Appendix A

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Sunderland 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 May 2015 – 4 June 2015

Report published: 20 July 2015

Children's services in Sunderland are inadequate
There are widespread and serious failures that leave children unsafe and mean that the welfare of children looked after is not adequately safeguarded or promoted. It is Ofsted's expectation that all children and young people receive the level of help, care and protection that will ensure their safety and help prepare them for adult life.

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

[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.

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Contents

The local authority 3

Information about this local authority area 3

Executive summary 6

Recommendations 8

Summary for children and young people 11

The experiences and progress of children who need help and protection 12

The experiences and progress of children looked after and achieving permanence 21

Leadership, management and governance 36

The Local Safeguarding Children Board (LSCB) 42

Executive summary 42

Recommendations 43

Inspection findings – the Local Safeguarding Children Board 43

Information about this inspection 48

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates five children's homes. Four were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of Sunderland's safeguarding arrangements was in April 2012. The local authority was judged to be good.
- The previous inspection of Sunderland's services for children looked after was in April 2012. The local authority was judged to be good.

Other information about this area

- The Executive Director of People Services in Sunderland took responsibility for children's services in September 2013. This is in addition to his responsibility for health, housing and adult services (since 2007), and also cultural and leisure services.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since September 2014 and is also the chair of the Adult Safeguarding Board.

Children living in this area

- Approximately 54,500 children and young people under the age of 18 years live in Sunderland. This is 20% of the total population in the area[3].
- Approximately 25% of the local authority's children are living in poverty[4].
- The proportion of children entitled to free school meals[5]:

  in primary schools is 21% (the national average is 17%)

  in secondary schools is 21% (the national average is 15%)

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[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.
[3] Source: ONS Mid-Year 2013
[4] Source: HMRC Snapshot as at 31 August 2010
[5] Source: DfE Schools, pupils and their characteristics

- Children and young people from minority ethnic groups account for 6% of all children living in the area, compared with 22% in the country as a whole[6].
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British and Mixed[7].
- The proportion of children and young people with English as an additional language[8]:
  - in primary schools is 5% (the national average is 19%).
  - in secondary schools is 4% (the national average is 14%).

Child protection in this area

- At 31 March 2015, 3,255 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,663 at 31 March 2014[9].
- At 1 June 2015, 394 children and young people were the subject of a child protection plan. This is an increase from 306 at 31 March 2014[10].
- At 31 March 2015, three children lived in a privately arranged fostering placement. This is a reduction from four at 31 March 2014[11].

Children looked after in this area

- At 1 June 2015, 575 children are being looked after by the local authority (a rate of 105 per 10,000 children). This is an increase from 490 (90 per 10,000 children) at 31 March 2014[12].
  - Of this number 175 (or 30%) live outside the local authority area
  - 66 live in residential children's homes, of whom 61% live out of the authority area
  - No children live in residential special schools
  - 450 live with foster families, of whom 30% live out of the authority area
  - 10 live with parents, none of whom live out of the authority area
  - No children are unaccompanied asylum-seeking children.
- In the last 12 months (1 June 2014 to 31 May 2015) there have been:
  - 43 adoptions

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[6] Source: ONS 2011 census
[7] Source: ONS 2011 census
[8] Source: DfE Schools, pupils and their characteristics
[9] Source: DfE Characteristics of children in need in England
[10] Source: DfE Characteristics of children in need in England
[11] Source: DfE Notifications of private fostering arrangements in England
[12] Source: DfE Children looked after in England including adoption

- 40 children became subject of special guardianship orders
- 217 children who have ceased to be looked after, of whom 4% subsequently returned to be looked after
- Nine children and young people who have ceased to be looked after and moved on to independent living
- Four children and young people who have ceased to be looked after and are now living in houses of multiple occupation.

Executive summary

There are widespread and serious failures in the services provided to children and their families in Sunderland. This is a corporate failure by senior leaders and managers that leaves children and young people unsafe. The local authority has established a voluntary improvement board with partner agencies and has an improvement plan but these measures have not had a discernible impact on improving practice or outcomes for children and young people. During the inspection, 21 children's cases were referred back to the local authority by inspectors to request that action be taken to ensure children's needs were met. This is one out of every ten children's cases looked at by inspectors.

Services have significantly deteriorated since the last inspection of children's services in April 2012. Poor practice has already been identified by two independent reviews of children's services commissioned by the local authority in 2014. A voluntary improvement board and an improvement plan are in place as a result. Despite this, inspectors identified widespread, systemic poor practice and services that are neither adequately ensuring the safety nor promoting the welfare of children and young people.

Of serious concern is the number of unallocated and unworked cases, particularly within the multi-agency safeguarding hub (MASH), where 122 cases have been held for five months without being progressed. This means that support for families is compounded by delay. A significant concern is that the local authority cannot know the extent and seriousness of the issues within these cases. This leaves some children potentially at risk of harm.

Children are left in circumstances that are actually or potentially unsafe without their needs or the level of risk being assessed or action taken. This is because there are fundamental shortfalls in frontline practice across the breadth of children's services. Assessments of children are often absent or incomplete and those seen by inspectors were mostly poor. A 'Back to Basics' training programme, introduced to improve front line practice, has only just started and is yet to show impact.

Far too often children and families do not have the support of a consistent allocated worker. There is insufficient oversight of practice by managers and a lack of communication and focus on key priorities. One of the reasons for this is the lack of stability within the workforce, caused by heavy reliance on agency staff and interim appointments at all levels, and compounded by a high turnover of social workers in some key teams. In addition, very high caseloads mean that workers are unable to undertake key tasks. While the local authority has introduced a clear strategy for developing the workforce, it is too new to have had any impact.

