties arise, and every effort is made to prevent placement breakdowns, with appropriate support and creative intervention packages put in place.

54. The local authority is committed to ensuring that children and young people are looked after within the city, when it is safe to do so. The vast majority of children, in cases seen by inspectors in which a child is living at a distance from York, are visited regularly by their social worker. However, scrutiny of children’s records identified a lack of information being provided to carers when children are first placed with them. Children who have a disability or complex health needs receive coordinated, high-quality placements, which are based on assessed needs.
55. Fostering services meet the needs of children well. Foster carers benefit from regular supervision, training and support. A particular strength is the offer of a specialist accredited trauma and attachment course, developed with a local university. At the time of the inspection, 20 carers had either completed or are undertaking this provision, designed to strengthen their understanding of children’s emotional needs. Foster carers spoken to by inspectors value this training, and report that it has increased their knowledge and resilience and helped them better to understand the needs of the children whom they care for. They confirmed that they receive a good service from the local authority and are treated as professional members of the care team around children. Carers report that clear information is shared with them to help them to make decisions about whether they are in a position to meet children’s needs. Foster carers exercise delegated authority on an individual basis, making day-to-day decisions for children in their care. This helps to normalise children’s experiences.

56. The sufficiency duty is met, although the local authority continues to face challenges to increase its in-house resource. There is an ambitious strategy, entitled ‘Make York home’, designed to increase the range and numbers of local foster placements while reducing the numbers of children in private-sector fostering and residential provision. There was a slight increase in the number of children placed with York carers between March and October 2016.

57. The local authority is working well with neighbouring authorities towards a regional approach to receiving unaccompanied asylum-seeking children safely and effectively into the region. The regional approach is developing a model for the delivery of sustainable, child-centred health, education and care. Currently, the local authority cares for four unaccompanied asylum-seeking children, who are very well supported. A programme to recruit foster carers for this specific purpose is well underway, and so far has recruited two carers.

58. Children enjoy a wide range of leisure activities that support their wider emotional and social development, both at home and in school. Carers and residential staff support children and young people well to become involved in social, recreational and friendship-building activities. Children’s successes and achievements are celebrated on an individual level by both their carers and senior managers.

59. It is a particular strength that the voices of children looked after are heard by senior managers and influence strongly how some services and policies are developed. Clear processes are in place for children to make a complaint. Advocacy support is strong, enabling children to feel supported in resolving issues of concern to them. Since April 2016, there have been 30 referrals made to the advocacy service. Advocacy support is available to children to ensure that their views are heard in looked after reviews, and a number of children benefit from such provision, with advocates either attending with
them or on their behalf. York has an impressive commitment to the provision of independent visitor support. At the time of the inspection, 28 children benefited from this provision. Five of these children have had support for over five years, contributing to children’s sense of stability.

60. The CiCC’s ‘Show me that I matter’ group is highly effective in representing the views and interests of children looked after. The council is facilitated well and has three separate groups to ensure that the views of children in different age groups are well represented. The groups are attended by enthusiastic, committed children and young people who are rightly proud of their involvement and impact on ensuring that the voices of children are heard.

The graded judgement for adoption performance is that it is good

61. When adoption is the agreed plan for the child, there is a strong focus on securing the right placement at the right time. The adoption service benefits from the leadership of a competent manager and from a team of skilled and experienced social workers, who are committed to finding adopters who can best meet the needs of the children in the local authority’s care, regardless of complexity.

62. The co-location of the adoption service with the fostering team and locality social workers ensures that children whose plan may result in adoption are known at the earliest opportunity, to facilitate timely family finding and matching. For a very small minority of children (two), the local authority recognises an over-optimistic view of the ability of some families to change to meet the needs of their child. This has resulted in delay in the children securing legal permanence outside their birth family and being matched at the earliest opportunity to an adoptive family.

63. The adoption team has a good understanding of national and regional policy developments, and the potential impact on local services. The development of regionalisation is advancing well, with the local authority taking a lead role in planning for shared resources, greater consistency of regional policy and practice, and access to a wider pool of adopters.

64. Adoption performance against the government scorecard is improving. Over the past 18 months, the time between a child becoming looked after and moving in with their adoptive family has been reduced. Five children were placed for adoption in 2016, with an average completion rate of 380 days. This is 56 days fewer than the performance targets set by the government. Performance has also improved in the past 12 months in relation to the number of days between the local authority receiving court authority to place a child for adoption and the local authority matching a child with their adoptive family. In the past year, 11 children have been matched to their adopters and, so far, eight of these children will be placed within the
government’s expected targets. It is clear from those children who have become looked after more recently (in the past year) that timeliness for achieving permanence through adoption has improved.

65. Adoption performance over a three-year average in 2012–15 was adversely affected by the search for adopters for two children who had highly complex needs. The timescales were proportionate and necessary for the individual children, and demonstrated that social workers do not give up trying to secure permanence through adoption, whatever the challenges. Performance is closely tracked and monitored. The reasons for delays are scrutinised, and learning from this oversight is used to develop training for social workers to improve timeliness for children further.

