North Somerset

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

and

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

Inspection date: 12 June – 7 July 2017

Report published: 25 August 2017

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

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

Executive summary

A stable senior management team has made improvements in some services for children since the last inspection in 2012, when safeguarding services were judged to be adequate and those for looked after children good. However, services for children are not yet consistently good enough, and there are pockets of poor practice, which mean that children do not always get the help they need quickly enough.

Some recommendations from the last inspection in relation to making a single record of strategy meetings, and joint interviews of child witnesses, have not yet been consistently achieved. The local authority has a good level of awareness of the shortfalls identified by inspectors during this inspection, but the impact of the newly strengthened arrangements, including training provided to staff, has not demonstrated consistent improvements in the responses to children and their families.

The senior leadership team has worked purposefully to make a number of improvements across the service. However, the trajectory of improvement has been adversely affected by a number of barriers. Staff turnover, at all levels within the service, has contributed to delays in driving improvements to ensure consistently good-quality services for children. The pace of progress has been further hindered following a complex investigation into a whistleblowing allegation, which left partnership working fragile. Partners have re-established effective arrangements and are now focused on joint priorities to implement key strategies to improve outcomes for children in North Somerset.

The leadership team has introduced a culture of challenge and continuous learning. Staff report a good awareness of, and commitment to, the overall plan and the implementation of key improvements across the service. There is sustained financial investment and a clear political commitment to provide high-quality children's services. The workforce within North Somerset children's services has now stabilised, and caseloads are reported to be manageable.

Senior leaders' ability to ensure sustained improvement across the service is limited by the inconsistency of frontline management oversight of casework. While training and focus on this key area for development have been strengthened, key weaknesses in social work practice are not always identified in a timely way through effective and purposeful management scrutiny.

Senior leaders have ensured that the use and implementation of key performance information have been significantly strengthened. While there remains some variability by managers in the use of this information to drive improvement, the leadership team continues to ensure that systematic monitoring of performance is implemented, and this is beginning to contribute to more effective scrutiny of activity.

Quality assurance processes are beginning to contribute to identifiable improvements across the service. While audit activity is completed by senior managers at all levels, the overall impact of activity has been variable, and findings from audits have only recently been used effectively to inform staff training and improve practice.

The quality of practice is improving in some areas, such as the strengthening of early-help services, improved commissioning arrangements and the introduction of a new framework to assess risk and protective factors for children. A new edge-of-care service is beginning to improve outcomes for children and the Consult service provides highly effective in-house counselling and therapeutic services to children, young people and their carers. Services for children adopted and to care leavers are now consistently good.

Key areas for development remain in social work practice across the service, for example the variability in the quality of assessments of children's needs and child in need and protection plans. Return home interviews are also variable in quality and timeliness and are not sufficiently used to inform assessments of young people or to inform plans to reduce risk. Arrangements to investigate allegations of abuse by professionals working with children are not always sufficiently rigorous.

Advocacy services for children are not promoted effectively by social workers and do not sufficiently enable young people to articulate their wishes and feelings. Decisions to look after children are not always sufficiently timely or robust, and some children who have been exposed to neglect experience delay before becoming looked after.

Corporate parenting in North Somerset is a key strength. Elected members have high aspirations for children looked after and care leavers. This commitment is demonstrated by a range of initiatives, including the recent establishment of seven apprenticeships, financial support for educational courses and ongoing mentoring, as well as exemptions from council tax for care leavers.

Children and young people are actively encouraged to share their views on the effectiveness of the service. This level of engagement has contributed to tangible changes to services provided and to sensitive consideration of the needs of looked after children and care leavers.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of the local authority's safeguarding arrangements/ arrangements for the protection of children was in July 2012. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in July 2012. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since May 2010.
- The DCS is also responsible for adult services, public health and housing.
- The chief executive has been in post since November 2013.
- The chair of the LSCB has been in post since August 2010.
- The local authority commissions an edge-of-care service, using a social impact bond model.
- The local authority uses the Signs of Safety model of social work.

Children living in this area

- Approximately 42,616[3] children and young people under the age of 18 years live in North Somerset. This is 20.3% of the total population in the area.
- Approximately 12%[4] of the local authority's children are living in poverty.
- The proportion of children eligible for and claiming free school meals[5]:
  - in primary schools is 9% (the national average is 14%)
  - in secondary schools is 8% (the national average is 13%).
- Children and young people from minority ethnic groups account for 7% of all children living in the area, compared with 25% in the country as a whole[6].

[2] The local authority was given the opportunity to review this section of the report and has updated it with national validated data and/or local unvalidated data where this was available.
[3] Census mid-year estimates 2015, Office of National Statistics.
[4] Child poverty statistics 2014 *given before housing costs,* Office of National Statistics.
[5] DfE School and Pupil Number 2016
[6] Census 2011, Office of National Statistics.

- The largest minority ethnic groups of children and young people in the area are Other White and Asian/Asian British/Indian.
- The proportion of children and young people who speak English as an additional language[7]:
  - in primary schools is 5% (the national average is 20%)
  - in secondary schools is 4% (the national average is 16%).

Child protection in this area

- At 31 March 2017, 547 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 629 at 31 March 2016. This excludes children on a child protection plan, looked after children and care leavers.
- At 31 March 2017, 150 children and young people were the subject of a child protection plan. This is an increase from 128 at 31 March 2016.
- At 31 March 2017, one child lived in a privately arranged fostering placement. This is a decrease from two children at 31 March 2016.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted and four serious case reviews (SCRs) have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2017, 227 children were being looked after by the local authority (a rate of 52 per 10,000 children). This is an increase from 221 (52 per 10,000 children) at 31 March 2016. Of this number:
  - 87 (or 41%) live outside the local authority area, (which excludes adoptive placements)
  - 15 live in residential children's homes, of whom 93% live out of the authority area
  - one lives in a residential special school[8], which is out of the authority area
  - 184 live with foster families, of whom 38% live out of the authority area
  - four live with parents, of whom none lives out of the authority area
  - nine children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 14 adoptions

[7] DfE School and Pupil Number 2016
[8] These are residential special schools that look after children for 295 days or less per year.

- 12 children became subject of special guardianship orders
- 108 children ceased to be looked after, of whom 9% subsequently returned to be looked after
- six young people ceased to be looked after and moved on to independent living
- no young people that ceased to be looked after are now living in a house in multiple occupation.

Recommendations

1. Ensure that all contacts benefit from multi-agency checks, that decisions take account of previous history and that the need to gain consent is properly considered within the context of national information-sharing guidance.

2. Ensure that strategy discussions routinely include information from key partners, that they are used to inform assessment of risk and action planning and that a single multi-agency record is kept of each meeting.

3. Review the performance of the disabled children's team to ensure that it is adequately resourced and that staff are skilled and trained to respond to the needs of children.

4. Ensure that senior managers identify effectively local patterns and trends of children at high risk of sexual exploitation and that this contributes to robust disruption activity.

5. Review arrangements to manage allegations against professionals working with children to ensure that processes are overseen effectively and monitored, and that cases are progressed.