There is some effective early help to families, provided, for example by the Strengthening Families service. However, early help services are not well coordinated or focused and the new early help strategy is yet to be formally agreed by partner agencies.

Services for children and young people missing from home or care, missing from education or at risk of child sexual exploitation are insufficient and poorly coordinated. Data and intelligence are not adequately collated and analysed to inform either service development or planning for individual young people.

The local authority is slow to take appropriate legal action to safeguard children. As a result children at risk wait too long before they become looked after. Once they do become looked after there are further delays in finding permanent homes for them. This situation is made worse because of a shortage of appropriate accommodation and placements.

While there is evidence of some better practice within the adoption service, including some good life story work, there is a lack of focus on support and preparation. As a result, there have been four adoption disruptions within 12 months.

Services for care leavers are particularly poor. The support and aspirations for care leavers are seriously lacking, with poor quality planning and a lack of appropriate housing.

The local authority and partner agencies do not have a shared, up to date strategic plan that sets out their current priorities for children, how they will be delivered and how their impact will be measured. A 'framework of cooperation' outlining how partner agencies will work together and a new 'safeguarding Joint Strategic Needs Assessment (JSNA)' were finalised in May 2015. They are positive developments but again it is too early for them to have had an impact on improving the range and quality of services.

Performance management and quality assurance processes are poor, based on unreliable data and do not always focus on services and areas of practice in the greatest need of improvement. Learning from audits, the complaints process and feedback from children, young people and their families is not used to drive improvement planning. In addition, scrutiny by elected members lacks rigour and has had little positive impact.

Recent changes within the Local Safeguarding Children Board, introduced by the experienced new independent chair, together with improved communication between agencies on the improvement board are positive developments. However, they are too recent to have had an impact on improving services or outcomes for children.

Recommendations

The following recommendations are those that inspectors considered to be the priorities for Sunderland. They do not address all of the detailed failings identified in this inspection and contained in the main body of the report.

1. Take urgent action to review the cases of all children and young people who do not have an allocated social worker or who are not being actively worked with, and provide immediate and appropriate assessment and help as necessary. (Para 31)
2. Review as a matter of urgency all cases where children are looked after under voluntary arrangements to establish whether this legal basis is sufficient to ensure their safety and emotional security; and take additional action where it is not. (Paras 58, 62,64, 65)
3. Increase the capacity, quality and focus of the MASH to meet the demand for service. (Paras 29, 30, 31, 32, 33)
4. Review the cases of all children being worked with under the public law outline or in care proceedings to ensure that robust plans are in place and that cases are progressing at a pace that matches children's needs. (Paras 62 ,63)
5. Ensure robust management oversight of frontline practice so that decision making, assessment and planning for children are timely, clear and meets their needs. (Throughout).
6. Ensure children are seen promptly and regularly and that their views inform assessments and plans in line with their developing needs. (Throughout)
7. Take urgent action to recruit qualified and experienced staff and retain and support professional skills and competence. (Paras 139, 140, 141)
8. Ensure manageable caseloads for social workers so that they can respond appropriately and in a timely manner to the needs of children and young people. (Paras 29, 140)
9. Work with partners to ensure that there is a single, clear, up-to-date multi-agency strategic plan to shape services for children and young people in Sunderland and against which progress can be measured. (Para 133)
10. Ensure that strategic planning is focused on the areas of practice most in need of improvement and is underpinned by clear arrangements for operational delivery and the measurement of impact. (Paras 129, 133)

11. Develop performance management and quality assurance processes that focus on key priorities to help drive improved performance. (Paras 128, 129)
12. Strengthen the function of scrutiny committee so that it has a clearer impact on improving outcomes for children. (Para 130)
13. Ensure that the local authority meets its role and responsibilities as a corporate parent. (Paras 110, 116, 131)
14. Ensure there is sufficient breadth and quality of placements to meet the needs of children looked after and care leavers. (Paras 59, 76, 113, 116, 132)
15. Provide an out of hours service that meets the emergency needs of children and young people and is effectively coordinated with day-time services to ensure consistent and safe work with children and their families. (Paras 34)
16. Establish clear practice standards, policies and procedures so expectations are clearly understood by social workers, early help practitioners and their managers. (Paras 141)
17. Strengthen the arrangements for disabled children's transition assessments to adult services. (Para 42)
18. Engage with partner agencies to agree the aims, structure and implementation of the integrated early help offer and its fit with wider services for children and young people. (Paras 40, 52)
19. Build on the recent review of services for children and young people at risk of child sexual exploitation to ensure that these services, and those for children missing from home, care or education, are comprehensive, joined up and have sufficient capacity. (Para 134)
20. Revise the arrangements for supervised contact to ensure these are driven by children's needs and that workers are sufficiently experienced and trained to oversee contact appropriately. (Para 69)
21. Strengthen the Virtual School so that it is able to track effectively the progress of all children looked after and care leavers. (Para 86)
22. Improve the quality, consistency and monitoring of all personal education plans (PEPs,) particularly target setting and action planning, so that these become a more useful tool to help young people make educational progress. (Paras 90)
23. Establish an effective recruitment strategy for adopters. (Para 103)
24. Reduce the likelihood of adoption breakdown by developing the adoption support offer so that children and adopters receive support that matches their needs. (Para 109)

25. Improve ways to keep in touch with care leavers, providing a place for them to drop in and have access to the care leavers' team. (Para 112)
26. Improve pathway plans so that they reflect the needs and aspirations of young people and involve them in the planning process. (Para 119)
27. Improve arrangements to provide and monitor education, employment and training opportunities for care leavers and increase options available to them, for example through apprenticeships. (Paras 111, 117, 18, 120)