66. Strong efforts are being made to enhance the skill base of children’s social workers and those within the adoption team to assess children’s needs consistently and robustly. Children’s recorded information and child permanence assessments detail clear chronologies of all family-finding activity, as well as comprehensive analysis and evaluation of children’s histories and identified needs. They are well written and tell children’s stories sensitively. Older children’s views are very well captured during this process. Assessments of brothers and sisters in child permanence reports are of good quality, and in the past three years there have been no reversals of plans for family groups when the plan has been for them to stay together.

67. Most prospective adopter assessments are of consistently good quality and completed within six months. They are thorough, suitably probing and are sensitive to the strengths, vulnerabilities and cultural heritage of each applicant, which assists suitable matching of children to them. Adopters report that their experiences of the assessment process and the training prepared them well to adopt. They valued the consistency of the adoption team, especially the honesty relating to the complex histories of many of the children who require a permanent family.

68. Detailed life-story books help children to explore and understand their experiences and identities. Life-story work is completed by qualified and experienced family support workers who know the children and birth family. This provides an informative picture of the child’s history and family, with clear and sensitive explanations of the reasons why they are not living with their birth parents. Social workers who know the children well prepare sufficiently detailed later-life letters that in the future will help the child to understand their history. The letters include clear and factual information about their birth family and their life before adoption.

69. Family finding is good, and it focuses well on making sure that children are found the best family to meet their needs as soon as possible. The use of national and regional search systems, in collaboration with voluntary adoption agencies and other authorities as part of a regional consortium, is
comprehensive. As a result, matching of children and young people to potential adopters is progressed without unnecessary delay, in most cases.

70. There has been just one revocation of an adoption order and only one child who has had a disrupted adoption in the past five years. The local authority recognises that any revocations or disruptions have a negative impact on children and their families, which further delays the child’s ability to attach to their permanent family.

71. The current recruitment strategy targets adopters who can prioritise the needs of older children, children who have additional needs and groups of brothers and sisters. Recruitment policy, materials and practice reflect the positive views of the adopters who met with inspectors, that the local authority is inclusive in its approach to applicants from diverse groups, for example minority ethnic groups and same-sex couples. Monthly adoption recruitment meetings are received well by potential adopters due to the clarity of information and the inclusion of experienced adopters to explain the process of adoption and to share their experiences.

72. Effective use of a consortium approach to early identification of ‘fostering to adopt’ carers ensures that this permanency option is embedded well in the authority, and 11 children have been placed for adoption through concurrent planning in the past five years. The adoption team is focused on increasing the numbers of ‘fostering to adopt’ carers, as the benefits for the child in attaching to a permanent carer are recognised.

73. The adoption panel has a suitably experienced, qualified and sufficiently independent chair, with a wide range of appropriate lay members and health and legal representatives. There is a strong user perspective from adopters, which provides the panel with suitably diverse viewpoints and experiences. The panel meets approximately every three weeks to minimise delay for children. Meeting minutes demonstrate well-considered, informed decisions and challenges, which help to protect children’s best interests. Recommendations following adoption medicals are reviewed to sufficient depth, and further clarity is sought, if required, to ensure that proposed matches of children to adopters are secure. As well as detailing the work undertaken by the panel, the chair’s six-monthly adoption report gives helpful feedback regarding the quality of assessments and social work practice. Quality assurance provided by the agency adviser ensures that the papers presented to panel are of a high quality, in order to minimise delays in decision-making. The agency decision-maker carefully considers panel decisions in a timely way, and the rationale for his decision is clearly recorded.

74. Post-adoption support is provided to all families that have experienced adoption, which includes families that have adopted elsewhere and come to live in the city. During 2015–16, 48 families were being supported, with a total of 67 children being assisted with additional resources. Several examples of
sensitive support to birth families were also seen by inspectors. Decision-making regarding ongoing contact with children post-adoption and the support options available are discussed with adopters and birth parents.

75. The progress of detailed and analytical adoption support applications is closely monitored by the adoption team manager, who has built up a body of knowledge regarding preferred providers for bespoke counselling, specific therapy and training.

76. Support after adoption was seen by all the adopters whom inspectors met as highly positive, and several examples of effective support were cited. Adopters all said that they would recommend York as an adoption agency, because of the realism, support and ability of the workers to manage expectations and anxieties.

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

77. As a corporate parent, the local authority has high aspirations for its care leavers. Effective systems are in place for care leavers to access support when they need it. Pathway support workers are skilled in building strong relationships with care leavers, and work hard to engage and support them. They know the young people well and have a good understanding of their individual needs and circumstances.

78. Social workers and pathway workers have manageable caseloads and, as a result, keep in touch with all of their of care leavers. Young people spoken to by inspectors reported feeling safe in their accommodation and knowing where to seek support if they require it. They also receive effective advice and guidance about health issues, including substance misuse, sexual health and pregnancy support. As a result, they are aware of how to access extended health services.

79. The pathway team is well aware of the risks facing young people, such as offending, alcohol and substance misuse. The team has received a range of training, such as on the issue of child sexual exploitation, including how to use the risk assessment tool and guidance on information-sharing pathways. Pathway workers use their knowledge well in being vigilant to helping to keep young people safe by developing and extending their understanding of personal safety. Care leavers’ individual pathway plans reflect strategies to minimise such risks.

