Nottingham 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 board[1]

Inspection date: 11 March 2014 – 2 April 2014

Report published: 14 May 2014

The overall judgement is **requires improvement**.

There are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help and care for children, young people and families.

It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

1. Children who need help and protection		**Requires improvement**
2. Children looked after and achieving permanence		**Requires improvement**
	2.1 Adoption performance	**Requires improvement**
	2.2 Experiences and progress of care leavers	**Requires improvement**
3. Leadership, management and governance		**Requires improvement**

The effectiveness of the Local Safeguarding Children Board (LSCB) **requires improvement**.

The LSCB is not yet demonstrating the characteristics of 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 Inspection 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.

Contents

Section 1: the local authority

Summary of key findings

This local authority requires improvement and is not yet good because

1. Common assessments are of variable quality. Some are good and include the voice of the child but others contain insufficient detail.

2. In a minority of cases seen, the escalation process was not utilised effectively to ensure that disagreements about the level of support children receive was resolved. This occurred within children's social care as well as between community-based teams and children's social care. This meant that children's needs remained unassessed and/or unaddressed during the period of dispute.

3. At the time of inspection 89 children assessed as being in need of statutory services were awaiting allocation to a social worker. These children are actively monitored and visited, but a small minority of the children's files sampled identified children who have needs that are likely to escalate unless they receive an appropriate service promptly.

4. Some children experience poor quality assessments and weak plans. In a small minority of children's files seen, there was drift in the child's plan and in their progress.

5. Drift in children's plans is exacerbated by a lack of robust challenge or escalation by the child protection conference chairs. The chairs have caseloads which are too high and this limits their capacity to use their independent oversight of children's progress to effect change.

6. The high caseloads of the child protection conference chairs limit their overall contribution to quality assurance in children's social care, for example in undertaking themed audits of casework.

7. Some children and young people's assessments and plans make insufficient reference to their personal characteristics such as their ethnicity, disability, sexual orientation and culture.

8. The 'consultation forum' is valued by social workers, but its impact has not been formally evaluated so its effect on planning for children is not clear.

9. Many plans for children and young people are not measurable and lack clear outcomes. They often consist of a list of tasks, some with no clear timescales. A small number of plans are significantly out of date, and when the plan for the child is considered by a core group or review conference they are not routinely updated. Poor planning is also a feature of looked after children's case files. The lack of thorough plans makes it difficult to monitor and review the progress made by children and young people, and makes it difficult for the child's

advocate and/or independent reviewing officer (IRO) to challenge slow or insufficient progress. This has led to delay for some children and young people in having their needs fully met.

10. Chronologies are of variable quality and the majority need updating.

11. In a minority of cases children's records are duplicated to their brother(s) and sister(s) records unedited. In these cases the record does not show that each child has a personalised assessment of need and a plan to meet those needs.

12. The electronic recording system and its templates do not support good social work recording practice. The dual recording systems run slowly and contribute to considerable amounts of wasted time, delays in uploading documents and frustration for staff and managers in children's social care. Having dual systems makes it difficult to see the full picture in relation to a child/young person and their progress, and increases the likelihood of missing key documents when undertaking a review of the child's history and current circumstances. The poor quality of these arrangements encourages workers to find alternative methods of recording work, which is stored elsewhere. As recording takes a disproportionate amount of social work time, this reduces the time available for direct work with children and their families.

13. In a small minority of cases seen, the local authority could have taken more decisive action earlier, which would have reduced the length of time children experienced neglect.

14. When children and young people become looked after, health assessments are not always carried out quickly enough and health care plans are not always present on their files or kept up to date.

15. The educational attainment of looked after children and young people is variable. Attendance at school has shown an improving trend, but during this academic year absenteeism has risen.

16. Fewer looked after children of secondary school age make the progress expected of them than those of primary school age. Attainment of children at ages 7 and 11 years is below that of the national average. The attainment gap between looked after children and the rest has narrowed, but too many 16 to 18 year olds do not participate in any kind of education, training or employment.

17. The quality of planning children's learning varies considerably.

18. The use of data and information to track the progress of looked after children and young people is underdeveloped. There are no arrangements in place to alert the virtual school at an early stage when children begin to experience problems in their education. Activity only takes place at the point of crisis rather than at the point of preventing concerns escalating. The virtual school ceases to monitor young people after the age of 16.

19. Foster carers are not always provided with all the available information about a child when they first come to live with them.

20. Looked after children and young people are not routinely seen by Independent Reviewing Officers (IROs) between reviews. IRO caseloads are too high and this is affecting the quality of the service they can offer.

21. The records of assessments and plans to support children returning home are not always present in their files and this makes it difficult to see how well they do once they have returned home.

22. Minutes and decisions of review meetings are not always completed in a timely manner or present on children's files. All meetings chaired by IROs should have a minute taker, but inspectors saw instances when this did not happen. Delays in minutes being written up by the centralised administration unit are common and means that minutes are not distributed promptly to all those who have a role in supporting the child.

23. The actions decided at children and young people's reviews lack specificity and timescales so the local authority cannot be sure that drift and delay does not occur for some children.

24. Children placed externally do not always have education and health resources available immediately upon placement. Providers are not always supplied with key documents about the child or young person when they are first placed.

25. Social work records of visits describe the progress looked after children and young people make and what needs to change to improve things for them, but care plans are not routinely updated and agreed in line with changes. The care plan is not regarded as the key document which summarises the child's circumstances and clearly sets out the arrangements to ensure that their needs are met.

26. Foster carers' files do not contain all the information they should in line with the Fostering Service (England) Regulations 2011.

27. The fostering and adoption services have benefitted from recent robust action to improve their impact and quality, but there is more to do to ensure that there is sufficient technical knowledge and expertise within both aspects of the service to maintain and strengthen this recent improvement.

28. In the majority of cases seen there was some delay in progressing plans for adoption. Delays are often built in at an early stage, with family finding not being started quickly enough. Adoption is ruled out too readily for a small minority of young children.

29. Insufficient use is made of parallel or concurrent planning to reduce delays in children achieving permanence.

30. The quality of prospective adopter assessments which are undertaken by a commissioned independent social work provider is variable.

31. Not all adopted children and their families have packages of support appropriate to their needs. The referral pathway and criteria for support are unclear and some requests are not being responded to in a timely way.

32. Many pathway plans for care leavers are too long, lack analysis and are not sufficiently outcome focused. Some young people do not see the point of their plan.

33. Too few care leavers have the opportunity to continue living with their foster carers after the age of 18 years.

34. Too many care leavers are not in education, employment or training.

35. Young people are not routinely provided with or have access to their full health history.

36. Recent organisational changes and turnover of staff means that a minority of children and young people have experienced too many changes of social worker. This has impacted on effective relationship building and their plans being progressed in a timely way.

37. A minority of social workers have been supervised by their manager too infrequently and experienced changes of managers. Records of supervision show little evidence of reflection about casework practice.

38. A minority of newly qualified social workers are not benefitting from an external mentor or protected caseloads.

39. Although social workers report that their caseloads are manageable, they have risen recently and, for a minority of staff, they are higher than the local authority's preferred maximum.

40. Performance management information and quality assurance relies too much on measuring outputs rather than the quality of service or outcomes for children.

41. Quality assurance is under-developed. Audits are not being used systematically across all areas and information from audits is not being aggregated effectively.

The local authority has the following strengths

42. There is a good range of effective early help services which children and their families benefit from and can access easily.

43. The quality of information sharing at the Locality Allocation Panels is good and ensures that children and families receive help appropriate to their needs.