Summary for children and young people

- Senior managers in the local authority do not currently make sure children and their families get the right support when they need it most. They do not listen well enough to children and young people to help them provide a better service.
- They do not make sure all of the staff at the local authority have the right support and training to help them meet the needs of children, young people and their families. Inspectors have told them that it is very important that they must quickly do much better for Sunderland's children and young people.
- When children and their families have problems that are easier to solve, they get good support from professionals in their community and their school. When they have more difficult problems, it can take too long to get the help they need. Social workers and managers change too many times and this makes it difficult for children and young people to build a relationship with someone who knows them well. This means they have to tell their story more than once to different people, which can be hard.
- Some children are not seen often enough by their social worker and do not get the help they need to understand the plans for their future. Not all children and young people are asked what they want to happen when decisions are made about their care.
- When children need to become looked after by the local authority they go to live with carers who look after them well. Because lots of children are cared for by the local authority, they do not have enough homes. This means that sometimes children and young people have to live outside of Sunderland. This means children often have to change school, which is not good for their learning. It can also be difficult for children to keep in touch with their family and friends.
- Some children need to live away from their parents permanently. When this happens, it sometimes takes too long to find them a permanent home. The local authority always tries to make sure brothers and sisters live together, and they do this well.
- When young people are old enough and are ready to leave care, they do not get a good choice of somewhere to live and they are not given enough support to live by themselves. Some young people want to stay with their foster carers after they leave care but often their carers do not get enough help and advice from the local authority to make that happen.
- Too many young people leave care without good qualifications, which makes it difficult for them to get a job. They do not get enough support to go to college or university. The local authority knows they need to get better at providing support.

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

Summary

Serious and widespread systemic weaknesses in children's social care services mean that the local authority is failing to ensure that the most vulnerable children in need of help and protection are effectively safeguarded.

Inspectors saw many examples of referrals by partner agencies concerned about children where not all necessary action was taken to ensure that they were safe. The work of children's social care is characterised by unallocated and unworked children's cases, leading to drift and delay in providing services to meet children and young people's needs. During the inspection, 21 children's cases were referred back to the local authority by inspectors to request that immediate action be taken to ensure children's needs were met. This is one out of every ten children's cases looked at by inspectors.

Frontline social work managers do not get the support they need from middle managers to make effective decisions. This is compounded by high staff turnover and a dependence upon agency staff. Senior managers do not have sufficient understanding of the issues faced by frontline staff, particularly in the Multi-Agency Safeguarding Hub (MASH), who have very high caseloads and are therefore unable to respond swiftly and appropriately to the needs of children and families.

The threshold for access to children's social care services is not clearly understood and applied by partner agencies and frontline workers in the MASH. Partnership work does not provide an effective and safe response to supporting families who experience parental drug and alcohol or mental health problems, or domestic abuse. The out of hours service, which is meant to ensure that children can receive urgent help and protection during evenings and weekends, is not fit for purpose. Private fostering arrangements do not meet statutory requirements.

Families experience too many changes of social worker. Social work practice is characterised by delays in response to requests for help, children not being seen, limited direct work, and poor quality or absent assessments. This leads to poor quality planning to meet children's needs. In most cases, children and young people are not sufficiently engaged in assessments or involved in shaping their plans. Assessments and plans do not generally take into account distinctive features, such as their ethnicity or disability.

In most cases reviewed in detail by inspectors, social work intervention has not led to sufficient measurable improvement in children's lives. Not all children in need (CiN) or those who are the subject of child protection concerns have a written plan as they should do. Even children that do have a written plan are not always seen as frequently as they should be.

Social workers do not manage core groups of professionals effectively to deliver child protection plans. Core group meetings are not well attended by partner agencies.

The range of early help services and programmes provided by the partnership is not well focused or coordinated by a clear strategy. As a result, it is not always clear what services are available to help, although several individual examples were seen of effective early help to support individual families.

Services to protect children who go missing from home or are at risk of child sexual exploitation (CSE) are seriously underdeveloped and lack coordination. Data collected about children at risk of sexual exploitation is of poor quality. This limits effectiveness, as the partnership does not have a clear understanding of the extent of the problem to enable them to address concerns. When children go missing, return home interviews are not routinely offered as they should be. Arrangements to support children missing education are more effective, but do not link effectively with those for children missing from home or care and those at risk of sexual exploitation. This is a missed opportunity to improve the protection of these children by developing a greater understanding of risks and how to reduce them. The recommended actions from a recently commissioned review of children at risk of CSE are too recent to demonstrate improvement.

Inspection findings

28. Vulnerable children in Sunderland do not get good enough help and protection from children's social care services. Serious and widespread systemic failings mean that the most vulnerable children in need of protection are not effectively safeguarded. Many examples were seen by inspectors of situations where the local authority has not taken all the action necessary to ensure children's safety. During the inspection, 21 children's cases were referred back to the local authority by inspectors to request that immediate action be taken to ensure children's needs were met. This is one out of every ten children's cases looked at by inspectors. Social work staff do not consistently follow safeguarding procedures. Neither they nor their managers get the management support and oversight they need. Senior managers do not have sufficient understanding of the issues to take appropriate action to improve performance and practice at the frontline.

29. Within the Multi-Agency Service Hub (MASH), which deals with all new referrals to children's services, there are not enough social workers to deal with the high number of reported concerns about children's welfare, including incidents of domestic abuse. This lack of capacity is not only because of the number of referrals that come in but also because these social workers are additionally responsible for ongoing work with children up to the point of an initial child protection case conference, the establishment of a child in need plan or case closure. This lack of social work capacity during the key early stages of work with children and their families, leads to very high caseloads for social workers and creates a 'bottleneck' that leads to delay in progressing work with children. This key challenge for the local authority has not been managed effectively.