80. Pathway support workers liaise closely with children’s social workers to ensure a smooth transition for young people moving to the leaving care service. This enables them to build up an early and positive relationship with the young person. For care leavers who have a disability and those who require adult
social care, transition planning begins soon after their 16th birthdays, thereby reducing uncertainty and anxiety for young people and ensuring that they continue to be supported effectively.

81. The physical health needs of care leavers are appropriately addressed within their individual pathway plans. Examples were seen by inspectors of young people independently accessing local medical services, such as general practitioners, opticians and dental services, and many had gym membership. However, pathway plans do not focus on how care leavers’ well-being and mental health needs are to be addressed. Care leavers do not have records of their health information. Although there are plans to provide care leavers with access to their health histories early in 2017, few young people are aware of this plan. In addition, care leavers spoken to by inspectors were unclear about how to access support for their emotional and mental health needs, and described loneliness and isolation as having the biggest impact on their emotional well-being.

82. Care leavers receive good support from carers and key workers to help to build up their skills to live independently, such as saving money, budgeting and cooking for themselves. A pathway life-skills toolkit has been developed to support carers and key workers in assessing the levels of help that care leavers need in their journeys towards independence. Care leavers in supported housing benefit from more personalised and incremental support that builds their life skills, resilience and confidence at a pace that enables them to cope with the challenges associated with a planned move towards independent living. Young people are encouraged to remain looked after until they are 18 years old, and they are supported to remain with their foster carers after their 18th birthdays. Currently, there are 11 care leavers supported by these arrangements.

83. Good partnership work between the virtual school, the pathways team and the Connexions service has ensured that the proportion of care leavers in education, employment or training is high, at 69%, compared to the England average (49%). Effective arrangements are in place to support those young people who are not in employment, employment or training (NEET).

84. The local authority has a clear focus on reducing the number of young people NEET further, and has very recently established two new initiatives to support those young people who are at risk of becoming NEET or who are difficult to engage. ‘Bright futures’, a local initiative funded by the careers and enterprise fund, jointly supported by a range of partners including the Connexions service, the Leeds City Region Local Enterprise and the York, North Yorkshire and East Riding Local Enterprise Partnership, seeks to provide young people with targeted information regarding career options and choices. A second initiative, the ‘Springboard project’, has very recently been established to support care leavers who are NEET with the skills needed to benefit from
structured learning opportunities. While it is too early to judge the effectiveness of either project, partnership working is strong.

85. Care leavers are encouraged to attend higher education, and 11% are supported in college. This is above the England rate of 6%. The nine care leavers subject to a custodial sentence are visited regularly to ensure that they have ongoing access to educational courses and training while in prison. Care leavers have preferential status and access, through a guaranteed interview scheme, to available apprenticeship vacancies within the local authority. However, few care leavers apply, and participation rates are low.

86. The ‘Show me that I still matter’ group is particularly proud of its achievements and the work completed through the ‘Aspire to more’ project, a national award-winning project undertaken in collaboration with Inspired Youth that celebrates care leavers’ experiences. The local authority celebrates young people’s success through annual awards. Care leavers use their voice well through the ‘Show me that I still matter’ group, to influence how the local authority responds to their needs. Young people said that they are well supported and feel that key workers listen carefully, record their views well and act on these. As a result, most are positive about the care and support that they receive.

87. The local authority has a range of suitable accommodation options for care leavers. A detailed sufficiency and placement commissioning strategy ensures that there is an understanding of the current and future placement needs of care leavers. A ‘staying put’ strategy has been adopted as the first choice for young people leaving care, if this best meets their needs. This is facilitated by the accommodation officer, who attends the review closest to the young person’s 16th birthdays to start planning for their leaving care.

88. Care leavers have the option to experience independence in a taster flat for four weeks and then to return to the foster care placement to plan for the move to a trainer flat, should they not wish to stay with their carer. Most care leavers (87%) live in suitable accommodation. This figure is affected by the nine young people who are in custody and one care leaver who is homeless, despite the local authority’s attempts to provide accommodation.

89. The pathway team maintains regular contact with those serving a custodial sentence so that appropriate plans can be made, ready for their release or until they reach their 21st birthdays.

90. There are no young people living in houses of multiple occupancy. A majority of care leavers live independently and successfully maintain their tenancies. Nine young people are at university and are supported to return to their foster care ‘staying put’ arrangements during holiday periods. There are two emergency accommodation options, ‘Night stop’ and ‘Crash pad’, which support care leavers at times of crisis. Every effort is made to support the
young person in their chosen accommodation. When there is a risk of the accommodation becoming unsuitable or the young person becoming homeless, a ‘second-chance meeting is quickly held. At this meeting, creative support packages are developed and discussed with the care leaver in order to meet their individual housing needs. Risk assessments are used well to inform decisions and actions.