44. Arrangements for professionals and members of the public to refer children where they have a concern are robust.

45. The Children and Families Direct service, which takes all initial enquiries, responds promptly, undertakes good assessments, refers on to appropriate services, including children's social care, and has good access to expert social work advice.

46. Increasing numbers of practitioners are using the local authority's preferred model of assessing and responding to children's needs – the 'Signs of Safety' model. This is increasingly leading to a shared language and shared understanding of risk and protective factors. Parents report understanding the model and it helping them to understand why people are concerned and what they need to do to reduce concerns.

47. Children educated at home are safeguarded, receive an appropriate education, and their numbers are reducing because of prompt action.

48. Domestic abuse incidents are assessed by a multi-disciplinary dedicated team which ensures that children at most risk are identified and protected.

49. Social workers have access to a regular multi-disciplinary 'consultation forum' which enables them to discuss children whose progress feels 'stuck'. They describe good outcomes from this.

50. Children who go missing from home, care and/or education, and those at risk of sexual exploitation are identified and tracked, to ensure that they receive appropriate services to reduce risks. The police officer co-located with other staff that support children in care has a positive impact on early identification of young people most at risk, enabling interventions to be put in place to help them quickly.

51. Only those children who need to become looked after do so. Those children at high risk of becoming looked after receive intensive support services, which keep the family together and improve outcomes for the child/young person.

52. Good use is made of legal proceedings to secure permanent long-term plans for children and young people and the time to get to a final hearing continues to reduce, which means that children's plans can progress more swiftly.

53. The full range of permanency options for children is considered by the local authority, which makes good use of Special Guardianship Orders; an increasing number of children are being adopted year on year.

54. The newly established team of adoption placement advisors, combined with a new marketing strategy, is leading to more inquiries and more families for children. Some children who have been waiting a long time have now been found adoptive families including older children, children with complex needs, and brother and sister groups.

55. Looked after children and young people who have emotional or mental health difficulties are able to have specialist mental health assessments and services quickly. This includes children and young people who are placed outside the local authority area.

56. The commissioning team undertakes unannounced visits to all external residential providers each year, which adds to the robust quality assurance of external provision.

57. A high number of care leavers are in suitable accommodation and the strong partnership between the local authority and Nottingham City Homes has increased the availability of suitable accommodation, including more in-house semi-independent units. Young people report that they feel safe where they live and have good support if they have any concerns.

58. The local authority's apprenticeship programme is small but effective and has resulted in some care leavers gaining permanent employment with the authority.

59. An increasing number of care leavers are being supported to go to university.

60. Care leavers are helped to live independently when it is right for them. When this does not work out, they receive prompt support and can return to more supported accommodation until they are ready to move on.

61. The multi-agency transition team supports disabled young people throughout the transition from children's services to adult services' support. Support continues until the care package is fully established.

62. The links and governance framework between strategic partners are well developed. There are clear links between One Nottingham, the Children's Partnership Board, the Health and Well-being Board, Nottingham City Safeguarding Children's Board (NCSCB) and the Corporate Parenting Board with robust reporting arrangements in place.

63. The Chief Executive has good oversight of the work of the NCSCB. The Lead Member for children and families understands the service pressures well and champions the needs of children and young people effectively.

64. The local authority has a detailed understanding of its local communities and uses this information to target resources where they are needed the most. Commissioning activity is needs-led and evidence-based.

What does the local authority need to improve?

Priority and immediate action

65. The inspection did not find any areas for priority and immediate action.

Areas for improvement

66. Ensure that there is sufficient capacity in the social care workforce to deliver effective and high quality social work and other statutory services to children and young people. In particular, that the caseloads of social workers and IROs are manageable and allow them to undertake their statutory duties to a high standard.

67. Ensure that all social workers receive regular, high quality, reflective supervision that provides the right level of critical challenge and support.

68. Ensure that all newly qualified social workers receive regular, high quality supervision and mentoring support, including protected caseloads.

69. Ensure that the electronic recording system is fit for purpose, works sufficiently fast, and that it supports social workers and managers in their primary tasks of improving outcomes for children.

70. Ensure that there is sufficient business support for the social work service so that meetings are minuted well, promptly uploaded and distributed swiftly. This applies to child protection arrangements as well as services for looked after children.

71. Develop a child-focused approach to care planning so that plans are specific and measurable, ascribe tasks clearly, and specify the desired outcomes for the child.

72. Clarify which circumstances should lead to updating a child's assessment, and how managers should oversee this to ensure that they are sufficiently comprehensive and take account of all relevant information.

73. Develop a quality assurance process for common assessments that measures impact as well as content, and ensures that they capture the voice of the child. Reviews of common assessments should be clearly recorded and retained with the child's other records.

74. Ensure that IROs/child protection co-ordinators have the capacity to provide sufficient challenge to improve plans and avoid drift and delay for children and young people. This is relevant for child protection arrangements as well as services for looked after children.

75. Improve the quality of written records so that they are personal to the child, contain good quality chronologies, and make clear the purpose and effectiveness of direct work with children and families.

76. Improve the quality of care plans for looked after children so that they cover all of a child or young person's needs, are specific about roles and responsibilities, and are updated as necessary.

77. Improve arrangements for those children who are placed outside the city to speed up their access to health and education services.

78. Ensure that there is an effective strategy to support the education of looked after children, including extending the remit and capacity of the virtual school.

79. Ensure that carers and providers are given the fullest possible information about a child when they are placed, including essential key documents.

80. When plans are made for children and young people to return home, ensure that the plan is informed by a full assessment of the child's circumstances and the plan sets out how the child and their family will be supported.

81. Ensure that children and young people are fully involved in decisions about where they are going to live when they need to move.

82. Increase the range of local authority foster carers to enable more children from bigger families to remain together, and for children in care to be looked after by families from similar backgrounds.

83. Ensure that foster carers' files contain all the documents required under statutory regulations.

84. Ensure that concurrent and parallel planning is embedded into care planning for children to ensure that the best outcomes are achieved without delay.

85. Ensure that family finding for children begins as soon as possible following a decision that it is in their best interest to be adopted.

86. Ensure that the needs of all adopted children and their families who request support are assessed promptly and, where appropriate, provided with packages of support.

87. Develop and embed the arrangements for 'fostering to adopt'.

88. Increase the number of care leavers engaged in education, training or employment.

89. Ensure that all care leavers are able to remain with their foster carers beyond the age of 18 where it is in their best interests to do so.

90. Ensure that service and business plans are outcome-focused and measurable. Senior managers should enable the workforce to understand key priorities and the action required by them and their managers to meet those priorities.

91. Develop a comprehensive performance management and quality assurance framework that focuses on outcomes as well as outputs and improves the experiences of children, young people and families.

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 who it is trying to help, protect and look after.

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

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

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

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

The inspection team

Lead inspector: Sheena Doyle

Team inspectors: Nigel Parkes, Pauline Turner, Carolyn Spray, Susan Myers, Hilary Crossley, Jon Bowman and Tina Shepherd.

Information about this local authority area[2]

Children living in this area

- Approximately 62,394 children and young people under the age of 18 years live in Nottingham City. This is 20.4% of the total population in the area.
- Approximately 35% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 32.3% (the national average is 18%)
  - in secondary schools is 29.8% (the national average is 15%)
- Children and young people from minority ethnic groups account for 45.9% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Pakistani, Black Caribbean, and White and Black Caribbean.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 28.0% (the national average is 18%).
  - in secondary schools is 23.4% (the national average is 14%).