30. The threshold for referral to children's services is not sufficiently understood and applied by partner agencies and social workers in the MASH. The majority of contacts come from the police, who have no triage process to assess the appropriateness of the referral before contacting the MASH. This leads to 50% of these contacts resulting in no further action. The MASH is expected to provide a swift initial response to concerns about children, but there are significant delays in decisions to progress referrals and take effective action.

31. Within the MASH, inspectors saw significant shortcomings including delays in the allocation of cases to social workers, children not being visited, poor quality case recording and the drift in the completion of assessments. Additionally, 122 children's cases had been held for five months without being progressed effectively. In the worst example, a social worker had 45 assessments to complete that were not entered on the children's electronic records. When inspectors identified these shortcomings, they were told that the local authority had been aware of the concerns and during the first week of the inspection deployed additional social work resources within the MASH to enable staff to assess risk and respond to unallocated and unworked cases.

32. The quality of social work assessments is poor. Social workers are confused about what type of assessment to complete. This is also the case for early help professionals, who use different types of assessment to inform their plans. In almost all cases looked at in detail by inspectors, social work assessments were of poor quality. They are not timely, comprehensive or analytical and do not lead to appropriate or focused help. Assessments have weak analysis of risk and protective factors. They do not consistently include an evaluation of the child's identity. Chronologies are not used effectively to identify historical factors and in some cases, assessments are absent or out of date. The voice of the child is not considered in the majority of assessments seen in the MASH and it is therefore unclear of the child's view of their situation.

33. Transfer arrangements for cases to progress from the MASH to locality social work teams for continuing work are not child-centred, safe or effective. Transfers are made via e-mail with no prior discussion or agreement between managers and are therefore sometimes missed. The delay experienced by

families at this stage means that social workers in the locality teams find it more difficult to develop effective relationships with children and their families as they have been waiting too long for help.

34. The out–of-hours service that provides emergency social work services at evenings and weekends is not fit for purpose. There are no staff members specifically dedicated to it. Arrangements rely on social workers who have been working through the day continuing to work out of hours. Tired out-of-hours social workers often focus only on responding to the immediate presenting safety issues for children. They frequently fail to complete essential records such as full referral details or records of child protection strategy discussions. As a result, this essential information is not available on the electronic records to ensure continuity between the day and out-of-hours services in keeping children safe.

35. The number of children subject to child protection plans in Sunderland is rising. In May 2015, 394 children were subject to a plan. This is a 29% increase from 31 March 2014. A high proportion of children in Sunderland (86%) are subject to a child protection plan for the category of neglect. This is much higher than both statistical neighbours (55%) and England (43%). The reasons for this have not been analysed and are not well understood by the local authority.

36. Not all those assessed as children in need (CiN) under Section 17 of the Children Act 1989, or who are the subject of child protection concerns, have a plan aimed at reducing risk and improving their welfare. In no cases looked at in detail by inspectors was there a good child in need or child protection plan; many were poor. Examples were seen where there was no written plan. Where they did exist, many were out of date, delayed in completion or had key omissions. Plans are not consistently reviewed or updated and so do not adequately reflect children's changing needs or level of risk. In the large majority of cases, children's needs arising from diversity factors are not sufficiently considered. This means that the help being offered to the family lacks focus and is not defined by clear expected outcomes.

37. The allocation of a case to a social worker does not consistently or reliably improve children's safety. Children experience too many changes of social worker. Nearly a quarter of all children subject to a child protection plan are not seen by their social worker in the timescale set by their plan. In the large majority of cases where action is required to remove a child permanently from their family, arrangements are not progressed in a timely manner. There are delays and missed opportunities in obtaining legal advice to help shape assessments and plans and poor contingency planning.

38. Child protection core groups do not always take place regularly and when they do, they are not well managed. They do not use the child protection plans to measure progress and ensure actions are focused on the issues and actions that will make the most difference. There is no designated minute-taker and so no formal record of the core group meeting to share with group members,

including children, young people and parents. Consequently, it is not always clear what action is required from whom and by when. Professionals from the different agencies who attend core groups report that they make their own notes and often have to contact social workers after the meeting to ask them what they need to do.

39. Partnership working to meet children's assessed needs is of inconsistent quality. In most of the cases looked at in detail by inspectors, multi-agency work is not effectively coordinated. There is some poor joint work between children's social care and the police. This includes poor information sharing to determine risk and weak decision-making on whether to undertake single or joint child protection investigations.

40. The consistently poor performance of children's social work services has resulted in a loss of confidence by their partner agencies. This has led to delayed referrals and refusals by agencies at early help panels to accept cases judged by children's social care to be ready to step down from child in need and child protection plans. As a result, many examples were seen of children remaining in the statutory system when this is not necessary and may not be in their best interests. Attendance of some agencies, in particular the police, at core groups and child protection conferences is poor.

41. Identified risks to children are not always clearly documented in case records. This compromises the council's ability to make the right decisions at the right time when children may be at risk of immediate harm. Significant gaps in case records include poor or absent records of strategy discussions and meetings and delays in placing child protection conference minutes on file. The outcome of child protection enquiries is not recorded consistently and the timeliness of progressing to an initial child protection conference (ICPC) is consistently poor. Performance in April 2015 was only 51% within timescale. In addition, social workers use offline documents for the majority of their recording including initial assessments, strategy discussions, child protection enquiries, reports to ICPCs and care plans. Consequently, children's electronic case records do not contain accurate details of social work activity and the dates of completion of work, which hampers frontline managers' ability to monitor and improve practice.

42. Transition arrangements between children's and adult services for disabled children do not consistently ensure effective planning for young people at this important point in their lives. This is because, unless disabled children are assessed as having complex needs, they have a review chaired by a non-social work qualified support officer when a detailed social work assessment to fully identify their needs would be more appropriate.