91. Care leavers have a good understanding of their rights and responsibilities, including how to raise an issue or make a complaint about the quality of service that they receive. They have a good level of knowledge of what support they can expect from their carers, key workers and others, including advocacy. Care leavers stated that the local authority listens carefully, records their views well and acts on any concerns that they raise. Care leavers, for example, know that they can apply for a grant to assist them with the costs of setting up and furnishing their first home, while for those aged 16 to 18 a bursary is provided through their nominated college or training provider, underlining the importance of education and skills. Care leavers who enter higher education benefit from a bursary to support them, and their accommodation costs are met by the local authority.
Leadership, management and governance | Good

Summary

The DCS and the senior management team share a well-articulated vision of continuous improvement and progress for all children in York. A whole-service restructuring is taking place and is due to be completed by January 2017. This journey of change is beginning to effect improvements in outcomes for most children across the service. It is not yet complete, so the full impact of change cannot be seen for all children.

The chief executive leads a corporate commitment, supporting a shared vision to deliver better than good services to children and families. Strategic priorities for children are shared and aligned across a comprehensive governance structure across the multi-agency partnership. These priorities are translated well through effective planning across all strategic boards, including the YorOK Children’s Trust Board, the CYSCB and the HWB. Highly effective links with the CYSCB ensure that thresholds of need for children are agreed and understood at both operational and strategic levels. Senior managers have developed strong and sustained relationships with multi-agency partners. The voice of children and young people is integral to strategic and operational activity to ensure that intervention is purposeful and meaningful. The promotion of children’s views is embedded within the foundations of the local authority and partnership culture.

Leaders and managers know and understand the service well, including its strengths and areas of weakness. There are strong and highly effective links between the council and voluntary and community sector organisations. Relationships are based on good, honest communication and consultation. The local authority is a strong and effective corporate parent. A robust sufficiency and commissioning strategy is in place to meet current and future placement needs.

Workforce planning is effective. Staff are supported through a wide range of training opportunities, feel extremely well supported and are highly committed to their work. This has resulted in high retention rates and a reduction in the use of agency workers. Inspectors found that, while staff supervision is regular, there are weaknesses in the quality of supervision records and the oversight of frontline managers. Supervision is not driving forward positive change for some children. Audit activity is not consistently strong and does not provide managers with a clear understanding of the experience and progress of all children, and too many children experience delay in their needs being assessed and identified.
Inspection findings

92. Effective leadership by the DCS, senior leaders and elected members is demonstrated through strong and dynamic partnership working and a clear focus on priorities. There is a whole-council approach and commitment to keeping children safe and to helping them to thrive and develop. These priorities are translated well through effective planning across all strategic boards, including the YorOK Children’s Trust Board, the CYSCB and the HWB. Together, they are driving forward a clear vision and transformation plan to improve outcomes for children in York.

93. The strengths of this collaboration hold a common purpose, with the commitment of all partner agencies to working imaginatively in a climate of change and budget reductions. This includes a recent financial investment for children’s services by the council of £1.9m and £0.5 million in a new case management system. This includes the facility for all staff to access online revised protocols between children and adult services to ensure a smooth suitable transition for children requiring services into adulthood.

94. The chief executive ensures that strong governance arrangements with clear lines of accountability are in place for the discharge of statutory duties. There are highly effective links to the CYSCB, ensuring robust governance of the wider role of the multi-agency partnership in the planning and scrutiny of services. Additional support and challenge are provided from the learning, culture and scrutiny committee and the chief officer’s reference and advisory group. The DCS provides a consistent, effective presence on all strategic boards to ensure the prioritisation of children’s needs. An example of his positive impact is that, with support from the CYSCB chair, the DCS successfully obtained agreement from partners to extend the child sexual abuse awareness-raising campaign, ‘It’s not OK’.

95. The CYSCB chair provides appropriate and regular reports to the YorOK Trust Board and the DCS. This includes local safeguarding updates from focused CYSCB sub-groups and national statutory changes to support proactive planning for change. An inter-board protocol approved between the CYSCB, the HWB, the YorOK Trust Board, the Adult Safeguarding Board and the Safer York Partnership ensures clear lines of governance and accountability for crosscutting issues. For example, there are robust high-level multi-agency arrangements in place for the management of domestic abuse across agencies. A joint coordinating group across York and North Yorkshire County Council coordinates training, commissioning and information sharing, increasing staff confidence effectively to identify and respond to children’s needs.

96. This well-established governance structure has supported leaders and managers in the initiation of an ambitious vision of continuous improvement
for children. The most significant developments and change have occurred in the past 12 months, and this has included further service restructuring. Consequently, the full impact of this restructuring for all children is yet to be seen, although evidence thus far demonstrates that it has the right trajectory for further improvement.

97. The new electronic client management system was introduced in March 2016 with the introduction of a new social care recording system. The migration of data and children’s records are complete and are beginning to provide improved case management capabilities with better functionality and ease of use. While most staff and managers welcome this change, not all staff have confidence in the system yet. Inspectors found gaps in recording in children’s files and in staff supervision records, making it difficult to identify how some children were progressing and how supervision is consistently supporting and monitoring social work practice. In addition, some performance management functions are not yet fully supporting senior management oversight of practice. For example, audit activity is not consistently strong. The transitional migration of information has led to reduced audit activity, with only six of 25 audits completed between June and August 2016.