6. Strengthen the quality-assurance role of the child protection chairs and independent reviewing officers (IROs) to ensure that reviews and conferences result in effective information sharing and purposeful, timely plans for children.

7. Ensure that life-story work is completed for all children, including looked after children placed in long-term foster placements.

8. Put in place a system to ensure that initial health assessments for looked after children are completed in a timely manner, and that notifications from social workers to inform health colleagues that children have become looked after are timely.

9. Ensure that the agency decision-maker clearly records the rationale for decision-making in respect of adoption matches.

10. Work with partner organisations to offer specialist health services that more flexibly meet the needs of young people who have complex emotional needs made worse by substance misuse.

11. Ensure that staff are provided with regular, high-quality supervision to support and challenge practice.

12. Ensure the consistent use of performance data by frontline managers to improve practice across the service and aid early identification of weak performance.

Summary for children and young people

- Not all services for children in North Somerset are good. Some things have got better since the last inspection in 2012, but not all children get the right help quickly enough.
- When children first need help, there are a lot of good services in North Somerset, such as children centres, where they and their families can get help.
- Social workers make sure that children get help quickly when they need it urgently.
- Social workers don't always ask other people, like teachers or doctors, who know the children well, for information so that they can decide how best to help them.
- When children need help, social workers complete assessments, so they can think about how to help them. These assessments don't always take into account everything the social worker needs to know to make sure that children are given the right help.
- If children have plans to help them, professionals don't always make sure that things agreed in the plan are done quickly enough. Some children live in neglectful circumstances for too long without getting enough help.
- When children go missing from their home or school, they don't always have a chance to talk to an independent person about why they ran away.
- Some services help children a lot, such as the Consult service, which helps children with their emotional needs.
- Children aren't always able to speak to an independent person when they need help to explain to social workers their views or worries, or when they need help to make a complaint.
- Care leavers get on well with their personal advisers (PAs). PAs keep in touch with nearly all care leavers and help them with practical things like getting a driving licence or a passport.
- Managers don't always make sure that social workers do everything they need to do as quickly as they should.
- When children can't live with their birth families, social workers work hard to find adoptive families for them. Social workers help children to settle in with their new families and help their new parents to understand how to look after them.
- Children's views are listened to well by senior managers in North Somerset.
- Senior leaders understand well that it is their responsibility to make sure that all children are well cared for and have good life chances and high aspirations.
- Senior leaders and managers of North Somerset want to make sure that all children and their families get good help and support. They understand what they need to do to improve some services for children.

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

Summary

A comprehensive range of early-help services provides good support to children and their families when needs first emerge. Services are well targeted and coordinated to meet the specific needs of the community.

Responses to children requiring statutory intervention are not yet consistently good. A minority of children do not receive help as early as necessary. When immediate risks to children are identified, the response is timely and proportionate.

Social workers see children regularly and know them well. Good-quality direct work with children, and the engagement of their parents, enable social workers to gain a comprehensive understanding of children's experiences. Children's assessments and plans are improving overall but are variable in their quality. The disabled children's team is not consistently identifying or acting to address children's changing needs in a timely way. This means that some families are not receiving the right support to improve their circumstances.

Child protection enquiries are mostly thorough and robust. The majority of strategy meetings are timely and result in clear plans for children. However, in a small minority of cases, information is not always obtained from all key professionals, and a single record from each meeting is not created and shared. Social workers are not routinely involved in evidential interviews of children to inform safety planning. Initial child protection and review conferences are timely and well attended by agencies. The majority of conferences are effective in identifying risks to children and inform planning arrangements to reduce risk. While the impact of scrutiny by child protection chairs is developing, this is not yet routinely leading to improved practice to ensure better outcomes for children.

There are effective multi-agency arrangements in place to oversee and tackle activity in relation to sexual exploitation for individual children. However, scrutiny at senior management level to identify patterns or trends is limited. Arrangements for children who go missing are variable, and the quality and timeliness of return home interviews are inconsistent.

Very few children living in private fostering arrangements are identified, and awareness raising of private fostering thresholds is under-developed. Responses to homeless 16- and 17-year-olds are effective, and services are well developed. Arrangements to identify and investigate allegations of abuse against professionals are not sufficiently rigorous.

Inspection findings

13. Early-help services in North Somerset are a key strength. A wide variety of services are available, and families benefit from well-coordinated and responsive early-help services that are easily accessible in children's centres or located in libraries and health centres. Early-help professionals are skilled and successfully support families for whom domestic abuse, parental mental ill health and substance misuse issues feature, through the provision of both intensive and universal early-help interventions. Black and minority ethnic families and travelling communities have been particularly successfully engaged in early-help and targeted services.

14. The number of families receiving support from high-quality early-help services has steadily increased, and parents spoken with during the inspection highly value these services. However, the local authority has yet to systematically evaluate the impact of the early-help offer on meeting the needs of children and their families and preventing escalation to statutory services. The quality of early-help assessments and plans is variable.

15. Thresholds for statutory intervention are well embedded, understood and applied across the partnership. The inclusion of good-quality information from referring agencies effectively aids decision-making regarding the best course of action.

16. The emergency duty team responds effectively to the needs of children and families outside office hours. The team works closely with health colleagues and the police to ensure that children are protected immediately. Information is shared promptly with daytime staff.

17. Responses to children who need help and protection are not consistently good. The referral and assessment team undertakes all initial screening of concerns about children's welfare. Responses to referrals are prompt, but decisions are not routinely informed by historical information or multi-agency checks. In some cases, referrals are not accepted until parental consent is gained, and consequently children's needs are not assessed sufficiently swiftly. (Recommendation)

18. The majority of child protection enquiries are timely and robust and children's experiences are captured effectively to inform analysis of risk and planning. However, in a minority of cases, children are not seen, or are seen alone, and children's safety and welfare are not always ascertained within timescales that reflect the presenting concerns.

19. Well-established relationships with the police safeguarding unit ensure timely and appropriate initial decision-making to protect children, and outcomes are proportionate to levels of concern. However, the majority of strategy discussions do not sufficiently benefit from multi-agency contributions to

safeguarding discussions and planning. Joint investigations of child protection enquiries are not being undertaken in some cases. 'Achieving best evidence' interviews of children continue to be undertaken exclusively by the police, and delays in the sharing of information on the outcome of police investigations hamper decision-making and service provision to children. The local authority has continued to challenge this practice with strategic police leaders in an attempt to remedy this matter. (Recommendation)

20. Social workers in the children and families teams know their children well and undertake sensitive and creative direct work with them, which captures their lived experiences well. Inspectors observed highly effective social work interventions, particularly by newly qualified social workers, that are clearly leading to improved outcomes for children and their families. Parents spoken to were positive about the help they were receiving and the difference that this is making to their lives. Social workers are persistent in engaging families. They are successful in building resilience in family relationships and in re-engaging young people in education. Experienced family support workers provide both practical and therapeutic interventions. Creative support ensures that families receive the help they need and leads to real improvements in children's circumstances.