43. Children at risk of child sexual exploitation and those who go missing from home and care are not adequately safeguarded. Understanding of the numbers of children involved, the effect this has on them and the impact of services in tackling the problem is seriously underdeveloped. Staff from different agencies

have received training and a risk assessment toolkit has been introduced to inform their responses to risk. This is not yet embedded in frontline practice, with some social workers unclear about how to use the tool. The Missing, Sexually Exploited and Trafficked (MSET) group meets monthly and has had some success in working with individual young people who are vulnerable to sexual exploitation or who have repeatedly gone missing but does not routinely compare data and intelligence from different sources to understand the wider picture or who are the most vulnerable young people. In particular, gaps in intelligence and data and a failure to make connections between cases of actual or risk of sexual exploitation, children missing from home or care and those missing education limits the effectiveness of this group. This means that professionals do not have the detailed understanding that would enable them to identify children at greatest risk, identify 'hotspots' or develop services. Although some examples were seen of disruption activity, this work is not yet effectively coordinated.

44. A national charity's 'Cut them Free' campaign and 'Chelsea's Choice', a themed drama production about a true story of exploitation, have been rolled out across all schools, reaching many children.

45. When children do go missing, return home interviews are not always offered. Social workers and managers are not clear on statutory guidance about when a return home interview should be offered. Return home interviews for children not known to children's services who go missing from home are undertaken by a commissioned service. However, there is no equivalent service in place for children and young people who are 'active cases' to children's services, when they go missing from home or care. Copies of return home interview records for children not known to the local authority are sent to the police. However, those that are carried out by social workers for young people who 'open cases' to children's services are not sent to the police. As a result, there is no opportunity to collate information from the full range of interviews to help shape and target services. When this was raised as a concern by inspectors, the local authority put in place revised guidance to staff to ensure copies of all return home interviews are collated centrally.

46. Arrangements to support children missing education are effective but school attendance remains a challenge. Thorough procedures are in place to ensure that any children missing from education (CME) are identified quickly and appropriate action taken to establish their whereabouts. Weekly school returns are followed up swiftly and investigations are referred to the five locality attendance officers. Information about the names and number of children missing education is not however cross-referenced with information about children vulnerable to sexual exploitation or missing from home or care. This limits the local authority's ability to assess who are the most vulnerable children. The authority provides appropriate support to parents of children receiving elective home education including advice and guidance, home visits and examination arrangements. However, procedures are insufficient to assure

the quality of alternative educational provision and they are particularly poor for those children educated outside of the local authority area.

47. The local authority cannot be assured that children who live within families where there are concerns about parental drug or alcohol misuse or mental health problems are supported and safe. Delayed responses by the local authority and the poor quality or absence of assessments, combined with confusion about the availability of services, leads to a lack of appropriate focus on these families' needs. The Safeguarding Joint Services Needs Analysis (May 2015), highlights fragmented pathway arrangements between preventive and early intervention services, Strengthening Families and social care. This includes duplication of service provision in some areas and scarcity of provision in others, with identified problems around the lack of consistent application of child protection thresholds. This mirrors the concerns identified by inspectors.

48. Poor partnership work provides an ineffective response to supporting families experiencing domestic abuse. Insufficient training and support means that social workers do not always have the knowledge they need to spot the signs and symptoms of domestic abuse, or to make effective interventions. The local authority does have a standard assessment tool for assessing risk in cases of domestic abuse but this is not routinely employed. The data on domestic abuse is insufficiently developed to help shape service and management decisions. The rate of domestic abuse referrals has risen sharply by 40% in the last year and the local authority and its partners do not know why. Domestic abuse contacts and referrals from the police are of poor quality. They are not informed by an assessment of the risks posed to children and do not provide a sound basis for social work decision making. The Police triage team uses an evidence-based assessment tool but does not routinely share this information as part of the notification to children's social care. Following referrals, children's services send standard letters to parents who may be either a victim or a perpetrator of domestic abuse, despite the possible risk of further violence inherent in this practice.

49. Private fostering arrangements do not meet statutory requirements. It is acknowledged by the local authority that insufficient work is being done to promote awareness of private fostering across the area. A small number of young people are appropriately identified as privately fostered when referred to the MASH. There were then considerable delays in the completion of assessments of private fostering arrangements and, where these do exist, they are of poor quality. Visits to support privately fostered children and young people are neither sufficiently frequent nor regular, and it is unclear from social work records what help is being offered.

50. There are delays in the progression of some cases being considered by the local authority designated officer (LADO), where child abuse is suspected by an adult who is in a position of trust. This means that children's safety cannot be assured. Despite prioritisation of cases by the LADO to ensure that the immediate safety of children is not compromised, there is insufficient capacity

to provide a timely response to all cases. As in the broader work of the local authority, there is a reliance on the use of offline systems that are not connected with other child protection processes. This leads to poor coordination.

51. The Strengthening Families approach is Sunderland's response to the Troubled Families national initiative. The model became operational in March 2013. By December 2014, Sunderland reported that all of the 805 families they were working with had been 'turned around'. The Strengthening Families panel provides a multi-agency forum for access to services, but the police no longer attend. This delivers less effective joint work to support families.

52. A range of services are provided by the local authority and partner agencies for families requiring early help. These services have greater stability in middle management, make some effective use of co-location of professionals to enable teams around the family (TAFs), and share a robust panel system that monitors thresholds for intervention. However, whilst there are examples of good early help making a difference to families, overall there is a lack of strategic coordination and data is not used to identify the different levels of need across the city and target services to address that need. As a result, help is not always available at the right time and in the right place.