Child protection in this area

- At 31 March 2014, 2,713 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,207 at 31 March 2013.
- At 31 March 2014, 479 children and young people were the subject of a child protection plan. This is an increase from 440 at 31 March 2013.
- At 31 March 2014, 14 children lived in a privately arranged fostering placement. This is a reduction from 16 at 31 March 2013.

Children looked after in this area

- At 31 March 2014, 584 children are being looked after by the local authority (a rate of 93 per 10,000 children). This is an increase from 561 (89 per 10,000 children) at 31 March 2013. Of this number:
  - 334 (or 57%) live outside the local authority area

[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.

- 74 live in residential children's homes, of whom 56% live out of the authority area
- six live in residential special schools and all are out of the authority area
- 415 live with foster families, of whom 65% live out of the authority area
- five live with parents
- seven children are unaccompanied asylum-seeking children.

- In the last 12 months:
  - there have been 42 adoptions
  - 43 children became subject of special guardianship orders
  - 259 children ceased to be looked after, of whom 6.9% subsequently returned to be looked after
  - 26 children and young people ceased to be looked after and moved on to independent living
  - nine children and young people ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates seven children's homes. Three were judged to be good or outstanding in their most recent Ofsted inspection. One of the homes opened December 2013 and is yet to be inspected.
- The previous inspection of Safeguarding and Looked After Children Services was in December 2010. The local authority was judged to be good.

Other information about this area

- The Director of Children's Services has been in post since November 2013.
- The chair of the LSCB has been in post since March 2012.
- The local authority has delegated the assessment of prospective carers to a social work provider: Social Work Choices.

Inspection judgements about the local authority

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

92. Children benefit from being able to access a wide range of effective early help services, including strong family support schemes. The Common Assessment Framework (CAF) and the lead practitioner role are well embedded in agencies in the city. More children are now benefitting from a CAF although their quality is variable. Good information sharing at the Locality Access Panels ensures that children receive additional support when they need it.

93. Children benefit from the support they receive from community-based family support teams, and the increasing number of closed CAFs shows that their needs have been met well and they no longer need extra help. Good outcomes achieved include: parents understanding and managing their children's behaviour better, improved attachments between children and their parent(s), better sleep patterns, better behaviour and achievement at school, and better support for young carers. Children receive help that is proportionate to the risks they experience, or are likely to experience, and this includes children at risk of neglect.

94. The arrangements for dealing with requests for information and services for children and their families are safe and efficient. The co-location of the Children and Families Direct Service with the social care screening and duty teams ensures that staff who take phone call enquiries from professionals or members of the public have easy access to qualified social work advice and expertise. These arrangements lead to good quality communication and speedy referrals to children's social care when required. The systematic use of 'safety net audits' ensures that those children and families where there are recurrent concerns are identified and they are not allowed to 'fall through the net'.

95. Information is shared between agencies appropriately and child protection enquiries are carried out in a timely fashion. The interface between the out of hours emergency duty team and day time services works well. Where issues of greater concern about a child are identified, strategy discussions are held promptly and involve relevant professionals.

96. Assessments undertaken by the screening and duty teams are comprehensive. Social workers apply the Signs of Safety model well and this clearly identifies known risk and protective factors for a child, leading to analysis and next steps. This approach robustly identifies key risks such as domestic violence, substance misuse and poor adult mental health. When children's circumstances are being assessed, they are seen and talked to on their own.

97. Arrangements are in place to ensure that children receive services appropriate to their changing needs and risks. This includes transferring support to children's social care or transferring them from statutory services to community

based services when their needs have lessened. These 'step up and step down' procedures are clear and robust. In nearly all the children's cases seen, children transferred quickly from screening and duty to targeted family support (step down) or to children's social care (step up), appropriate to their level of need.

98. Children at risk of harm are appropriately discussed at child protection conferences and made the subject of child protection plans. Conferences are well attended by parents, who are encouraged to contribute throughout. They are helped to understand the concerns that others have about their children through good use of the Signs of Safety model. This helps them to understand what people are worried about and what needs to change to reduce concerns and ensure their child is safe. Parents say they now feel more involved in developing child protection plans. However, there is more to do to fully embed the Signs of Safety model in conferences and maximise its full potential by all chairs.

99. Allegations of abuse or mistreatment of children by professional staff and carers are taken seriously and dealt with promptly. The local authority designated officer (LADO) ensures that all allegations are robustly followed through with clear outcomes recorded.

100. There is effective action to ensure that children educated at home are safeguarded and receive an appropriate education. Reducing numbers of families are choosing to home educate their children because they are dissatisfied with the school. There is a good reduction in the number of teenagers whose parents choose home education.

101. Children meeting the Equality Act 2010 definition of disabled are well supported by two disabled children's teams. Families can access low level services without a social work assessment, removing unnecessary bureaucracy for them, and all initial assessments are jointly undertaken by a social worker and an occupational therapist, which is good practice. Disabled children and their families benefit from good multi-agency working and integrated meetings. Disabled children can access a variety of support services and their transition to adult services is facilitated well by the multi-agency transitions team.

102. The multi-agency domestic abuse response team (DART) based at a local police station provides a thorough response to all notified domestic abuse incidents. Those children and families in need of support are identified swiftly. The team ensures that a full picture of the household is built up by gathering further information from police, health and social care systems. This information is considered alongside the specialist domestic abuse risk assessment completed at the time of the incident. There is a good range of support services for survivors of domestic abuse and their children, which they are put in touch with promptly. In the most serious cases, referrals are made swiftly to children's social care and/or to the Multi-Agency Risk Assessment Conference (MARAC) for assessment, services and detailed monitoring.

103. Both MARAC and the multi–agency pregnancy liaison group are effective. Good quality information is shared and actions are agreed. The pregnancy liaison group ensures that unborn children's needs are considered well and results in, for example, supportive intervention programmes for parents who misuse drugs.

104. At the time of inspection, 89 children assessed as being in need of statutory services were awaiting allocation to a social worker although all child protection and children in care were allocated. Prompt allocation is being hampered by social workers' high caseloads. These children are actively monitored by team managers who make sure that duty social workers visit the children regularly and seek updated information from other professionals. Despite these measures, a small minority of the children's files sampled identified children who have needs that are likely to escalate unless they receive an appropriate service promptly.

105. Assessments of children vary in quality. Some are good and thorough, but others do not address all the issues affecting the child. Poorer assessments result in weaker plans. In a small minority of children's files reviewed by inspectors, there was drift in the child's plan and in their progress. This was due to a variety of factors, including non-engagement by parents. Drift is exacerbated by a lack of robust challenge or escalation by the child protection conference chairs. The chairs always bring their views about a child's plan to the relevant social worker and team manager, but they have high caseloads and, while their commitment to championing children's welfare and safety is strong, they have limited capacity beyond this to ensure that children are always making sufficiently rapid progress and that their plans are on track. High caseloads also limit their overall contribution as a service to quality assurance and strategic development plans within children's social care.

106. Some children and young people's records show that assessment and plans took very good account of their individual characteristics such as any disability, their ethnicity, and personal identity issues. Other records made insufficient reference to the personal characteristics of the children, and the general standard of recording in this area requires improvement and better consistency.

107. The 'consultation forum', a multi-agency regular meeting, enables social workers to benefit from the opportunity for high quality reflective discussion about work with a child and family which feels 'stuck'. The group makes recommendations which often give a new direction and impetus to case work. The forum is highly valued by social workers who can describe anecdotal benefits, but its impact has not been formally evaluated so its effect on planning for children is not clear.

108. Many plans for children and young people are not measurable and lack clear desirable outcomes. They often consist of a list of tasks, some with no clear timescales. A small number of plans are significantly out of date and, when the plan for the child is considered by a core group or review conference, they are

not routinely updated. In the majority of the children's case files reviewed by inspectors it was difficult to see what the plan was achieving for the child. Most children's files contain a chronology, but these are of variable quality and most need updating.