98. The restructuring of social work teams in September 2016 and the planned restructuring of early help into local area teams in January 2017 are beginning to create the foundations for positive change. The local authority recognised a need to further improve the delivery of early help interventions and the quality and timeliness of children’s assessments to improve how families are supported. Inspectors agree that there is a need to build workers’ skills, knowledge and confidence to improve the analysis in children’s assessments and the timeliness of their completion, and to ensure that they are proportionate to children’s needs.

99. The organisation promotes an open culture of learning to inform continuous improvement. The DCS invites internal and external scrutiny and challenge of frontline practice, engaging in reciprocal regional peer reviews. For example, in March 2016, the DCS invited the CYSCB chair to complete a peer challenge of the progress of the referral and assessment service. The transparency and requests for feedback to inform plans for change also extend to partners and staff. For example, all staff can access online information on up-to-date research and tools to support them with operational practice.

100. Multi-agency partnerships are a particular strength, and thresholds of need for children are agreed and understood at both operational and strategic levels. The early help strategy and threshold document is currently under review in preparation for the restructuring of early help services in January 2017. There is an expressed commitment to early help investment in new models of delivery to embrace a ‘whole family’ approach. The partnership ensures that there is a robust response to identifying and protecting children at risk of and subject to child sexual exploitation, including those who go missing from
home, care or education. Appropriate policies and procedures receive senior management oversight, and the expertise of the child sexual exploitation coordinator ensures that effective plans are in place to minimise risk to children.

101. Senior leaders are highly visible and accessible. They are aware of individual children for whom there is a high degree of risk or complexity. Inspectors identified a strong and tangible commitment to putting children at the heart of the strategy and delivery of services. This is demonstrated by children having a direct link to decision-makers and thereby influencing strategic plans. Managers continue to challenge themselves and partners to look at innovative and different ways to engage with all children of all ages and with different levels of need. Firmly embedded across the organisation is a dedication to listening to children and understanding their experiences to develop services that make a difference to their lives. A well-established voice and involvement strategy promotes a network of diverse youth groups, including the CiCC’s ‘Show me that I matter’ group, the care leaver’s ‘Show me that I still matter’ youth council and young inspectors.

102. Children’s services commissioning of activity at a strategic and delegated local level is effective, and receives scrutiny and oversight from the YorOK Trust Board and integrated commissioning board. Commissioning decisions follow a transparent review process, with close partnership working with the children’s rights and advocacy service.

103. The local authority is a strong and progressive corporate parent. A successful local sufficiency strategy supports operational practice, informing managers and workers of children’s needs, areas of current demand and projections for the future. This proactive response fully aligns with the ethos of the ‘Make York home’ strategy that is successfully increasing the numbers of children looked after who are remaining and returning to live in the city to improve their outcomes. Managers know the service area risks and capacity, and are actively planning for identified changes in the demographics of the foster care population. This includes recognition and promotion of increased numbers of children who remain living with their carers beyond the age of 18 years in ‘staying put’ arrangements and the ageing foster carer population.

104. An ambitious children and young people in care strategy 2016–2020 is driving forward six key strategic themes, including that ‘good is not good enough’. This demonstrates the concerted efforts by senior leaders and managers to obtain full political ownership of corporate parent responsibilities. The recent appointment of a new chair is already having a positive impact on the focus of the corporate parenting board’s responsibilities, including an ‘open door’ invitation to the CiCC’s ‘Show me that I matter’ group and recognition that care leavers’ needs should be a higher priority.
105. Evidence of early impact can be seen in the development of knowledge and skills in those professionals who have contact with children, to support the early identification and intervention of those children who have emerging emotional and mental health needs. This has led to innovative solutions, including emotional literacy support assistants and mental health well-being workers in schools.

106. A positive learning culture is demonstrated through a variety of methods. Senior managers, including heads of service, are included in a corporate training needs analysis process. There is a comprehensive learning and development offer for all practitioners and managers, including a specialist programme for children’s social care staff. The local authority is part of the University of York ‘Making research count’ consortium to undertake research, using the findings to develop and improve social work practice. An assessed and supported year in employment programme is in place for all newly qualified social workers. Experienced social workers are also actively encouraged to undertake the practice educator award delivered by the University of York.

107. Exploring lessons learned from serious case reviews is driven by the CYSCB and promoted through the YorOK Trust Board. Communication from the YorOK Trust Board is strong, with regular information and newsletters disseminated to frontline staff. Detailed and recent information on activities of the trust ensure that staff are aware of new initiatives and resources. This includes the launch of a neglect graded care profile in July 2016, and storyboards that include useful resources to support staff in working with children at risk of and subject to child sexual exploitation and those living in situations where there is domestic abuse. This provides workers with a consistent and shared knowledge of developments and promotes ownership of ambition for children within the organisation.

108. Staff have good access to a wide range of single- and multi-agency training. A comprehensive training, learning and development strategy extends to foster carers and providers. This includes a successful offer of a specialist-accredited trauma and attachment course developed with a local university. Carers report to inspectors that this training helps them to support the children whom they look after and improves their confidence.