53. Gaps in the provision of early help mean that families experience inequality of access to the services they need. For example, the early help offer for children under five years has much clearer pathways, but this is not the case for children over five. Victims of domestic abuse and others who need to attend parenting programmes experience waiting times of up to five months. There is some targeting of service where there are three or more agencies involved with families through TAFs but the number of families engaging with this service is low, only five in the East locality at the time of the inspection.

54. Local authority family support workers provide some effective services for children just below the threshold for safeguarding. However, there are not enough of them to meet the demand and so some families wait too long to get the help they need. Examples were seen by inspectors of families caring for disabled children with complex needs experiencing delays in getting services and of others experiencing gaps in services.

55. For those receiving services, many families are engaging successfully with the early help provided and they have their cases reviewed to ensure their changing needs are met. Almost all of the 536 children who have been subject to an assessment under the common assessment framework (CAF) last year have been to the Strengthening Families panel and their circumstances have been reviewed. Good preventive work provided in children's centres was also seen by inspectors. This includes targeted work with parents from ethnic minority groups who are accessing parenting programmes, and a language, literacy and mathematics course that is making a discernible difference to their lives. Where outcomes have improved, this work is underpinned by effective

support that meets identified need through a child-focused plan. Some examples were also seen by inspectors of effective use of TAFs involving mental health support services, 'Wear kids' and the Sunderland Youth Offending Service.

56. The youth drug and alcohol project (YDAP) works well with young people up to the age of 18. Effective targeting of young people who present at Accident and Emergency is a good way to engage with young people when they may be at their most receptive. As a result, the number of young people engaged in programmes has gone up by 20% to 126 young people in the 12 months to 31 March 2015. The YDAP is performing above national average in key areas such as early access, with 100% of young people waiting less than three weeks to access the service and planned exits from the service at 87%. This demonstrates good outcomes for this vulnerable group. The rate of first time entrants to the youth justice system is on track to achieve the challenging 2014-15 target of less than 650 FTEs per 10,000 of 10-17 year-olds, following a period year on year improvements.

57. A Charter mark for schools in anti-bullying ensures quality standards that subscribing schools must adhere to, which the large majority do. This includes the completion of a Cyber Safety Agreement. The children's anti-bullying team and individual school leads use creative means of getting the messages across within settings including, drama, poster competitions and poetry.

Ofsted

The experiences and progress of children looked after and achieving permanence	Inadequate

Summary

There are serious and widespread failures in services for children looked after. Some children have remained at home in harmful or potentially harmful situations for too long before becoming looked after. When children do become looked after, they are often unable to develop trusting relationships with their social worker because of frequent staff changes. Children wait too long to be placed with permanent carers and to achieve legal security. The local authority has lost the confidence of the family courts. When children return home from care, the local authority does not always ensure these decisions are underpinned by assessments that demonstrate risks have been addressed, or provide sufficient on-going support and monitoring.

There are significant failings in quality assurance arrangements to ensure that children looked after and care leavers receive prompt and effective services that reflect their identified need. There is limited evidence that challenge by independent reviewing officers (IROs) leads to sustainable improved outcomes for children looked after. There is insufficient placement availability and choice. Increasingly children are being placed outside the city and placement stability is deteriorating.

Corporate parents are not sufficiently ambitious for children looked after. The educational attainment gap between children looked after and all children is widening. Not all children who go missing from care or who are at risk of sexual exploitation are identified or receive a return home interview.

Adoption is not considered soon enough for children who are unable to return home to their birth families. Children do not achieve permanence quickly enough. Permanency planning is not taking place by the time of the second looked after child review. Foster to adopt arrangements are under-developed. Children wait too long to be matched to an adoptive family and adopter recruitment is on hold. There are too many adoption disruptions because of poor support at critical times.

Outcomes for young people preparing to leave care are very poor and the local authority is failing to support young people in the most basic ways. Health, housing, education, employment and training needs are not met and young people spoken to are dissatisfied with the service they receive. Some young people spoken to said they felt unsafe and lonely where they live.

Inspection findings

58. There are currently 586 children and young people looked after by Sunderland City Council. This is an increase of 96 children (20%) since March 2014. This represents a rate of 107 per 10,000 children in the population, which is almost double the England average of 60 and above the average of 84 in similar councils. The local authority has not undertaken any analysis of the reasons for this increase or why a high number of these children are looked after under voluntary arrangements.

59. The local authority acknowledges that only a small number of 'connected persons' placements were previously approved as foster care arrangements. This means children were placed with family members and other connected persons without their capacity to provide safe care being formally assessed or monitored. The local authority took action to address this after a serious incident notification in August 2014 that highlighted the issue. The action taken has not however been sufficient, because inspectors found continued poor practice, including a failure to take action when assessments of carers are not approved. This means that some children remain in placements that may not be appropriate for their needs or may not even be safe. Inspectors found a small number of cases where children have remained in family placements after a temporary approval has been ended due to the unsuitability of carers. The local authority were already in the process of reviewing these children's cases and have been asked to expedite this by inspectors to ensure that children are safe and having their needs met.

60. Insufficient attention has been given to understanding the needs of children and their families and children's pathways into care. There is also a lack of concerted effort to improve early identification and provide support to families at risk of breakdown. There is no family group conference service to work with extended families and help them to make plans in family meetings to support children where concerns have been raised about their care. This also means children are not given early opportunities to live within members of their extended family when remaining with their parents is no longer possible. Consequently, some children have become looked after who otherwise could have remained within their wider family.

61. When children return home from care the authority is failing to comply with recent amendments to the Care Planning Regulations, as this is taking place without the approval of a nominated senior officer. A failure to undertake assessments before returning children home means the local authority cannot be satisfied that the concerns that led to them being removed from home have been adequately addressed. There is also limited evidence that once children return home they have a specific return plan or are visited regularly to ensure they are settled and safe.