109. Social workers know their child or young person well and can describe the child's needs, characteristics and circumstances well. They are also able to describe a good variety of direct work undertaken with children and young people. This is less evident in their written records, which tend to lack accounts of direct work with children/young people. The electronic recording system allows staff to duplicate a child's record to their brother(s) and sister(s) records unedited. Although staff have been given clear instructions about the need to personalise records after duplication, this is not always done, and in a few cases the record does not show that each child has a personalised assessment of need and a plan to meet those needs.

110. Two sub groups of the Nottingham City Safeguarding Children Board (NCSCB) effectively oversee and coordinate arrangements for identifying children and young people vulnerable to child sexual exploitation as well as those who are missing from home or care. Children identified as being at risk of sexual exploitation, or who might be at risk from going missing, are discussed at multi-agency strategy meetings which are independently chaired to determine next steps. These arrangements are good and they lead to co-ordinated plans to tackle the risk. Young people at risk of sexual exploitation are provided with additional support from the NSPCC's Respect and Protect project. All plans are robustly monitored by a senior manager to make sure they are working and helping to keep children and young people safer.

111. Children missing from education benefit from being tracked by a dedicated team of family support workers and educational welfare officers, who offer support as appropriate and troubleshoot difficulties. The team is currently tracking 282 children and young people. Of these, 208 are being supported by education welfare officers to improve their attendance, and 74 children and young people are currently without a school place. A small proportion of those missing education remain untraced, such as those who apply for a school place but then leave the area, but thorough efforts are made to identify them and take remedial action whenever possible. Persistent action in one case led to a school phobic pupil thriving in alternative provision.

112. There are also 108 children and young people who are electively home educated who benefit from the support and tracking of the Elective Home Education service.

113. Where the behaviour of a child or young person causes concern to a social worker or other professional, but the reasons for the behaviour are unclear or there are insufficiently serious consequences, practitioners benefit from being able to present their case to the 'concerns network', which enables expert advice to be provided and supports better practice.

114. The monitoring of private fostering arrangements is good. Systems are in place to ensure that children are visited sufficiently frequently and additional visits are made if a concern is raised. Good efforts are made to raise awareness of private fostering, including briefing sessions to school and health staff, and an ongoing publicity campaign to raise professional and public awareness.

115. The electronic recording system and its templates do not support good social work recording practice. It is likely that the slowness and lack of user friendliness contribute to the poor recording practices identified above, as there is a clear difference between the knowledge of children and their families that social workers have and the information which is recorded. The dual system of recording information about children and their families within the electronic client record and within a separate electronic document storage system creates many difficulties for staff and managers. It is difficult to see the full picture in relation to a child/young person and their progress, and it is possible to miss key documents when undertaking a review of the child's history and current circumstances. The two systems interact very slowly with each other and the slowness of this interface creates frustration and wastes valuable staff time. Recording takes a disproportionate amount of social work time which, in effect, reduces the time available for direct work with children and their families.

116. Some social workers experience regular supervision of sufficient quality but others have experienced more infrequent supervision and changes of managers. There is a high proportion of social workers who have recently qualified in the workforce. Some experience good support for their assessed and supported early career which is an entitlement, but others do not benefit from a protected caseload and support from a mentor who is not their line manager. Supervisions relating to children's progress are uploaded to the electronic document storage system and provide additional evidence of managerial oversight of practice. However, they tend to focus on identifying tasks for the worker to complete rather than achieving clearly defined outcomes for children.

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

117. Decisions for children to come into the care of the local authority are made in their best interests and are, on the whole, made in a planned way. The local authority reviews each child's circumstances carefully to ensure that it only looks after those children and young people who need to be removed from their families and cannot be supported at home safely. One care leaver said: 'I thought they had ruined my life by bringing me into care when I was 15 years old. Now I'm 17 I know it was the best thing that could have happened to me, now I have a life, I have a future'.

118. Children and young people who may be at risk of coming into care are offered a wide range of effective prevention services. Of the 42 children presented to the edge of care multi-agency panel in a three month period only 13 came into care, with all the others receiving good services to support them in the community and remain with their families. The local authority is getting better at acting more swiftly and robustly where children and young people are experiencing neglect, although in a small minority of cases seen the local authority could have taken more decisive action earlier.

119. Good use is made of legal proceedings including pre-proceeding work. This means that parents understand the consequences of failing to look after their children, what needs to change, and the consequences if there is insufficient improvement. Good quality social work assessments inform plans for children and young people and this helps care proceedings to move along more quickly.

120. The local authority makes timely applications for legal proceedings such as care orders for children and young people who need alternative legal security and these are accepted by the court as appropriate. Timescales for securing final legal orders for children are good and continue to improve with decisions being made increasingly quickly. Social workers and children's guardians work together well to agree the best plans for children and young people. The local authority always considers the full range of permanence options for children, including whether a child would benefit from a special guardianship order (SGO) for a settled future. Of the 107 children and young people presented to the SGO panel, 63 were felt to be suitable for a SGO as of February 2014 with alternative permanence options being recommended for the other children. This includes SGOs made for foster carers where this is in the child's best interests.

121. When decisions are made for children to return home after being in care, they rarely come back into care and are successfully rehabilitated. Some children benefit from support from the commissioned reunification project.

122. Social workers understand the importance of building relationships with children and young people. They carry out direct work with children and some social workers use tools such as the 'three houses' from the Signs of Safety model to help them to understand how children feel, and to analyse this within the child's

whole context. The majority of social workers know their children well and can articulate the plans for the child.

123. Case records reflect the child's situation in the majority of cases, although aspects of the child's journey and life are often contained in different documents. The end result of assessments and analysis is not always reflected in their care plans, which are often out of date, lack detail and lack timescales for actions. Social workers' reports for review meetings offer this detail in the large majority of cases, however the care plan is not utilised as a key essential document bringing everything together. The lack of thorough plans makes it difficult to monitor and review the progress made by children and young people, and makes it difficult for the child's advocate and/or IRO to challenge slow or insufficient progress. This has led to delay and drift for some children and young people.

124. The local authority has traditionally had a stable social care workforce, which has meant that children benefit from consistency of worker. However, more recent organisational changes and turnover of staff means that some children and young people have experienced changes of social worker. This has impacted on effective relationship building and their plans being progressed in a timely way.

125. There are effective arrangements to oversee and reduce risk for children and young people who go missing from care, are at risk of child sexual exploitation, misuse substances or are involved in offending, with a good range of intervention services. A strength of the arrangements is the co-location of an experienced looked after children police officer in the 15+ service for older looked after children and care leavers. This means that children and young people at risk are identified quickly and receive a swift assessment and service. Interventions are demonstrating positive outcomes for the large majority of children and young people in helping to keep them safe.

126. Looked after children's health needs are met in the long term, but health assessments when they first become looked after are not always carried out quickly enough and health care plans are not always present on their files or kept up to date. The local authority recognises this is an area for development. Children and young people's emotional health needs are responded to promptly and are well informed by up to date strengths and difficulties questionnaires, which helps to gauge their emotional health. Children and young people benefit from a dedicated Child and Adolescent Mental Health service (CAMHS) specifically for looked after children and young people, including those who are placed outside the city. The service makes sure that children and young people's therapeutic needs are being met in the specialist placements they live in.