109. Senior managers receive regular performance information on frontline operational practice through a revised comprehensive quality assurance framework. Snapshot scorecard data provide managers and senior leaders with a review of activity. The scorecards demonstrate when statutory timescales are met and when they are not. At the time of the inspection, 49% of children had not received a timely assessment of their needs. Senior managers had been aware of this deterioration over a six-month period and articulated that this was in part due to capacity issues prior to the restructuring and the poor performance of some frontline staff and managers.
The restructuring has begun to address some of these issues, and social workers now have small and manageable caseloads. This is evidencing more direct work with children, but is not yet impacting positively on the timeliness or quality of children’s assessments. (Recommendation)

110. Staff supervision is regular, although the performance scorecards do not provide detailed analysis or information on the quality of supervision. Inspectors saw variability in the quality of supervision records at all levels of the organisation. Records do not evidence how staff are challenged and supported to reflect on their practice or, importantly, how their interventions are impacting on children’s lives. This is a particular weakness in the supervision records of frontline social workers by their managers. (Recommendation)

111. Senior managers are progressing well an articulated vision of workforce requirements, which are seen as integral to the planning and restructuring of children’s services. Leaders know their workforce requirements and have had success in recruiting and retaining staff. This is reflected in the turnover of staff, which is low, at 1%, making the local authority a regional and national outlier. Staff spoken to by inspectors said that they felt valued, safe and supported. There are no agency staff in management posts at the time of inspection, and managers invest in staff progression, recognising that a skilled and confident workforce is crucial to supporting change and promoting good social work practice. A dedicated permanent principal social worker is a member of two of the CYSCB sub-groups, which ensures active oversight of operational practice links with developing future innovation projects, for example supporting managers and staff with the development of the rollout of the neglect graded care profile.

112. Senior managers endeavour to establish the right workforce with sufficient skills and knowledge to drive forward innovation and change. There is a willingness and commitment from staff at all levels and across the wider multi-agency partnership to achieve the vision to progress and improve outcomes for children. This is evidenced both in the imminent transition of early help arrangements to three multi-disciplinary teams across the city and the recent implementation of a multi-agency integrated assessment framework. The vast majority of key partners’ agencies have signed up to this model of assessment. Already, improved information sharing within single assessments is in evidence, although this is not yet leading to an improved analysis of children’s holistic needs. (Recommendation)

113. Despite an unsuccessful innovation bid to support new models of working to assess parent capacity to change, managers have not been prevented from tenaciously progressing this. Senior managers have a contingency plan for alternative project implementation with buy-in from agency partners to access alternative resources. There is a shared belief that this improvement will lead
to better assessment and analysis of risk and, ultimately, better than good plans to improve children’s outcomes sooner.

114. York’s willingness to explore, implement and adapt innovation models that meet local requirements includes implementation of the family drug and alcohol court pilot. This model is community based and developed around a pre-existing adult public health commissioned substance misuse service. Although the numbers of children who have a child protection plan in which substance misuse is identified as a significant factor are low, this continues to be a priority for partners in order to improve the life chances and experiences of these children.

115. There are strong, reciprocal working relationships between Cafcass and the local authority. The local authority actively participates and has representation on the family justice board. The local judiciary reports good compliance with timescales for children progressing through the PLO and that good-quality social work evidence is presented to the court, thus reducing the need for additional evidence or independent experts to be called.
The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is outstanding

Executive summary

The City of York Local Safeguarding Children Board (CYSCB) is outstanding. The independent chair is resolute in his leadership of the board. This has resulted in strong and highly effective multi-agency partnership working across the city. These partnerships are fundamental to the work of the CYSCB in sustaining the commitment to safeguarding children and in ensuring a focus on the strategic priorities. Governance arrangements are strong and highly effective. Challenge by the chief executive of the strategic leads and oversight of the work of the independent chair, through the chief officer’s reference and advisory group, ensures that the CYSCB is focused on its priorities and maintains an ambitious work programme.

Key to the success of the board is the explicit focus on understanding the perspectives of children and young people by asking for and listening to their views and, most importantly, acting on them. This ensures that the voice of the child is actively considered across all aspects of the board’s work and leads to improvements in the quality of practice.

The priorities of the board, aligned and underpinned by the work of the sub-groups, strengthen the effectiveness of partnership working. The priorities are rightly linked to the strategic priorities of the key partnerships and have a very clear focus on improving frontline practice and developing clear policies and procedures. Consequently, the board is highly instrumental in influencing and shaping services for children in York.

The priorities are further underpinned by an extensive and comprehensive learning and development programme. This is based on a detailed needs analysis, lessons learned and the outcomes of the well-embedded performance and quality assurance processes. A specific accomplishment of the board, in collaboration with a national charity and another local authority, facilitated by the chair, has been the ‘It’s not OK’ campaign, to raise awareness about child sexual abuse and exploitation. Performance monitoring and quality assurance arrangements are rigorous, with section 11 audits augmented by themed and multi-agency auditing programmes. In addition, the quality of performance data from the partnerships is comprehensive and is used well to reflect on outcomes and drive the work of the board, while contributing further to scrutiny and oversight.