62. When children do become looked after either by compulsory removal from home, or under a voluntary agreement to come into care, this is rarely

underpinned by effective pre-proceedings work under the Public Law Outline (PLO). Letters before proceedings are not consistently agreed with legal advisors and so the local authority cannot be confident that they are all of the required standard. Cases in the pre-proceedings stage are not regularly reviewed. Authoritative action is not taken soon enough to issue care proceedings where parents are unable to demonstrate and sustain change within the child's timescale.

63. Applications for care orders do not proceed quickly through the family courts. Consequently, the Judiciary and Children and Family Court Advisory and Support Service (Cafcass) have lost confidence in the local authority's ability to effectively support and progress children and their families through family proceedings. Delays in completing assessments at the pre-proceedings stage and poor quality assessments are two of the reasons performance is outside the requirements of the Public Law Outline where cases are expected to conclude within 26 weeks. Children's cases are currently taking an average of 34 weeks. This means children and young people are experiencing delays in achieving legal permanence and security. There is no strategic oversight of cases in the pre-proceedings process or when care applications have been issued and therefore senior managers are unaware of the delays.

64. Over half (52%) of looked after children are accommodated under Section 20 of the Children Act 1989. This is almost double the national average of 28%. The local authority has no current management information about the length of time children remain looked after under voluntary arrangements or the reasons for it. The local authority began auditing these cases from February 2015. This action remains incomplete with only 66 of 308 children subject to Section 20 being reviewed by a senior manager. There is limited evidence these reviews have led to any remedial action being taken.

65. Inspectors considered all 66 audits of the cases of children subject to Section 20 and a further 112 audits on cases of children with full care or placement orders. The findings show significant delay in securing permanence for children either through care outside their birth family, return to parents or kinship or connected persons care. Inspectors found 11 children subject to the pre-proceedings process, some for more than 12 months with no decision to issue care proceedings despite a lack of improvement in their circumstances. Inspectors also found two children experiencing delay in assessments for Special Guardianship Orders (SGO), one for more than two years; and four children whose plans for possible return to their families have not progressed. In relation to children on full Care and Placement Orders, inspectors found five awaiting assessment for SGO and seven children awaiting revocation of their Placement Order. Evidence in one case had been filed with legal advisors for over 18 months. Given that only 178 of 586 cases have been audited so far, the true extent of delay in progressing children's plans is likely to be far higher.

66. Challenge by IROs does not lead to sustainable improved outcomes for children looked after. IROs are not given sufficient profile and status as

additional guardians of the child's plan. Where IROs identify drift and delay, they escalate this to senior managers but this has little or no impact. Only a minority of children achieve a plan of permanence by their second looked after review. Consequently, children experience unnecessary delay in the implementation of their care plans. Excessive caseloads of more than 100 mean IROs cannot fulfil all of their statutory duties and are not able to track progress on children's plans between reviews. The timeliness of reviews has deteriorated from 94% in timescale in 2013-14 to 76% in 2014-15.

67. Children's needs are not formally reassessed once they become looked after and so care plans are often not informed by children's current developmental needs. Care plans are not always clear about desired outcomes for children and what is expected of the various professionals involved in their lives.

68. Inspectors have seen no evidence that placement and information records are routinely provided to carers when children are placed, or updated when children move placement. This means key information required by carers in order to provide appropriate care for an individual child is not always available. This includes delegated authority for carers. This is a statutory requirement.

69. Arrangements for children's contact with their birth families are not informed by children's needs and are not reviewed by social workers. The contact service is under-resourced and consequently children's contact is being supervised on an ad hoc basis by a variety of staff from across the local authority. Not all dedicated contact supervisors have relevant qualifications and none of the 25 staff had received any relevant training prior to the service starting in April 2014. Children see too many different workers during family contact; this is not helpful for their emotional development and wellbeing. This failure to consider children's needs and routines, to review contact arrangements or to supervise contact with suitably trained staff is compounded by the use of unsuitable venues. This exposes children and young people to risk of harm.

70. There is insufficient local placement capacity to meet the needs of children looked after. Consequently, 166 children (31%) are placed outside the local authority boundary and this has a negative impact on their ability to keep in contact with family members and other significant people in their lives. Children's education is also disrupted at critical periods in their learning, with 146 school age children moving schools for reasons other than a key phase in their education.

71. The local authority currently has five children's homes, four of which are judged good. One children's home requires improvement. The local authority has taken immediate steps to implement an action plan to improve the effectiveness of this home and no further enforcement action has been required. Where young people are placed in private residential homes outside the city, robust commissioning and effective regional consortium arrangements ensure the provision is only used where it is judged good or better by Ofsted.

72. The local authority's fostering service does not have a clear strategy to respond to some significant challenges that it is facing. Despite rising numbers of children looked after and declining placement stability, recruitment of foster carers is not currently being prioritised and there is growing pressure to find enough carers for sibling groups and teenagers with challenging behaviour. The service is overwhelmed with the number of connected person carer assessments that are being requested. Currently the team are assessing 17 such carers, five of which are overdue. Connected person carer assessments are of a poor quality. More positively only two children are currently waiting for long-term carers to be identified and no brothers and sisters are currently placed apart unless this has been in accordance with their care plan.

73. The chair of the fostering panel has recently resigned and a new chair has taken over. The panel is properly constituted and works well together. The panel does not however receive performance information or reports. First reviews of foster carers are presented to panel, though currently there is a backlog.

74. The panel has turned applications down, but the majority have then been overruled by the agency decision maker (ADM). The panel does not currently have confidence that the recommendations they are making will be supported by the ADM. This role has been filled with a series of interim post holders. Consequently senior managers cannot be assured that decisions are being made in the best interests of children.