21. The quality of assessments is improving, and there is a focus on strengths and risks that results in appropriate services for families. However, assessments are not always sufficiently analytical or detailed to ensure that needs are fully understood, or updated when circumstances change, or completed in children's timescales. While chronologies are increasingly being completed, they are often difficult to follow and are not used as a tool to inform planning.

22. The quality of child in need and child protection plans is improving. Plans for children are mostly outcome focused and help families understand what needs to change and the consequence of not achieving this. However, too many plans do not include timescales for completion of actions, making it difficult to see whether progress has been made to reduce risk and achieve desired outcomes. The quality of contingency planning is variable.

23. The disabled children's team is not serving all children in need consistently well enough. The changing needs of children are not always identified or acted on in a timely way. Safeguarding responses to children who have disabilities are mostly robust and well coordinated. However, where families receive direct payments, the majority of plans seen by inspectors were not sufficiently comprehensive, and a minority of children in need have not been seen by a social worker regularly. As a result, families are not receiving timely support to improve parenting capacity and reduce the risk of family breakdown. The local authority recognises this area for development and is in the process of strengthening arrangements to support these children. (Recommendation)

24. The quality of supervision and management oversight is not yet consistently good. Staff are positive about management support and the availability of managers at all levels. However, supervision is not always regular or driving planning and reviewing overall progress. As a result, changes in children's circumstances are not fully explored, and, for a small number of children, this has led to drift and delay in taking action to meet their needs and to ensure that they are protected.

25. The independent reviewing service, which includes child protection chairs, is not yet monitoring outcomes effectively for children, or the performance of the local authority. The majority of disputes are resolved at an informal level, and high caseloads have had an impact on chairs' ability to monitor progress and identify whether risks are reducing and outcomes are achieved in a timely way. (Recommendation)

26. Despite staffing pressures, the IRO service has ensured that child protection conferences are timely. The majority of conferences are robust and consider needs and risks to inform planning effectively. However, chairs are not consistently applying categories of abuse to reflect the presenting concerns and, as a result, children's plans do not always actively address their family circumstances. Advocacy is not currently available to children involved in child protection processes and this is a missed opportunity to maximise the voice and experiences of children in the child protection process.

27. Operational multi-agency arrangements for overseeing and reviewing missing children are well established. A missing coordinator within the referral and assessment team tracks and records all missing episodes effectively. However, the collation of information gathered from individual episodes of missing is not yet sufficiently informing mapping locally. Return home interviews are not always timely or of sufficient quality to consistently identify changing risks or to inform safety planning. Recent strengthening of arrangements and staff training have not yet had a satisfactory impact on multi-agency coordination and responses to children missing from either home or care.

28. There are effective arrangements to identify and monitor children who are missing education. Good alternative provision is available, and the majority of children receive at least 25 hours of education per week. Children's progress and attainment are rigorously monitored, and a high number of children successfully return to mainstream school.

29. Arrangements to identify and support children at risk of sexual exploitation are mostly robust, timely and well coordinated. Social workers are skilled in recognising and responding to sexual exploitation, including changing risks. The recently introduced sexual exploitation risk assessment form is providing a comprehensive framework to ensure that social workers plan effectively for children and that risks are reducing.

30. While there is a variety of services and organisations to support families who are affected by domestic abuse, substance misuse and parental mental ill-health, current interventions for perpetrators of abuse are not sufficient to meet need. Partner agencies work well together to ensure that the children who are exposed to domestic violence are identified and assessed. Multi-agency risk assessment conferences arrangements are robust and well embedded. However, children and young people do not benefit from specific services to build resilience and to deal with their experiences of living with domestic abuse.

31. Arrangements to assess and meet the needs of 16- and 17-year old homeless young people are well understood. The majority of assessments are timely. Data is scrutinised on a monthly basis to identify patterns and trends; this is used to inform preventative service provision. Accommodation options are sufficient, and helpful counselling support and other services are available to young people.

32. Arrangements to promote and identify private fostering in North Somerset are extremely limited, and there have been no private fostering notifications in the last year. This means that the local authority and its partners cannot be confident that they are safeguarding effectively all children and young people who are living with adults to whom they are not related. (Recommendation)

33. Arrangements to identify and investigate allegations of abuse against professionals are not sufficiently rigorous. The designated officer service does not consistently track casework to ensure that investigations are well coordinated and responsive to the needs of the children. Allegations meetings are timely and well attended; however, action plans and case recording are not comprehensive and children's disclosures do not routinely inform planning. The role and function of the designated officer is well understood by key agencies, but further work is required to raise awareness across the wider partnership. (Recommendation)

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

Summary

Outcomes for children looked after in North Somerset require improvement to be good. Decisions to look after children are appropriate but not always timely, and a small minority of children experience drift and delay prior to coming into care. A new edge-of-care service has recently been introduced, but it is too early to identify the impact of this. No cases were found of children entering care unnecessarily.

Most social workers know their children well and visit them regularly, although the voice of the child is not always sufficiently evident on the case record. Support services to address the emotional health needs of looked after children are a key strength in North Somerset. The Consult service provides a range of valued support to carers and children. Support to unaccompanied asylum-seeking children and children who have a disability is well coordinated and child centred, and there are efforts made to promote their cultural and diversity needs effectively within placement. The virtual school offers effective support to ensure that the educational needs of children looked after are met and are monitored effectively. There is limited placement choice for older children who have complex needs. Recent recruitment campaigns have not yet been successful in increasing the pool of local carers.

Care plans vary in quality and are not always robust; weaker examples do not have clear timescales or contingency arrangements. There is limited direct work undertaken with children, and, while life-story work is well embedded for most children, there are very few life-story books for children in long-term foster care. Foster carers are well supported, but are not always provided with information about the children they care for in a timely way.

There is insufficient evidence of IRO challenge and scrutiny, especially in relation to placement stability and driving care planning for children effectively. Children's participation in service development is a strength and is evidenced by a clear, child-focused pledge, and the annual survey seeks, and acts on, children's views.

The local authority is in contact with almost all care leavers, and young people receive good care and support in relation to gaining education and training opportunities. For the very few care leavers with mental ill health and with a history of substance misuse, the provision of suitable, flexible accommodation and effective specialist health services does not meet their needs well enough.

Permanence through adoption is considered at an early stage and children are prepared well for their transition to their adoptive families. Adopters have access to a wide range of support services.

Inspection findings

34. Decisions to bring children into care are appropriate but not always timely. Children sometimes wait too long in neglectful situations and assessments of parental capacity to change are too optimistic. Services put in place are not always effective in reducing risk to children experiencing neglect. This can sometimes lead to drift and delay and missed opportunities to intervene earlier. In a small number of cases seen, the home situation deteriorated quickly following a step-down of support, which led to emergency, rather than planned, intervention to make children safe at a later date.

35. The local authority has worked hard to improve the timeliness of court proceedings, and over the last 12 months these have averaged 26.5 weeks. Assessments provided to the court are mostly detailed and thorough and provide a clear rationale for care thresholds. A dedicated case manager holds regular performance meetings to check on progress and oversees the Public Law Outline tracker. There is clear guidance available to social workers to assist in all aspects of court work, including the 'capacity to change' toolkit, developed in conjunction with Bristol University. However, these tools are not yet fully embedded across the service. The Children and Family Court Advisory and Support Service (Cafcass) reports that practice can be inconsistent, especially in relation to cases of neglect.