The CYSCB annual report is an accurate and transparent overview and assessment of performance and it contains plans to progress further improvement.
Inspection findings – the Local Safeguarding Children Board

116. The CYSCB coordinates well the key partnerships to ensure the effectiveness of their safeguarding arrangements, and to focus on the critical priorities to improve and develop services to children further. The independent chair is highly effective and has been fundamental in developing the focus of the board and maintaining mature and challenging partnerships. The partnerships all contribute financially to the work of the board. Prudent financial management and planning have enabled the CYSCB to prioritise funding for key initiatives. When necessary, additional funding to support important areas of work, such as the implementation of multi-agency child sexual exploitation strategies and training, has been commissioned and secured from the local authority, police and the clinical commissioning group.

117. Membership of the board is robust, with partners who have sufficient seniority to hold their agencies to account. Attendance is good, membership is stable and there is a very strong commitment from members, including positive involvement of the lay member with close, highly effective working relationships, which ensure that progress is sustained. Representation of key partnerships across the board is highly influential in ensuring that key safeguarding issues and practice are disseminated. In particular, the representation from the police is commendable, with the chief constable as statutory board member, an assistant chief constable as chair of the partnership, practice scrutiny and review group (PPSRG) and other police representatives as active key members of sub-groups. Representation from education partners is extensive, including academies and independent schools. The representation by health partners is wide ranging and very strong.

118. The governance and effectiveness of the board are strengthened through the CYSCB independent chair’s membership of the chief officer’s reference and advisory group (CORAG), which meets regularly and includes the senior officers of the council, police and health partners. CORAG does not replace the statutory functions of the CYSCB, but ensures that there is a clear focus on keeping children safe, by ensuring that chief officers are aware of any issues and that they can use their authority to progress safeguarding issues swiftly across the partnerships.

119. The CYSCB chair also chairs the inter-board chairs’ group, which has a clear protocol between the City of York HWB and its sub-board, YorOK Children’s Trust Board, the CYSCB, the Safeguarding Adults Board and the Safer York partnership. As a consequence, the priorities of the board are clearly linked to the strategic objectives of the key partnerships to safeguard children.

120. Representation on the key strategic groups, highly effective governance, consistent and comprehensive reporting to the learning and culture policy and scrutiny committee of the local authority and regular engagement of the lead
member for children facilitate a strong culture of reciprocal challenge to and from the CYSCB partners.

121. The CYSCB is instrumental in shaping service development through its thematic priorities, linking to the work of the sub-groups. The thematic areas for priority are clearly set out in the comprehensive business plan. The priorities are early help, domestic abuse, neglect, child sexual abuse, exploitation and going missing.

122. The board demonstrates rigour and forward thinking through the inclusion of female genital mutilation as an additional priority. This is in recognition by the board that the known local incidence of female genital mutilation is very low and, consequently, it is especially important for the workforce to be very skilled in its identification and to respond to the practice. To augment and strengthen the role of the sub-groups in shaping services, the groups are instrumental in developing policies and procedures to support and improve frontline practice. Impact can be seen through the recent implementation of the graded care profile, which is raising social workers’ awareness of the impact of neglect. Evidence can be seen in children’s records and is articulated by social workers in practice discussion. Policies are shared through the priority, delivery and scrutiny group (PDSG) and signed off by the full board’s members.

123. The CYSCB has a strong focus on the quality of frontline practice to safeguard children. The business plan clearly highlights how the board focuses on frontline practice, recognising the critical importance of an effective referral and assessment process. The service is appraised annually by the independent chair of the CYSCB on the invitation of the DCS. The chair is keen to involve CYSCB members in this type of activity, to develop their understanding of frontline practice and to add rigour to this appraisal process. As a result, a recent visit has been undertaken by a CYSCB health representative to the referral and assessment team, to appraise the effectiveness of the health partnerships at the front door and to seek to identify any areas where practice needs to be improved.

124. The CYSCB chair is outward looking and has identified areas for further strengthening of the work of the board through increased focus on work with adult services. This is to ensure that adult services are aware of the impact on children of living with parents or carers who have mental illness, or have substance-misuse or alcohol-related difficulties. The CYSCB also recently had an external peer review, the findings of which will be actioned and contribute to further strengthening of the board’s activities.

125. Statutory board members have a comprehensive understanding of the priorities and expectations of them to ensure the effectiveness of safeguarding arrangements in their individual organisations. This commitment is demonstrated well through the strength of auditing and review processes.
126. The PPSRG is very effective in using auditing processes, including multi-agency auditing, to consider assurances of safeguarding, to evaluate the progress of the board priorities and to appraise frontline practice. These processes have identified areas of good practice and areas of development, and have influenced improvements. These have included the quality of minute taking, consistent attendance by professionals at children’s reviews and the recording of the voluntary accommodation of children according to section 20 of the Children Act 1989. Section 11 audits are undertaken routinely and are subject to scrutiny, challenge and moderation. There have been no particular themes arising from section 11 audits.

127. Multi-agency performance information provided to the board as performance scorecards is very comprehensive and is highly scrutinised. It is used effectively to consider trends, to direct the work of the sub-groups and partner agencies, and to inform the training needs analysis. Data is provided by a wide range of partners, including the police, the independent domestic abuse services, children’s services, education and health. The sub-groups of the board consider the data and provide commentary, which is then considered by the priority, delivery and scrutiny group (PDSG).