127. The educational attainment of looked after children and young people is variable. Attendance at school has shown an improving trend, but during this academic year absenteeism has risen. Persistent absence is decreasing

significantly, as is the use of fixed-term exclusions. While there is generally an improving trend in the attainment of looked after children, it is not consistent nor yet sustained. The proportion of young people gaining five GCSEs with English and mathematics is around the national average for looked after children, with a good number gaining five GCSEs. Children make reasonable progress from their starting points between the ages of 5 and 11 but fewer children of secondary school age make the progress expected of them.

128. Attainment of children at ages seven and 11 years is below that of the national average. The attainment gap between looked after children and the rest has narrowed, but too many 16 to 18 year olds do not participate in any kind of education, training or employment. The quality of planning children's learning varies considerably. In the best examples, Personal Education Plans (PEPs) capture children and young people's progress and their academic and personal targets well. The use of data and information to track the progress of looked after children and young people, and alert managers with responsibility for overseeing the education progress of looked after children (the 'virtual school'), are underdeveloped. Arrangements are not in place to alert the virtual school at an early stage when children begin to experience problems in their education. The virtual school does not have a secure enough understanding of the quality of education of all looked after children and ceases to monitor young people after the age of 16. Not all looked after children attend good schools, particularly following an inspection of a large number of schools in 2013 which saw their gradings reduced. The local authority is considering the educational needs and services for each looked after child carefully, balancing the merits of each child staying in the same school with the consequences of moving them. Additional support arrangements are in place for looked after children to improve their attainment, but the local authority is aware that it needs to do more to improve their outcomes.

129. Foster carers and residential staff are routinely involved in all aspects of children and young people's lives and encourage and support their education and interests. They attend review meetings, contribute fully and have delegated authority to make day to day decisions in relation to the children and young people they care for. Foster carers report that they do not always receive sufficient information about a child when they first come to live with them to ensure that they are able to immediately meet the child's whole needs. This is rectified but not always as quickly as it could be.

130. The large majority of children live in homes that are judged as good or outstanding by Ofsted. Some evidence was seen by inspectors of highly individualised positive and proactive placement matching based on young people's specific needs, including their ethnicity, disability and sexuality/gender and identity. However this is variable in quality and breadth, and the information is not consistently held on children's and foster carers' files. This means that although some children and young people live in homes that are tailored to their very specific needs, this is not the case for all children.

131. Short term placement stability is showing a small decline, standing at 13%, which is higher than statistical neighbours and the England average (10% and 11% respectively). Some children have experienced unplanned endings of their placements and have not been involved in decisions about placement moves. However, decisions to move children and young people are appropriate for almost all, and are based on ensuring that young people's needs are met and risks managed. Long term placement stability is in line with comparators with 66% of children and young people remaining in the same place for at least two years.

132. IROs know the children and young people they are responsible for and use creative methods to engage them in sharing their wishes and feelings. This includes children and young people who use alternative methods of communication and for whom English is not their first language. Children and young people are seen by their IRO prior to their reviews and a small minority of young people even chair their own meetings. Children and young people have their IRO's contact details and are able to contact them between meetings. However, they are not routinely seen by IROs between reviews. This is because IRO caseloads are too high and this is affecting the quality of the service they wish to offer. For example, if an IRO is concerned about the plan or progress being made by a child or young person, they are able to raise a concern through the established escalation process, but do not usually have any capacity to follow this up to ensure that robust action has been taken in line with the concern raised. They are reliant on the social work service following up on actions required without any independent oversight or challenge, which hampers their effectiveness.

133. Minutes and decisions of review meetings are not always completed in a timely manner or present on children's files. All meetings chaired by IROs should have a minute taker but inspectors saw instances when this did not happen. Delays in minutes being written up by the centralised administration unit are common and have a negative effect on progressing plans for children, as minutes cannot be distributed promptly to all those who have a role in supporting the child. The actions decided at children and young people's reviews lack specificity and timescales so the local authority cannot be sure that drift and delay does not occur for some children.

134. Contact arrangements for brothers and sisters and other important people in children and young people's lives are promoted and given high priority to ensure that family bonds are maintained.

135. There is a high proportion of children and young people placed outside the city due to the lack of provision within the city's boundary. However, many are placed within 20 miles in Nottinghamshire county. Planning for placement with external providers is thorough and timely, informed by risk assessments and information about the child's history. One provider spoken to was extremely complimentary about the support offered by the local authority, including an unannounced visit by commissioning staff. The commissioning team undertake

unannounced visits to all external residential providers each year, which adds to the robust quality assurance of external provision. However, children placed externally do not always have education and health resources available immediately, although good work is undertaken to secure this soon after. Placement providers are not always provided with key documents about the child or young person.

136. Looked after children and young people are visited regularly by their social workers and they are seen and seen alone, with visits increasing if necessary. This includes children placed outside the local authority area. Records of visits describe the progress children and young people are making, and what needs to change to improve things for them includes changes of services being offered. The young people placed at a distance from the local authority visited by inspectors were positive about their placement and the support they receive, including regular visits and contact from their social worker and IRO. Providers were complimentary about the quality of planning and preparation prior to placement. There is evidence of the young people's needs being met comprehensively. One young person was not attending school before moving to his current placement but now has a 100% attendance record. Another young person expressed satisfaction and feeling safer by living away from her home area, and said that this helps her stay away from drugs and sexual exploitation, which led to previous placement breakdowns. However, changes to services being provided, or changes in children's progress, does not lead to care plans being updated.

137. Management oversight and decision making is evident on children and young people's case files, with assessments and plans being routinely endorsed and commented on by managers. Some good examples of reflective analysis and evaluation by managers were seen on core assessment documents, and social workers benefit from additional informal case discussions with their managers as well as formal discussions in supervision sessions.

138. The majority of social workers benefit from regular supervision which is recorded. The quality of notes is satisfactory with the worker's training needs identified and some reflective case discussion. However, a small minority of social workers have experienced long gaps between formal supervision sessions which is unacceptable and means that these social workers do not always have sufficient time and space to reflect on their practice.

139. The recruitment, training and retention of local authority foster carers has not been robust in recent years. This means that there is an insufficient range of placements within the city presently. The local authority has taken steps to rectify this with a robust and creative marketing strategy. Early signs are that recruitment and retention of carers is improving as a result. There has been an increase in enquiries about fostering and plans are in place for targeted recruitment within specific communities to better reflect the needs of looked after children and young people. This includes specialist remand placements and placements for larger groups of brothers and sisters. The training

programme for foster carers covers all the essential topics. Revised procedures for managing and reporting on allegations are now in place and are sufficiently robust. The progress of all allegations about carers are overseen by a senior manager who ensures these progress to proper conclusions. At the present time, foster carers' files do not contain all the information they should in line with the Fostering Service (England) Regulations 2011. However, all reviews of foster carers are now up to date to ensure that placements meet the needs of children and young people. The fostering and adoption services have benefitted from recent robust action to improve their impact and quality, but there is more to do to ensure that there is sufficient technical knowledge and expertise within both aspects of the service to maintain and strengthen this recent improvement.

140. Looked after children and young people know how to complain and know their rights and entitlements. They have access to an independent advocacy service and they are encouraged and supported to attend their reviews. The majority of children and young people report that they are happy with how the local authority looks after them. They are represented by an active and influential Children in Care Council whose views are listened to and acted upon by senior officers and elected members.

The graded judgment for adoption performance is requires improvement

141. There has been a year-on-year increase over the last three years in children being adopted in Nottingham. In the twelve month period before the inspection, 40 children were adopted. In the same period 43 children achieved permanency through SGOs. Adopters spoken to said that they found the introduction to adoption sessions helpful and informative. Initial enquiries are responded to promptly and prospective adopters do not have to wait long before attending information or preparation training. The two stage process of assessment is working well with the sessions giving prospective adopters a good insight into the reality of adoption. Adopters talked of some delays in the approval process but, overall, were satisfied with the service they had received.