36. When children return home from care, the quality of care plans informing such decisions is inconsistent and some lack rigour. For some children, there is evidence of carefully balanced, therapeutic assessments of need prior to a return home. In recognition of these inconsistencies, the local authority has recently commissioned a new 'turning the tide' edge-of-care service, which has begun to work with 11 children and families in the last few weeks. While this service has the potential to help children to safely remain at home, through the provision of a range of intensive support, it is too soon to measure the impact of this service on children.

37. Viability assessments of children's family members provide a clear analysis of the suitability of connected carers and the nature of support required. However, diversity needs are not always explored fully in the assessment, which leads to uncertainty regarding the capacity of connected carers to meet a child's cultural and ethnicity needs. Support is available to those carers who go on to secure a special guardianship order, via a dedicated kinship support team, and there is access to in-house psychological support and parenting training.

38. Children are mostly seen regularly by their social worker. In most cases, social workers know their children well and are able to clearly articulate the wishes, feelings and experiences of children. However, this is not always well reflected in case records. Some records of visits to children are too brief and task focused and contain limited commentary about the child's wishes and feelings. Advocacy for children looked after is not promoted effectively and, although there is a system for children to access an advocate, very few children do so.

39. Arrangements to support children missing from care are not sufficiently robust. Return home interviews are not routinely completed or purposeful, and many contain only limited information, which does not sufficiently inform risk-reduction measures as part of care planning in a timely way. The early identification and coordination of services to support looked after children at risk of sexual exploitation is effective. Sexual exploitation risk assessment forms are completed appropriately for looked after children and robustly inform planning.

40. Health assessments for children are not always timely, and performance has declined in the last 12 months. The designated nurse is working hard to ensure that the timeliness of both initial and review health assessments improves. Recently introduced tracking mechanisms are just beginning to make improvements. Social workers are not notifying health colleagues that children have become looked after, and this has further compounded delays in health assessment timeliness. (Recommendation)

41. The local authority has taken positive action to sustain an in-house psychological support service. The Consult service works with children following a referral to the improving outcomes panel. Support is available to children and their carers via a range of therapeutic approaches, training and groups for mindfulness and other topics. Staff and foster carers value this service highly. The local authority is in the process of implementing plans to help foster carers to further develop therapeutic skills to work with traumatised children.

42. Most children who are looked after achieve and make good progress at school. Attendance at school is good and in line with that in similar authorities. Slightly more absences are authorised than in similar authorities, or in the England average, while the number of absences defined as persistent is below these comparators. There have been no children permanently excluded in the current year. The gap in achievement between children who are looked after and their peers in the early years of education (key stage 1 and key stage 2) is narrower than in similar authorities. By GCSE stage (key stage 4), the gap is wider but still below that of similar authorities.

43. Children who are looked after attend good education in North Somerset. Children who do not attend school full time access at least 25 hours a week of

alternative education, or they are closely monitored while such provision is arranged.

44. Headteachers champion the importance of providing children who are looked after with stability in their education, and work well together to avoid unnecessary moves between schools. When children would benefit from a period of time in alternative provision, headteachers work very supportively through the 'out of school panel', chaired by the head of the virtual school, to determine the best outcome for the child.

45. The virtual school functions effectively in its role of monitoring the attendance and progress at school and alternative provision of looked after children and of overseeing improvement where necessary. Children are monitored closely for signs of bullying or discriminatory behaviour shown towards them by other pupils.

46. After a sharp rise in the number of children whose parents elected to educate their children at home, the numbers have stabilised. The authority maintains regular contact with families and provides good transitional arrangements for those who choose to re-enrol their children in school.

47. In a minority of cases, schools have reportedly not been well supported by social workers to help children. Headteachers report that social workers sometimes fail to attend personal education plan meetings. As part of its role, the virtual school has been supporting training for teachers and social workers to adopt the new electronic personal education plan (ePEP). The ePEP is used effectively to track and monitor the educational achievements of children looked after. Despite significant training provided by the local authority, headteachers have not found this training to be sufficient to enable them to adopt best practice in using the new system or to provide opportunities for designated teachers and social workers to benefit from training together. The local authority recognises that more work needs to be done to ensure that the ePEP is successfully established and to improve the quality of target setting in ePEPs to ensure that they are appropriately specific, measurable and time bound.

48. Unaccompanied asylum-seeking children are well supported by social workers, who have the relevant experience and expertise to assess their wide-ranging needs. Although these children are not always living in foster placements that culturally match their heritage or background, clear plans are in place to ensure that their cultural, health and educational needs are met.

49. The majority of children looked after who have disabilities are supported effectively by care and other services that are well matched to their individual needs. There is a good variety of support services available for children and their carers, including a range of activities throughout the school holidays, evenings and weekends. The transition from children's to adult services is well

managed, and adult services staff attend relevant meetings after the child's 17th birthday.

50. Most children who are looked after live in foster homes, either in the local authority or within a 20-mile radius. This means that children have the opportunity to grow up in family settings close to their community, and the local authority works hard to promote contact for children with friends and family, including for those children living out of the area.

51. Placement stability for children looked after in North Somerset is improving overall. While placements for teenagers who have complex needs are limited, the local authority is striving to recruit foster carers to meet this demand. The local authority has put in place a new fostering strategy in recognition of the need to recruit more foster carers to meet demand. However, there has been limited progress to recruit more carers at this time, and this remains a significant challenge for the local authority.

52. A permanence policy is not fully embedded across the service, and a new matching matrix is helping some, but not all, children awaiting a match. This means that some children wait too long to be matched with permanent foster carers.

53. While there is age-appropriate life-story work undertaken with children in foster care or living with family members, not all children understand why they are looked after, or why they have moved on to live with different carers. This is a missed opportunity to help many children to make sense of their history and to support better outcomes, and the local authority has already recognised this as an area for development. (Recommendation)

54. Children mostly live with their brothers and sisters in safe, secure homes where their needs are well met. Children's attachments are analysed in detailed 'together and apart' sibling assessments, and these inform care planning and contact decisions. There is evidence that delegated authority decisions are discussed and recorded on the case record.

55. The quality of care plans is not always robust; they often lack detail and do not consistently include clear timescales or contingency arrangements. Reviews of children's care plans are not always timely, and the quality of recording is variable. Social workers' reports to the review meetings are not of a consistently good quality. There is insufficient evidence of IRO challenge and scrutiny, especially in relation to permanence decisions for children in long-term foster placements. Some IROs reported that they prefer to resolve issues informally and, as such, there is minimal use of the dispute resolution protocol. The manager has recently implemented a new 'quality assurance alert' system, but this is not used consistently. This means that the IRO's review of the child's care plan is not consistently influencing improvements in

care planning. Children's participation in their reviews is good, and meetings are kept small to encourage their attendance. (Recommendation)

56. Foster carers and connected carers are well supported and provided with a range of training opportunities. However, foster carers reported that they are not always provided with information about children prior to placement, and that children's social workers are inconsistently responsive to their requests for information. The fostering panel operates on a frequent basis, but does not always offer sufficient rigour or balance in the minutes of meetings to ensure that the rationale for decisions is fully understood.