128. The PDSG is the central and vital operational arm of the CYSCB. The PDSG is highly effective in streamlining the work of the board sub-groups, providing challenge, monitoring progress and, importantly, ensuring that the work of the groups is shared across the partnerships effectively. The group uses data and analyses to highlight any areas of risk, learning and effectiveness, which are then taken forward to the full board meeting. As part of the commitment to improvement, the board has recently included a discrete focus on children who have a disability, through the use of specific scorecard information, to ensure that their specific needs are considered in all safeguarding matters. However, this approach is not yet fully embedded.

129. The CYSCB has a strong culture of learning. Analysis of learning needs is used well to inform the learning and improvement offer from the board. The learning needs analysis ensures effective planning and the use of available training and development resources. The learning needs analysis is based on priorities, serious case reviews and ‘lessons learned’ reviews, key findings from single- and multi-agency audits, outcomes from regulatory inspection activity and the evaluation of current training.

130. Training is evaluated both at the time of delivery and to establish what learning has been taken forward to improve practice. To ensure further that professionals are kept up to date, the CYSCB produces information in the form of a newsletter, which provides information on any new initiatives, relevant legislation and practice updates as well as easy-to-read ‘one minute guides’ jointly with North Yorkshire LSCB and child death overview panel (CDOP).
131. While York has not had a serious case review recently, the structure and governance arrangements of the CYSCB are highly effective in drawing out the key messages identified through ‘lessons learned’, single-agency and thematic reviews, and case file auditing. Arrangements for case reviews have been significantly strengthened. Following changes to the board structure in February 2016, the case review sub-group has increased its rigour with revised terms of reference. Most importantly, representation has improved, with the involvement of education, the mental health trust, police and the National Society for the Prevention of Cruelty to Children (NSPCC). Key messages and learning have also been taken forward from a child’s case of neglect, with an action plan in place and auditing processes to consider the effectiveness of the learning. The findings were shared effectively with the neglect sub-group to inform its work planning and the development of robust procedures.

132. Children’s voice is prominent in every aspect of the CYSCB’s work, and scrutiny of the local authority and partnerships. There is a dynamic voice and involvement group through which children’s views are promoted to help to drive improvements in the engagement of children and understanding of their experiences. For example, this includes views in child protection plans and improved recording of children’s views by the police in return home interviews, to provide a real focus on what is going on for children.

133. The annual report is a comprehensive, accurate and transparent overview and assessment of performance, with an understanding of the effectiveness of services. The report clearly highlights the key areas of practice across all agencies and the actions being taken by the board to address shortfalls.

134. Board members clearly understand their responsibilities with regard to ensuring that thresholds for child protection are well understood and applied. Clear guidance on thresholds is available across the partnerships and on the easily accessible and informative CYSCB website. The board, through the early help sub-group, is working proactively to review the current threshold guidance and procedures to ensure that they reflect changing structures in the authority and are more user friendly.

135. The CYSCB has an established and highly proactive sub-group for child sexual abuse and exploitation, the remit and scope of which include children who go missing. Clear, open and coordinated partnerships are well established. This enables the appropriate sharing of intelligence between partners to inform the understanding of risk and intervention. The sub-group receives high-quality comprehensive data, which is used to inform the strategic response of the board. There are clear, well-defined practice guidance and a locally agreed child sexual exploitation risk assessment tool to support referral, assessment and planning in relation to child sexual abuse and exploitation. Performance data and analysis from return home interviews with children who have been missing are used comprehensively to consider and coordinate work. The
group has also been proactive in promoting a multi-agency information sharing form, which is available to professionals to report intelligence about any activity that they have seen that potentially relates to child sexual abuse and/or exploitation.

136. The child sexual abuse, sexual exploitation and ‘missing’ sub-group brings together partners and has been extremely influential in raising the awareness and responses to child sexual abuse and exploitation across York. The ‘It’s not OK’ campaign has been highly effective in bringing together organisations across the city to raise awareness and to provide support and training to practitioners, parents and young people. This initiative was funded by the board and shaped by the partnerships. Outcomes have been very positive, for example, in raising both an awareness of risk indicators and the confidence of workers to respond to those risks. Most importantly, it has encouraged young people to speak out about any worries or concerns.

137. Arrangements to review and report on child deaths are comprehensive. The CDOP covers both North Yorkshire County Council and the City of York, and includes representatives from health, education, children’s services and the police. From January 2017, the panel will include a lay representative from the CYSCB to improve perspective and challenge. Recent reviews of child deaths in York have not highlighted specific themes. There have been some delays for reviews while awaiting some post-mortem outcomes. This has been a particular issue in one area, but the appointment of an additional pathologist should help to remedy the situation. A strength of the panel is its consistent membership and its influence on reviewing processes and improving practice. For example, it provides hospital practitioners with a resource box that includes the equipment that they need to respond quickly to child deaths and to gather essential information, and practitioners visit parents following reviews to provide feedback and, when appropriate, support.
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 whom it is trying to help, protect and look after.

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

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

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

The inspection team consisted of eight of Her Majesty’s Inspectors (HMI) and one Social Care Regulatory Inspector from Ofsted.

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