142. A newly established team of adoption placement advisors (APAs) is finding more families for children. The team is highly thought of by social workers and is devising creative and ambitious ways to attract potential adopters including open evenings, mail shots and collaborations with other authorities. The new marketing strategy has increased the number of initial enquiries from potential adopters. Plans are in place to increase the range of adopters by targeted recruitment in diverse communities. Adopters are also identified through local consortia arrangements and national networks. This means that some children who have been waiting a long time have now been found adoptive families, including older children, children with complex needs, and brother and sister groups.

143. The combined adoption and fostering panel meets on a weekly basis, and this increased frequency of meetings is helping to minimise delays in achieving

permanency for children. The four independent panel chairs scrutinise and quality assure the written work, including assessments, about the children and carers brought to panel. The chairs provide constructive feedback to social workers and their managers, and identify how staff can improve their practice, leading to a continuing overall improvement in the quality of reports. This is leading to more suitable matching and placements. The agency decision maker thoroughly and promptly considers the recommendations made by panels and arrangements are robust.

144. Progressing children to matching panel from the point of the plan being approved currently takes 52 weeks on average instead of the recommended 26 weeks. The average time taken between a child entering care and moving to live with an adoptive family takes two months longer in Nottingham than the national average.

145. In many cases the delay has been contributed to by difficulties in obtaining the medical information required by the panel for both children and carers. Managers have made good progress to improve this timescale, which is reducing year-on–year, by doubling the number of panels each month from two to four, and increasing the capacity of medical advisors. Overall, this means that children are being adopted more swiftly. Currently 54 children with a placement plan are waiting to be adopted with another five having been matched to carers. A further 32 children whose original plans for adoption proved unsuccessful are now achieving permanency through long term fostering or SGOs. SGOs are regularly considered by the local authority and some long term foster carers have converted to adopters for children. This has helped some children to achieve permanency with fewer moves.

146. There are some good examples of individual support packages for adopted children including direct work with children and support services from CAMHS. Life story books are of good quality and information provided to children about adoption is age appropriate and also good quality.

147. In the majority of cases seen by inspectors there was some delay in progressing plans for adoption. Delays are too often built in at an early stage, with family finding not being started quickly enough. Although plans for permanency are considered routinely at their second review, not all children are considered for adoption or it is ruled out too readily. This includes some very young children for whom adoption might offer some very clear benefits. There is insufficient challenge from IROs when plans are delayed or changed.

148. Delays are contributed to by the absence of parallel or concurrent planning, and social workers and their managers lack a clear understanding of the value of such approaches in helping to reduce delays for children.

149. Prospective adopter assessments are undertaken by an independent social work provider. The quality of these assessments is variable, but feedback from panels and from managers in the adoption and fostering service to the provider

has led to better quality assessments. Adopters are not routinely spoken to or given information about 'fostering to adopt'. The local authority is aware of this and intends to rectify these shortfalls.

150. Support for adopted children and their families is inconsistent and not all are provided with a package of support. The referral pathway and criteria for this service are unclear and some requests for support are not being responded to in a timely way.

151. A peer review of the adoption service commissioned last year by the local authority produced good recommendations about how to improve the service. Not all the recommendations have yet been implemented and other actions have been slow to secure positive outcomes for children. Senior managers are aware of the need to accelerate the pace of progress.

The graded judgment for the experiences and progress of care leavers is requires improvement

152. The majority of care leavers have up to date pathway plans that are reviewed in a timely way, and they are routinely involved in writing and reviewing their plans. Many of the plans are too lengthy, lack rigorous analysis and are not sufficiently outcome-focused. Some young people spoken to by inspectors said they do not feel the plans have any impact on their lives or serve any meaningful purpose. Some did not understand the reason for the plan. The quality of pathway plans is an area recognised by the authority as requiring improvement. Good work is underway to improve their format and quality in consultation with young people.

153. A high number of care leavers are in suitable accommodation, and the authority is performing well in this area in comparison with statistical neighbours and England. Strong partnership arrangements between the local authority and Nottingham City Homes has increased the availability of suitable accommodation for care leavers, including more in-house semi-independent units. This means that all young people leaving care have access to accommodation that meets their needs and circumstances. Care is taken to place young people in neighbourhoods that are considered to be 'safe', with a number in close proximity to children's homes to provide additional support for the young people. Young people report that they feel safe where they live and have good arrangements in place to seek support should they have any concerns. Young people who become homeless receive timely help and advice to find suitable accommodation. Unaccompanied asylum seekers have access to specialist accommodation and expert advice, ensuring that they receive appropriate services and support.

154. Currently only three young people over 18 remain living with their foster carers. This equates to 10 per cent of care leavers. This is limiting the opportunity of continued family living and choice in relation to young people moving to independent living at the appropriate time. The 'staying put' strategy is

currently being reviewed with the intention of enabling more young people to remain with their foster carers where this is in their best interests.

155. Too many care leavers are not in education, employment or training. The local authority invests considerably in a scheme run by Business in the Community – the Routes Into Sustainable Employment (RISE) programme for care leavers. However, this is not proving to be effective in securing sustainable employment for young people. Too few young people participate in the programme and only a small number move on to employment. In contrast, the small in-house apprenticeship programme is effective and has resulted in a higher proportion of care leavers gaining permanent employment with the authority.

156. An increasing number of care leavers are being supported by the local authority to go to university, including some who are studying at Master's degree level. Young people say they have good support while at university and the effective use of discretionary funding is helping them to achieve their goals.

157. Enthusiastic, skilled and committed workers in the 15+ team know young people well and encourage them to make the transition to independence. When young people do not adapt to independent living or there is a tenancy breakdown they receive early support and, where appropriate, return to more supported accommodation until they are ready for independent living. Young people spoken to by inspectors describe warm and helpful relationships with the staff who support them. They express satisfaction with the support they get to move towards independence and feel they have enough support to ensure that their transition is successful. One young person said 'No matter what I threw at them they stuck by me. I was really bad but they didn't give up on me, now I have a college place and plan to go to university and I know they will be with me all the way making sure I achieve my goal'.

158. Care leavers are offered good help to gain independent living skills such as cooking, budgeting and shopping. They are visited regularly by their personal advisers and provided with a 'setting up' allowance. The frequency of visits and the size of the grant frequently exceed the statutory minimum requirements. Young people are helped to understand their rights, including their entitlement to state benefits such as the Disabled Living Allowance, and how to make a complaint.

159. The health needs of care leavers are addressed. They understand how to access primary health services and receive suitable advice and guidance on issues such as sexual health, drugs and alcohol from their personal advisor. There are easily accessible services to support care leavers with a range of issues, including a specialist advice service that has extended opening hours seven days a week. Care leavers have priority access to the CAHMS service for initial assessment and are seen quickly. They have access to therapeutic services and specialist placements to meet their identified needs. Care leavers are supported to access all their key documents such as their National insurance number and birth certificate.

160. Young people are not routinely provided with nor have access to their full health history; the local authority recognises this as an area of development.

161. Care leavers have good opportunities to contribute to service design and delivery. They are represented on the corporate parenting board and their contribution is valued. There are good examples of how they have influenced change, including the introduction of bus passes for apprentices, ensuring that they are not disadvantaged by taking up employment. Good succession planning is ensuring that young people are prepared to take over key roles as other young people move into adulthood and cease to be eligible to represent their peers. Participation is inclusive and individual views and opinions are valued equally.