57. The local authority is striving to be child focused and to shape its services in response to the wishes and views of children in its care. The annual 'Bright Spot' survey is an effective mechanism for communicating with children, and it has led to new initiatives, such as the 'document and keep safe boxes' for all children coming into care. The materials in the boxes are helpful, informative and relevant for children.

58. The Children in Care Council (CiCC) is not as well established for younger children as it is for care leavers. The Unite group (18 years and above) is coordinated and vocal and has led on a number of developments, such as the information leaflet for care leavers. The younger group, Ambitious Voice, has struggled to build its membership. While some children are regular attenders and contribute consistently, the group is very small and not fully representative of all children. The local authority is aware of this and has plans in place to forge closer links with a number of groups set up to address children's emotional well-being, in order to build the CiCC's membership and to develop a stronger profile. The local authority is, however, well informed of the views of younger children looked after through feedback from the Bright Spots survey, which has an excellent response rate.

The graded judgement for adoption performance is that it is good

59. The North Somerset adoption and permanence team is ambitious for children and makes determined efforts to achieve permanence through adoption for all children who need it. Adoption is considered by the second statutory review for all children who cannot be cared for by their birth family. In the last year, 14 children have been adopted. This includes older children, brothers and sisters together and children who have complex needs and disabilities. No children have had their adoption decision reversed in the last year.

60. Overall performance in relation to the timeliness of adoption is improving. Its success in finding placements for older children, brothers and sisters together and placements for disabled children, which are very positive outcomes for these children has, however, had a negative impact on its overall performance data.

61. Social workers and managers know their children well. They track all of those children awaiting permanence. Social workers have promptly referred the majority of the 13 children currently awaiting a match to a full range of regional and national links. Good use is also made of adoption exchange days and adoption activity days, resulting in adoptive families being identified for the majority of children without delay.

62. The arrangements for recruitment and preparation of adopters are thorough. A comprehensive preparation course provides adopters with a good understanding of the needs of adopted children. Newly approved adopters spoken to during the inspection felt that the emphasis on attachment and PACE (playfulness, acceptance, curiosity and empathy) techniques has prepared them well for their adoption journey.

63. Foster to adopt is actively promoted, with prospective adopters having to 'opt out', rather than 'opt in'. Of the eight sets of potential adopters currently being assessed, half are seeking dual approvals for fostering and adoption.

64. Assessments of potential adopters are good and are undertaken in a timely way and in line with national requirements. Assessments comprehensively reflect the adopter's history, motivation, capacity to adopt and their practical and emotional circumstances. This enables the adoption panel and agency decision-maker to make informed decisions about approvals.

65. Child permanence reports are of a mixed quality. Managers are aware of the need to improve the consistency and quality of reports, and have taken recent action to improve these.

66. Overall, matching is effective, and a particular strength is a meeting that takes place between every adopter, the medical adviser and a clinical psychologist prior to a match. This meeting informs the creation of relevant and individualised adoption support plans. There has only been one adoption disruption in the last year. The low number of disruptions highlights the effectiveness of matching processes and support services.

67. The adoption panel is well established and has members from a range of different backgrounds and with a range of different skills. Panel minutes demonstrate scrutiny and appropriate challenge. While the agency decision-maker's minutes regarding adoption plans demonstrate appropriate scrutiny, the rationale for decisions in relation to matches is less clearly recorded. The minutes fail to show what documents have been considered and they do not clearly explain the reason for the life-long and life-changing matching decisions made for children. (Recommendation)

68. Adopted children benefit from well-assessed, meaningful contact with birth family members. A dedicated social worker facilitates and promotes letterbox

contact, enabling children to benefit from receiving letters from their birth family that will add meaning and value to their lives.

69. Social workers use a range of tools to help children to prepare for their move to their adoptive family. Beautifully presented life-story books, written in child-friendly language, alongside lots of photographs, bring children's histories to life. All adopted children also receive a later-life letter, which is extremely detailed and written for an older audience.

70. Adoption support is a strength. The North Somerset adoption and permanence team provides an effective range of support for children and their parents. This includes a sitting service, support groups for adopters, children and young people, therapeutic parenting programmes, individual therapy, school holiday activities and play schemes and celebration events. Adopters spoken to during the inspection were unanimous in their praise of the support they have received, describing how the non-judgemental, 'can-do' and extremely supportive approach of their social workers has made a significant difference to their and their children's quality of life. Good use is made of the adoption support fund, ensuring that families who require specialist support receive it. Birth parents also have access to appropriate counselling and support and are routinely signposted and referred to this.

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

71. Care leavers in North Somerset are well supported by an experienced team of PAs who are committed to meeting the young people's needs. The local authority is currently supporting 121 care leavers, while 12 care leavers have been supported to remain with their foster carers. A further six young people are currently in custody, but are well supported and monitored by PAs and other key professionals. PAs visit young people regularly, plan effectively to meet their needs and ensure that preparation for independence is robust and that young people experience a smooth transition to adulthood.

72. The authority is very successful at keeping in touch with care leavers until they are at least 21 years old. PAs are in touch with almost all those young people who left care in the last five years. Many young people regularly visit the attractive and welcoming base room set aside for their use in the town hall. Young people value highly the care and support they receive from their PAs and the practical support they are given with basic needs, such as food. PAs know the care leavers they are in contact with well, and work effectively to support them to understand the impact of their life choices and to ensure that they reduce the risk of potential harm that they are exposed to. Care leavers who are parents, or expectant parents, benefit from the introduction of volunteer peer mentors who work alongside their PAs.

73. The progression coach provides a mentor role for care leavers and holds a weekly employment search 'surgery' in the base room, which young people attend well and value highly.

74. The vast majority of care leavers have an up-to-date and robust pathway plan that includes their health history, records of national insurance numbers, birth certificates and passport applications. Plans are sufficiently detailed, and the best include a detailed review of previous targets and information about whether they have been fully or partially achieved. A minority of weaker plans do not include a robust review of measurable outcomes, and in these examples targets are repeated. An audit of the quality of pathway plans completed in January of this year was thorough and appropriately self-critical and resulted in strengthened arrangements to ensure that plans for care leavers are measurable and outcome focused.

75. Support for care leavers to take up education or training opportunities, such as apprenticeships or university places, is very good. The local authority funds vacation and term-time accommodation, and young people are paid an annual bursary. Additionally, care leavers receive a one-off payment to buy books or a laptop and software, and receive financial assistance with travel if needed. Young people taking up an apprenticeship do not have to pay council tax. The authority currently employs 12 apprentices and has recently confirmed the appointment of a further seven, all of whom are care leavers. The number of care leavers who are not in employment, education or training is slowly declining from a high rate at the end of 2016.

76. The care leaving team helps its young people to celebrate their achievements by running an annual celebration event and 'care leaver of the month' awards. Young people requested that this annual celebration took place outside the town hall last year, and the team enabled this to happen. The young people responded very well to this expression of trust and respect.

77. Young people leaving care understand their entitlements well and speak very highly of the help that they receive from their PAs. Young people particularly value the support they receive to access gym membership, passport applications, driving tests and benefit claims. A care leavers' forum has been established by a former care leaver, in conjunction with staff at the care leavers' service. This group is both energetic and actively engaged in service development, such as the redesign of the leaflet that explains entitlements to care leavers. Young people said that this updated version is very clear and helpful.

78. The financial impact on care leavers who live in supported housing and take up employment instead of living on benefits is a disincentive to seeking employment. Young people are safe and feel safe in supported accommodation and are understandably reluctant to move out until they are ready. The authority has been slow to roll out the accredited programme it

helped to design, which is intended to encourage and enable young people to develop the practical and emotional skills needed to move on into unsupported accommodation.

79. The range, type and locations of suitable accommodation are not sufficiently extensive to meet the needs or wishes of those care leavers who have the most complex support needs. The authority knows this from the report it commissioned in January 2017 and is exploring inventive ways of trying to resolve the matter. Overall, there is enough accommodation and young people said that the authority is quick to place them, but that occasionally the placement breaks down because they are not ready for the move. The use of bed and breakfast accommodation has significantly decreased and is now only rarely used, in emergency circumstances. However, the local authority recognises the need to cease the use of bed and breakfast accommodation, as this is an inappropriate placement for vulnerable young people.

80. While a number of services are in place for care leavers who have mental ill health, coupled with a history of substance misuse, the provision of help and support by health services does not consistently meet their needs. PAs and the designated nurse for children who are looked after support these most vulnerable young people well. Outreach services are provided in some cases, however, and group work takes place at a local centre that is used by clients of all ages, some of whom have extreme drug dependency and can display challenging behaviour. This inevitably deters some young people from seeking this help. (Recommendation)

Leadership, management and governance	Requires improvement to be good

Summary

Senior managers, elected members and partner agencies are committed to improving outcomes for children and demonstrate understanding of their roles. Recently strengthened partnership working is leading to improved delivery of services. Senior managers are well aware of the strengths and weaknesses of children's services, having identified and taken action on many of the deficits seen in this inspection. However, action taken to address areas for development identified in the last inspection in 2012 have not resulted in consistent and sustained improvements in some key areas. The local authority recognises that more work is needed to ensure that practice is consistently good.

Supervision and management oversight are not sufficiently helping to raise practice standards or ensure timely progression of children's plans. The IRO's quality assurance role, while developing, is not yet effective in driving the improvement of casework to improve outcomes for children.

Strategic arrangements to safeguard children and young people who go missing or who are at risk of sexual exploitation are improving. However, scrutiny of potential disruption activity is limited, as, despite a robust initial response, subsequent key activities, such as return home interviews and support to all children at lower levels of risk, are inconsistent.

Senior leaders and partners have implemented a comprehensive and well-resourced early-help offer to enable children and families to receive the right level of support, when they first need it. Services to children who are adopted and to care leavers have been prioritised effectively and are now good. The authority has established an effective initial response to children and families in need of services, through its front door arrangements. However, not all social work practice is as effective as it should be, so not all children receive a timely response.

The scrutiny and use of performance information have been reinforced in North Somerset and are now beginning to have a positive impact on outcomes for children. Quality assurance arrangements and audit activity are improving and these are contributing to the improved quality of social work across the service.

The workforce is increasingly stable as a result of the implementation of a well-considered workforce and recruitment strategy. Many social work staff are relatively inexperienced, so the provision of high-quality staff development is a key priority.

Inspection findings

81. The senior management team in North Somerset has a clear vision for improvement across children's services. The local authority knows and understands the strengths and weaknesses of the frontline services. Senior leaders have recognised most of the areas of deficit identified in this inspection and have already started improvement actions. However, significant challenges remain, as not all children are receiving a good enough service. While some improvements have been made in the services offered to children and families, these are not yet sufficiently widespread or embedded. Some areas for development, identified at the last inspection in 2012, have not yet been implemented or sustained. The pace of change in the local authority has been adversely affected by staff turnover and variability in the use of performance information and quality of management oversight.

82. Improvements have been made and strengthened arrangements are in place to respond to children in need of help and protection. The edge-of-care service has been reinforced, services to care leavers and adoption services are now good and partnership working is now better established. Responses to children at risk of sexual exploitation are improving at strategic and operational levels, although the local authority recognises that this needs consolidating.

83. Senior managers and political leaders demonstrate a strong commitment to external scrutiny and challenge. Investigations into a significant whistleblowing concern, while rigorous, had a detrimental impact on the quality of partnership working. This, in turn, delayed the pace of improvement in the authority. Leaders in North Somerset have since worked hard to repair relationships, to develop a learning organisation and to embed a culture of openness and transparency, with the intention of driving and sustaining improvements across the service. Research projects, such as the, 'Your life, your care' survey, conducted with a local university and a national charity, involving young people in care, have resulted in improvements in services for children in care and care leavers. However, the lead member is not fully aware of the variability in the quality of frontline practice, and this limits the effectiveness of challenge and scrutiny to improve outcomes for children.

84. The children's joint strategic needs analysis (JSNA) provides a comprehensive summary of the issues and services for vulnerable children in North Somerset and is used to inform commissioning arrangements effectively. The JSNA is used to inform the work of the Health and Wellbeing Board (HWB), and these are well aligned and set out local priorities for children in North Somerset.

85. Appropriate and clear governance arrangements between key strategic bodies are overseen and coordinated by the HWB, which is chaired by the leader of the council. These recent arrangements combine much of the work undertaken previously by a series of boards and partnerships, and this

strengthens the support for plans progressing and holding partners to account.

86. While the early-help offer is comprehensive, and there is a wide range of appropriate services available for children and young people in all age ranges, not all services are evaluated effectively by the local authority. As a result, senior managers are unable to fully assess the impact of these preventative services on outcomes for children.

87. Arrangements to identify and respond to individual children at risk of sexual exploitation have been strengthened and continue to be a key priority for senior leaders. However, senior management scrutiny of those children most at risk is limited, and intelligence about this group of children is not being used effectively to track and disrupt perpetrators. While the local authority has recently undertaken a recommissioning process to increase the availability of intervention services to children at risk of sexual exploitation, work with taxi drivers and hoteliers has yet to be fully completed.

88. The local authority has further strengthened the corporate parenting arrangements, and corporate parenting is well embedded and energetically pursued across the partnership. Effective arrangements are in place to ensure that children looked after are prioritised and the local authority is ambitious in the pursuit of opportunities for children in North Somerset. The local authority now offers a comparatively high number of apprenticeship opportunities and provides relief on council tax to care leavers.

89. The views of children looked after and care leavers are routinely gathered and considered by the local authority, and this is a key strength in North Somerset. The Children in Care Council (CiCC) is an active group of young people, and their views are shared effectively with senior leaders, leading to improved outcomes for children looked after and care leavers. Feedback has resulted in creative improvements that looked after children and care leavers have identified as important to improving their lives.