162. A range of creative methods are used to consult with young people, ensuring that their voices are heard. They are involved in decisions that affect their lives, including: a residential weekend to help develop a 'setting up your home' pack, re-design of the 'Have your Say' document to encourage greater take up, and participation in the 'Benchmarking Forum', contributing to their overall confidence and presentation skills.

163. Inspectors met with a good number of care leavers who are confident and positive about their future. Senior managers and staff working directly with care leavers know them well and speak proudly of their achievements. The achievements of care leavers are regularly celebrated with young people playing key roles in all such events.

164. Young people are helped to stay in touch with their immediate and extended family. Where circumstances prevent this, young people have appropriate support to help them understand why.

165. A good system is in place to ensure the smooth transition to adult services for disabled young people. The multi-agency transition team includes staff from both children's and adults' services who jointly develop a care package the young person will need in adulthood. Support continues until the young person has completed the transition and the care package is fully established.

Leadership, management and governance requires improvement

166. A lack of capacity, the failure to prioritise effectively, and service and business plans that are not sufficiently outcome-focused or measureable have all contributed to shortfalls in the quality of some services provided. While expending a great deal of time and effort, senior managers have been slow to identify and respond to problems as they emerge and have not been sufficiently focused on those issues and areas that will have the most impact.

167. Within the last five months, a corporate director with previous and substantial experience of managing the combined roles of Director of Children's Services (DCS) and Director of Adult Services (DAS) has been appointed. She is taking decisive action to identify areas of weakness and improve outcomes for children and young people. Senior managers now have a good understanding of areas in need of further development and are taking remedial action to rectify shortfalls. Given the range of improvements required, along with the longstanding nature of some poor management which has now been rectified, senior managers recognise the need to prioritise activities and outcomes. The failure to identify management shortfalls previously has also highlighted for them the need to be able to identify problems at an earlier stage.

168. The strategic and governance framework between partners is well developed. There are clear links between One Nottingham, the Children's Partnership Board, the Health and Well-being Board, Nottingham City Safeguarding Children's Board (NCSCB) and the Corporate Parenting Board, with robust reporting arrangements in place. The local authority's high level strategic objectives are clear, explicit and linked to key performance indicators, each of which is 'owned' by a named manager, ensuring unambiguous lines of accountability.

169. The Chief Executive has good oversight of the work of the NCSCB. He meets regularly with the independent chair of the NCSCB and the DCS and there is good evidence of two-way challenge. The Lead Member for children and families is highly visible, extremely active and engages with children, young people and foster carers in a variety of different forums. Care leavers speak well of him and say he has championed their cause.

170. The local authority knows its communities well. Building on the existing joint strategic needs assessment (JSNA), commissioners are working closely with the voluntary sector to develop local needs analyses. An annual programme of strategic commissioning reviews means that commissioning activity is needs-led and evidence-based. This approach has led to, for example, a young carers service designed and developed in consultation with young carers themselves, the development of a domestic violence service targeted at teenagers, and the 'drug aware' programme in schools across key stages 1 to 4, which has seen more young people successfully completing treatment programmes.

171. There are satisfactory contract monitoring arrangements in place for the independent social work service that has been commissioned by the local authority to undertake prospective adopter assessments. The local authority is aware of the current variability in the quality of this service, and has plans in place to address the shortfall through the re-tendering process.

172. The local authority continues to maintain its strong commitment to early intervention and prevention, for example, by continuing to fund 18 children's centres. Further refining of performance management data in relation to the use and effectiveness of CAFs has led to a greater emphasis being placed on the importance of CAFs to support children and families. Completion rates which had previously dipped are now increasing. The investment in auditing 450 CAFs has provided good information on which to plan further improvements.

173. Feedback from children and families suggests that they are benefitting from early help packages of support delivered through the CAF. More recently, multi-agency targeted family support teams have been set up to focus on those families in need of more extensive support but who do not require the involvement of children's social care statutory services. It is too soon to evaluate their impact and, for the moment, there is no reduction in the volume of referrals to children's social care.

174. There are good and effective partnerships with health, housing, the police and the local business community. Nottingham City Homes' involvement in the Corporate Parenting board ensures that care leavers have a good range of suitable accommodation. The partnership with health has helped to deliver a responsive, high quality CAMHS which is delivering prompt and effective support to children and young people. The partnership with the police has resulted in significant improvements in identifying and responding to domestic abuse. Victims are now more confident in the support available, as evidenced by increased referral rates.

175. Further work needs to be done to develop the same level of partnership working with education partners, including academies. The forthcoming appointment of a Principal Education Strategy Lead is intended to address this shortfall. Key tasks will be to improve the engagement of academies with other child welfare agencies, and improve the education of looked after children.

176. The virtual school is currently reactive and tends to focus only on urgent situations when looked after children are already in crisis. Systems are not sufficiently developed to alert the virtual school when children and young people begin to experience difficulties. There is not a secure enough understanding of all of the issues, for example, why absence from school rises when it does, or how effective the funding to support individual children is. The areas of good performance cannot be closely linked with action taken by the virtual school.

177. There is a strong commitment to corporate parenting. Chaired by the Lead Member, the Corporate Parenting Board has helped to eliminate the CAHMS waiting list for looked after children, set up an apprenticeship scheme for children in care and negotiated the appointment of a designated police officer for children in care resulting in fewer police visits to children's homes. The Board has been less successful in addressing issues around the variable quality of personal education plans (PEPS) and health plans for children in care, although concerted action is now being taken.

178. Better use needs to be made of performance management information and quality assurance audits to understand the experiences of children and young people. Performance management tends to be compliance driven and relies heavily on quantitative data. An extensive data set is used to hold managers to account and to assist operational teams in managing the day-to-day business and inform commissioning activity, but its emphasis is on outputs rather than on the quality of service or outcomes for children. This has contributed to the failure to identify and address shortfalls in the quality of some services currently being provided.

179. Quality assurance is under-developed. Audits are not being used systematically across all areas, and information from audits is not being aggregated effectively. Children's social care urgently needs the kind of comprehensive performance management and quality assurance framework that has recently been launched for use across the family community teams, including children's centres and targeted family support teams.

180. The quality of supervision is variable. Although most staff say that they feel well supported, there is little evidence of reflective supervision and the poor quality of most plans for children suggests a lack of sustained critical challenge or a lack of awareness of the importance of such plans. The level of support for newly qualified social workers is also variable. The newly qualified social workers in the screening and duty team receive regular mentoring support in addition to monthly case work supervision, but other newly qualified staff do not. Given their high number in the workforce, it is important that they have access to high quality support and supervision in order to maximise their learning and promote their retention.

181. The diversity of the workforce reflects the profile of the local community and inspectors were impressed by the level of commitment shown by staff. While turnover rates are not significantly higher than the national average, capacity has been and still is a significant issue. The size of social work caseloads makes it difficult for social workers to do high quality work and the IRO service is over-worked and under-resourced. The situation is aggravated by the acknowledged shortcomings of the current electronic recording system and the level of business support available. Both issues need to be addressed. There also needs to be a more robust approach to recruitment and retention.

182. Strategic core development standards, which have been agreed with partners, are being used effectively to ensure that the children's workforce has the right level of knowledge and skills. To date, 485 members of staff in children's social care or the family community teams have completed Signs of Safety training. A further 445 have completed the strength-based communications styles programme. The local authority currently has no way of evaluating these programmes as they are not fully implemented. However inspectors saw emerging evidence of the impact of these initiatives, particularly Signs of Safety.