90. The use of performance information has recently been strengthened and now includes a robust suite of data. Managers at all levels do not yet use this information consistently. While some managers use this information effectively, others do not use data systematically to analyse and improve performance. For example, the timeliness of assessments and frequency of visits to children are not robustly scrutinised by all managers. (Recommendation)

91. Quality assurance arrangements are improving but are not yet ensuring that all children receive a good-quality service. Managers at all levels, including the DCS, audit children's case files. The monthly thematic audit cycle is well supported by a clear methodology, and this auditing programme contributes significantly to senior management oversight of specific cases. Audit findings

are well identified, learning is disseminated effectively to staff and findings are used to identify key training priorities for staff. However, the quality assurance function of the independent reviewing officers is underdeveloped and not yet contributing to addressing drift and delay for some children. The IRO annual report has been considered by the LSCB executive meeting members and Children's Champion Group. However, the IRO service has not submitted an annual report to the LSCB, and this has therefore affected the LSCB's ability to monitor the effectiveness of frontline practice and outcomes for children.

92. Management oversight in North Somerset is inconsistent. Frontline managers do not consistently identify weaknesses in casework or challenge drift and delay. There is a lack of focus, particularly in relation to the timeliness of assessments and on influencing the progression of plans for children. While most social workers are supervised regularly and feel well supported, the quality of supervision records is variable. Some good examples were seen of reflective and analytical supervision notes, but weaker examples lack sufficient detail and do not reflect the quality of supervision that is reported by social workers to take place. Senior managers are aware of these ongoing weaknesses but have made insufficient progress in dealing with them. (Recommendation)

93. Workforce development is a key priority for senior leaders. The training programme is comprehensive and wide ranging, and the impact of improved training opportunities is beginning to contribute to improving practice standards. However, the evaluation of training events is not yet sufficiently robust.

94. The principal social worker is committed to ensuring that improvements within social work practice are made, sustained and monitored effectively and reviewed. The principal social worker delivers regular training programmes, easily accessible to social workers. Best-practice standards are disseminated effectively. This scrutiny and oversight, coupled with consistent training and monthly newsletters, are starting to drive improvements in practice.

95. A well-targeted and effective staff recruitment framework has contributed to an increasingly stable workforce. Key messages from the annual staff survey are used by senior leaders to inform decision-making regarding service development and to identify key learning needs across the workforce. The local authority has significantly reduced the use of agency staff over the last year, and a high proportion of the remaining agency staff have now been in post for a considerable period of time. As a result, social worker turnover rates are reducing and are now at 14%. Eighteen new social workers have joined the local authority in the last 12 months.

96. Caseloads are reported by social workers and managers to be manageable. A very small number of social workers in specific teams carry a higher number of children's cases, but there are clear plans in place to reduce these to an

acceptable level, and managers monitor these cases closely. There is a comprehensive support package for newly qualified social workers, which includes dedicated support from consultant social workers, regular workshops and a supportive newly qualified social worker peer system.

97. Commissioning arrangements and sufficiency strategies are clear, but these are not yet resulting in sufficient choice of placements for some looked after children, particularly teenagers. The quality of independent placement provision is overseen by the assistant director, and key partners scrutinise effectively the quality and standard of provision provided. Inspectors saw how this quality assurance mechanism has improved the outcomes for individual children by, for example, reducing the use of residential units, by matching skilled foster placements to specific young people.

98. The complaints process in North Somerset has been strengthened and is now effective. Senior managers collate and disseminate well any learning from complaints, and this has contributed, for example, to improvements within the IRO service as well as to the introduction of advocacy services to child protection processes. A newly designed complaints leaflet for children is in the process of being introduced to ensure that children are easily able to access the complaints process and share their experiences.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The LSCB in North Somerset is inadequate. It does not fully understand the experiences of children locally and therefore does not always identify where improvements can be made.

A comprehensive dataset is not available to assist the board in monitoring and evaluating frontline practice or holding partners to account. Important performance information, such as annual IRO reports, has not been presented to the board, and the first private fostering report has only recently been presented. This means that the board has not been aware of activity in these areas of work and, therefore, it has not held partners to account or focused attention on service improvement. Despite some challenge by the chair, there is a reliance on board members to report information to the board as it arises. This means that the board is not sufficiently proactive in investigating and understanding local practice.

There is a developing system in place for the board to assure itself that all recommendations from multi-agency audits are being progressed, or that practice has improved. Similarly, there are no single-agency audits regularly reported, or a system in place for the board to assure itself that partners are examining their own practice robustly.

The board has an effective learning and development framework, and a range of multi-agency training courses is available for partners. However, there has been no complete training needs analysis conducted and there is limited evaluation of the quality, availability and take-up of single-agency training. Evaluation of training courses requires further strengthening to show learning and practice improvement.

The annual report does not provide a thorough and robust assessment of the performance and effectiveness of local services.

The board has been effective in developing multi-agency arrangements regarding sexual exploitation and missing. However, arrangements to train taxi drivers and hoteliers have been too slow, and planned work has not yet started.

The child death overview panel (CDOP) and SCR sub-group are well run and effective. The SCR, 'Holly', has been widely publicised and has contributed to the board's work to revise and monitor thresholds. A refreshed threshold document, improved training and a neglect strategy and toolkit are now available. The young people's subgroup is an emerging strength of the board, and young people are directly involved in the work of the board.

Recommendations

99. Ensure that a comprehensive dataset is developed in order for the board to monitor and challenge partners regarding safeguarding performance and to measure outcomes against its business priorities.

100. Ensure that the board requests and receives annual reports from a range of partners in order to scrutinise practice and hold partners to account.

101. Ensure that the business manager is sufficiently resourced to meet the needs of the board.

102. Ensure that a full training needs analysis is completed and that the quality, availability and take-up of single-agency training are monitored. Ensure that methods are developed to evaluate all training courses over time.

103. Develop a system to report on single-agency audits and ensure that recommendations from all audits are tracked to ensure partners' compliance and improved practice.

104. Develop reporting arrangements to the board following recommendations of section 11 audits and widen their reach to encompass community, leisure and faith groups.

Inspection findings – the Local Safeguarding Children Board

105. The LSCB in North Somerset is inadequate. Despite evidence of a great deal of board activity, it is often difficult to discern the impact that this is having on the help, protection and care of children. The LSCB does not fully understand the experiences of children locally and therefore does not always identify where improvements can be made. Lack of dedicated hours for the business manager, who covers several other managerial roles within the local authority, has not assisted in the board's effectiveness. (Recommendation)

106. Partner agencies are well represented on the board. An executive group, made up of senior leaders and the sub-group chairs, meets quarterly and ensures that progress is made against board priorities. The lead member sits as a participating observer and two lay members ensure that the voice of the local community is heard. Board members participate in other boards and partnerships, and there is an expectation that this crossover will ensure alignment of priorities. Governance arrangements are weakened by the fact that the DCS acts as the board's vice-chair, and this dilutes the level of independent challenge of performance and impact of practice on children. The DCS sits on the HWB, and the LSCB chair is also the Adult Safeguarding Board

chair. The chair has been proactive in ensuring a more joined-up approach to safeguarding arrangements, and some sub-groups, such as sexual exploitation/missing, are now jointly organised between children and adult boards. Terms of reference for sub-group members set out roles and expectations, but attendance at some sub-groups has not always been consistent and has led to challenge from the chair.

107. A comprehensive dataset is not available to assist the board in monitoring and evaluating frontline practice. Information obtained is weighted towards the local authority, lacks sufficient detail and is inconsistently recorded from one month to the next. The numerous gaps include insufficient data regarding child protection cases, children's health, education, workforce profile, children who have disabilities, private fostering and staff training. The chair is ineffective in challenging partners to improve the volume and quality of data, but currently the LSCB does not have an accurate understanding of services and trends in order to fully monitor service provision or hold partners to account. (Recommendation)

108. Although the board receives reports and presentations, there have been some omissions of important performance information. For example, annual IRO reports and information from child protection chairs have not been presented to the board, meaning that the board is unaware of whether key meetings and reviews are happening on time, of whether children and families are participating, of the level of multi-agency involvement or of how practice concerns are being addressed. The first private fostering report has only recently been compiled and presented to the board, and therefore there has been a lack of urgency in holding partners to account for awareness raising and activity to improve the quality of the response to children living in such arrangements. Some areas of work are not comprehensively reported to the board annually, such as children's complaints or the work of Cafcass, and there is a reliance on board members to provide feedback that they regard as significant from their own agency. This means that the board is not being sufficiently proactive in investigating and understanding local practice. (Recommendation)

109. The early-help sub-group has worked effectively to raise the profile of early help and to develop services. Work to develop the triage system as part of the 'One Front Door' is leading to better analysis and swifter identification of need by early-help coordinators. The sub-group recognises that more needs to be done to increase early-help involvement in schools and, therefore, has deployed schools' ambassadors to work with staff and designated teachers to promote awareness and to consider potential crisis points, such as school transitions. An early-help dashboard is not enabling the board to systematically evaluate the effectiveness of early-help services to children and their families. (Recommendation)

110. The board has provided a robust response to raise awareness and develop multi-agency arrangements regarding sexual exploitation and missing. The sub-group has become a joint children and adult group in recognition that the safeguarding needs of care leavers and those of vulnerable adults both require scrutiny. Strategies, guidance, action plans and practitioner tools, such as risk assessments, have been developed, following a child sexual exploitation audit in 2016. Sexual exploitation/missing remains as a business priority in recognition that more needs to be done. Work with the licensing team to train taxi drivers has been slow, and planned work with hoteliers has not yet started.

111. Although there is a comprehensive learning and development framework, more needs to be done to ensure that practice improvements are made and sustained. There is no complete training needs analysis for all partners, or information regarding the quality, availability or take-up of single-agency training. There is a wide range of multi-agency training courses available, but the training evaluations designed to measure impact at four months are not being completed. There are no alternative measures being consistently used in order to demonstrate how learning or practice has improved. (Recommendation)

112. Recent audits on domestic abuse and child sexual exploitation reflect the board's business priorities, and at the time of the inspection an early-help audit was just being finalised. Audits are collated in two parts, regarding children (subjects) and then practitioners' knowledge and understanding of the audit theme. Audits seen during the inspection did not provide clear messages from children regarding the practice or services received, and there was no feedback from parents or carers. Although there is evidence that some recommendations from audits are being progressed, there is no robust mechanism in place for the board to track whether partners are acting on recommendations or that practice has improved. Similarly, there is no regular reporting of single-agency audits or a system in place for the board to assure itself that partners are examining their own practice robustly. (Recommendation)

113. The LSCB works with other Local Safeguarding Children Boards to conduct section 11 audits, and work is under way to develop peer challenge workshops. A section 11 report from 2016 highlights the strengths and weaknesses found in North Somerset, but board minutes do not reflect how these findings have been addressed. The board has yet to reach out to faith, community and leisure organisations to conduct similar audits. The board is working on section 175 returns from early years providers, schools and colleges regarding safeguarding arrangements. (Recommendation)

114. The LSCB annual report does not provide a comprehensive assessment of the performance and effectiveness of local services. There is insufficient information in some areas, such as audit findings. It is over-reliant on sub-

group reports, which vary in quality, and overall it is too descriptive and fails to illustrate the difference made by the board. The LSCB recognises the deficits in the recent report and has devised a new template to improve quality in future.

115. The board has demonstrated some effective work in monitoring thresholds. An audit presented in 2016 showed that there was confusion regarding the early-help process, and work from this has led to the early-help triage process. The published SCR, 'Holly', brought further scrutiny of thresholds and has led to a refreshed threshold document and the introduction of a neglect strategy and toolkit. The board has monitored the SCR action plan effectively, and an action plan from health has resulted in improved safeguarding arrangements. For example, health visitors and general practitioners (GPs) are meeting at least monthly to discuss families of concern and are now able to use a shared electronic recording system. Training since the SCR has been bolstered to include more information on neglect, and a further threshold audit planned for 2018 will ensure that the board monitors progress over time.

116. Decision-making in response to potential SCRs is swift and effective, as the SCR sub-group meets as a panel bi-monthly to consider whether cases reach the SCR criteria. Actions from the last published SCR, 'Holly', have been monitored and completed by the board. Training and learning have been widely disseminated and are included on the LSCB website, and this has led to improved practice and outcomes for children in some areas.

117. The CDOP arrangements covering North Somerset and three other local authorities are strong. Agencies work well together on the panel and all provide relevant information regarding child deaths. The CDOP annual report provides clear information regarding numbers of deaths, themes and actions taken. Suicides of young people using bunk bed slats to hang themselves have been taken up with the Royal Society for the Prevention of Accidents, and the panel has worked with local planning departments regarding the proximity of roads and pathways, following a cyclist being knocked from her bicycle.

118. The recent development of a young people's sub-group is an emerging strength of the board. Young people, aged 16 to 18 years, have made presentations to the board on concerns such as online safety, have developed promotional materials and are working on improvements to the LSCB website. The group has developed its own priorities, such as anti-bullying, internet safety and the accessibility of policies and procedures in schools, particularly for pupils who have learning difficulties. Its work is assisting the board in developing priorities that matter to young people and ensuring that their voice is heard at all board activity.

Information about this inspection

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

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

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

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

The inspection team

Lead inspector: Emmy Tomsett

Deputy lead inspector: Joy Howick

Team inspectors: Lorna Schlechte, Rachel Griffiths, Karen Wareing, Nick Gladfield, Nicola Bennett

Senior data analyst: Matthew King

Quality assurance manager: Janet Fraser

Any complaints about the inspection or the report should be made following the procedures set out in the guidance 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.gov.uk/government/publications/complaints-about-ofsted. If you would like Ofsted to send you a copy of the guidance, please telephone 0300123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding and child protection.

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

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

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

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