What the inspection judgements mean: the local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place, however, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

Section 2: The effectiveness of the local safeguarding children board

The effectiveness of the LSCB requires improvement

Areas for improvement

183. Ensure that the Family Support Pathway clearly identifies arrangements for children in need and that this contributes to effective 'step up' and 'step down' arrangements between community and statutory services so that children receive the most appropriate level of service according to their needs.

184. Ensure that the 2014–15 Nottingham City Safeguarding Children Board (NCSCB) Annual Report reflects statutory requirements, in particular that it provides a robust analysis of service development and impact across the partnership.

185. Monitor the intervention of adult services with service users who are parents so that the Board can be assured that children in these households who require support and protection are provided with this in a timely manner.

186. Ensure that the Board hears the voice and experiences of the most vulnerable children and that this contributes to the Board's future effectiveness.

187. Monitor the robustness of evaluation that each agency provides following practitioner's attendance at formal NCSCB training to ensure that training effectively contributes to practice improvement.

188. Ensure that elected members are able to directly hear from the independent chair of the NCSCB and assure themselves of the effectiveness of partners' contributions to safeguarding children and young people.

Key strengths and weaknesses of the LSCB

189. Governance arrangements of the NCSCB are well established, effective and ensure compliance to statutory responsibilities. Attendance by agency representatives is good with the large majority of members attending all board meetings, which indicates the seriousness and priority that partners give to the NCSCB. No agency has left themselves unrepresented where changes in personnel have occurred and all members hold sufficiently senior posts within their own agency to deliver on the key priorities of the well-developed and targeted NCSCB business plan. Recruitment of lay members has been specifically targeted to bolster and support the further engagement of schools with the NCSCB, although it is too early to see the impact of this approach.

190. The quarterly Safeguarding Assurance Group of senior strategic leaders, which the NCSCB chair attends, ensures that strategic priorities across the partnership are aligned, avoid duplication of activity and drive continual improvement. This is an effective forum for unblocking barriers and achieving timely solutions.

191. In contrast, while the overview and scrutiny function receive a copy of the NCSCB annual report, the governance arrangements are not sufficiently robust and the panel do not hear directly from the NCSCB independent chair on safeguarding issues or other priorities of the NCSCB.

192. The NCSCB independent chair is held in high regard by partners; he brings constructive and robust challenge to the Board. He also chairs the Nottingham City Adult Safeguarding Partnership Board (NCASPB), which ensures that the profile of children is also a focus for agencies that work with vulnerable adults. The NCSCB independent chair has a good understanding of the Board's strengths and areas for development and uses his influence to continually drive improvements. While the linkages between the children's and the adults' Boards have good potential for synchronising service development, its full potential remains under-developed. For example, recent data analysis suggests that there has been an increase in referrals from adult services to children's social care. However, the NCSCB has not yet assured itself of the quality of adult services intervention so that children in such households are actively considered and, where necessary, appropriately helped and protected.

193. The NCSCB independent chair attends the Children's Partnership Board and provides effective and appropriate challenge. In particular, the Board has explored the effectiveness of early help in terms of supporting children and young people before their need escalates to the point when statutory services are required. This was undertaken by looking at the number of children with child protection plans, including those who have experienced neglect, but who had not had the opportunity to benefit from early help. This challenge is beginning to result in increased completion of common assessments (CAFs) that are appropriately targeted to all vulnerable children, but the impact on children who are subject to child protection plans is not yet evident.

194. The NCSCB provides good focus, supported by sub groups, on domestic abuse, child sexual exploitation and missing children. The NCSCB has an increasing focus on looked after children. This has led to some improvements such as the ready availability of CAMHS services for looked after children. However other issues, such as the educational attainment of looked after children remains poor compared with similar areas. It recently conducted an audit on looked after children placed outside the area and has a working group that considers looked after children who go missing. This ensures that the focus on the most vulnerable children is prioritised across the partnership, but the effectiveness of this focus is still too variable.

195. NCSCB sub groups are chaired by a range of partners, which demonstrates the commitment from the partnership to strong collaborative working. The NCSCB independent chair meets them on a bi-monthly basis to ensure that sub groups are making progress against agreed action plans. As a result priority activities are progressed in a timely manner.

196. The NCSCB is supported by a recently developed Local Learning and Improvement Framework, which appropriately co-ordinates learning activity from serious case reviews (SCRs), Significant Incident Learning Process (SILPs) audit activity, data analysis and local intelligence. Since January 2013, five serious incident notifications have been made to Ofsted by Nottingham City. Serious incident notifications are managed effectively, with recorded outcomes for all five that have led to SCRs, SILPs, single agency reviews or been appropriately managed via the Child Death Overview Panel (CDOP).

197. The SCR sub-group appropriately considers the criteria for initiating SCRs and SILPs. Partnership rigour given to discussions about the application of the criteria is well evidenced and reflects the mature professional relationships that exist locally. SCR action plans are specific, thorough and have clear timescales for completion. The sub-group effectively tracks actions to completion. At this point the NCSCB Quality Assurance sub-group tests, through dip sample audit, that actions have led to improved practice.

198. Learning from audits, SCRs and SILPs informs and updates the core training offered by NCSCB, and specific briefings about neglect, learning from SCRs and child sexual exploitation have all been run for front line practitioners by the NCSCB. These events are supported by the NCSCB Excellence in Safeguarding Practice briefing note which is a short, easily accessible document for practitioners. It translates learning from local SCRs and SILPs into guidance for good practice on issues such as domestic abuse, emotional abuse, distressed young people or those at risk of self-harm, sexual abuse, parents that resist engagement with services, and direct work with children who have a disability. Although the document is clear, there is no systematic evaluation of its impact on practice.

199. Multi-agency themed audits are targeted and provide a robust analysis of practice. Recent audits reflect the increasing use of the Signs of Safety model that is being rolled out across the partnership. This is supporting practitioners to deliver increasing consistency and focus on children's needs. However, multi-agency auditing of partner records has stalled. The Board has recognised this and a new multi-agency audit framework has been agreed and multi-agency auditing processes re-started at the time of the inspection.

200. Robust arrangements are in place to ensure that action plans resulting from Section 11 audits are monitored through to completion. Year-on-year the NCSCB has seen greater compliance and almost all agencies show green on a rag rating of compliance to all areas, with few at amber and no red areas.

201. An appropriate range of NCSCB agreed policies and procedures are in place, supplemented by comprehensive practice guidance. These are reviewed and updated regularly to reflect learning, and further capacity has been secured to ensure continued robustness of updating.

202. The current Family Support Pathway that outlines thresholds for partnership intervention with families does not yet provide sufficient guidance on arrangements for children in need. The NCSCB is aware of this and a current refresh is underway. While this document clearly highlights how professionals can escalate their concerns about any agency decision making, the NCSCB does not monitor how effectively this is used.

203. The Board has very limited engagement with children, families and the community to secure their views in influencing the development of its work and safeguarding practice, and this is a shortfall. While a good level of engagement between the NCSCB chair and the Youth Council is informing the 2014–15 NCSCB business plan, the NCSCB is not yet hearing the voice of the most vulnerable children and young people, such as those in receipt of safeguarding services or who are looked after.

204. Although the NCSCB provides a range of learning opportunities including formal training, agencies have been slow to evaluate the impact of training on individual practice. Partners have yet to embed evaluation of training into routine staff skills development. It is not evident that the evaluation of training is effectively used strategically.

205. The 2012–13 NCSCB annual report is not sufficiently analytical and is overly descriptive. Most significantly, it does not present service weaknesses, causes of weaknesses and action being taken to address weaknesses, nor provide an evaluation of the performance of local services, and this is a significant shortfall.

What the inspection judgements mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

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