75. Foster carers feel supported by their supervising social workers and, in cases seen by inspectors, social workers were visiting foster carers every six weeks. Training and development programmes have been maintained. In the case files seen by inspectors, appropriate agreements, checks and references were in place. However, foster carers do not receive formal written confirmation of delegated authority. This means that they do not have the authority to make safe and unchallenged decisions for children and care planning regulations are not being complied with.

76. The stability of short- and long-term placements for children is deteriorating. There has been an increase in the number of placement moves children experience with 76 (13%) out of 586 having three or more moves in the past twelve months. This is a rise from 12% in 2013-14 and compares to a 10% average for 2013-14 in similar local authorities. Five children have experienced six moves. One of these is just five years old. Placement disruption affects children's ability to develop stable and supportive relationships with trusted adults. This is critical to the emotional development of children unable to return to their birth families.

77. This instability is compounded by the significant turnover in social workers that children experience. In the past 12 months almost one third of children looked after have had a change of social worker. One young person told inspectors they had had 12 social workers. This has had a negative impact not only in the

child's ability to develop a meaningful relationship with their social worker but also in relation to: delays in the completion of assessments of children's needs; delays in progressing cases within the Public Law Outline (PLO); delays in children achieving permanent care outside their family; and delays in progressing children's plans either for reunification to their families.

78. Not all children looked after are seen regularly by a social worker. At the time of the inspection, there is no record of 72 children and young people having been seen by a social worker in 2015. One young person spoken to by inspectors commented 'my social worker is unreliable; they sometimes don't come when they are supposed to and they are often late'. Not all statutory visits by social workers are well recorded which makes it difficult to see the purpose of the visit or how the visit monitors and drives forward the child's plan.

79. There is a lack of evidence of management oversight on the vast majority of children's files. Rationale for decisions is unclear. The local authority does not have accurate performance data about statutory visits to children, which means senior managers are not aware whether they have been visited or not.

80. Children and young people who are living in permanent long-term foster homes are not always given access to the services they need to help make these placements successful. For example, when these children and young people receive life story work this is due to the commitment of individual social workers and foster carers rather than an organisational understanding of their needs or a policy and commitment to support this.

81. Procedures to identify and support children who go missing from care or are at risk of child sexual exploitation are underdeveloped. Currently return interviews are not offered in all cases and not all interviews are conducted by a professional with sufficient independence from the carers. Information obtained from interviews is not used or analysed to inform safety plans for individual children or understand 'push' and 'pull' factors. Information is not aggregated to identify patterns, themes and trends.

82. Not all children at risk of child sexual exploitation receive a risk assessment. Where these are undertaken, their poor quality and failure to analyse the full range of findings including the child's history of going missing means children at risk of sexual exploitation are not identified and protected. The local authority's data in relation to missing children and children at risk of sexual exploitation are unreliable. The local authority was unable to provide inspectors with a clear statement of the numbers of children involved. Inspectors sampled 18 return home interviews and cases where children were at risk of child sexual exploitation. In the vast majority of missing cases, children had gone missing on more occasions than is recorded in the authority's performance data. This means senior managers are unclear about the numbers of children at risk of child sexual exploitation and going missing from their care. This is a serious failing.

83. The Council's Pledge to all children looked after and care leavers does not reach the vast majority of children and young people. There is no website to communicate information to children and young people. The 'Change Council', which is the local authority's Children in Care Council, does not fully represent the views of all children looked after, with just five members attending the last two meetings. There are no mechanisms in place to allow Council members to canvass the views of their peers. Despite their small numbers the 'Change Council' has had a significant impact in improving some services, for example, successfully lobbying to keep two children's homes open and to increase the payment made to care leavers.

84. No children in Sunderland are allocated an independent visitor. Only eight children looked after receive the support of an advocate, despite the contracted service having capacity to allocate an advocate within 24 hours and the contract having no limit to the number of advocates who can be commissioned. This number is very low given there are 370 children and young people looked after over the age of seven.

85. The authority has made an improvement of 2.8% in reducing the numbers of children and young people at risk of offending, but this is from a very high starting point. The 2014-15 figure of 13.3% (29 out of 218 children aged 10-17) continues to fall from a high of 16.1% in 2011-12. However, the rate of children and young people offending in Sunderland remains high at 10.4 per ten thousand children compared both with North East local authorities at 6.5 and England at 3.75 per ten thousand. The lack of a restorative justice approach within the local authority's own residential provision is having a negative impact on the numbers of cautions and reprimands young people receive. As a result of this children looked after in Sunderland are around three times more likely to be cautioned or convicted for an offence when compared with children looked after nationally and twice as likely when compared with statistical neighbours.

86. The vast majority of children looked after attend good or outstanding schools. The virtual school does not however have enough staff to support adequately the 446 school-age children who are looked after. Attendance in Sunderland schools is in line with schools in the rest of England but the number of pupils who are persistently absent is slightly higher than nationally. The proportion of children looked after who have had at least one fixed term exclusion has, for the last three years, been higher than for similar groups nationally. No looked after child has been permanently excluded for the last two years.

87. Most children looked after enter school from a low starting point. Too many school moves for very young children mean they are frequently set back in their attainment. For example, out of 15 looked after children at Key Stage 1, three have moved schools four times since starting school, one has moved three times and nine have moved twice.

88. For those looked after for an average of two years or more, the rate of progress at the end of Key Stage 2 and Key Stage 4 is a mixed picture. The number of children achieving a Level 5 in reading at Key Stage 2 was higher than previous years, but at Level 4 children looked after performed below the general population of children locally and nationally. Children identified as having special educational needs perform less well than similar groups nationally at both Key Stage 2 and Key Stage 4.

89. Performance in GCSE examinations at five A*to C in all subjects shows an improving trend and has doubled in the last year from 40% to 80%. Standards in the proportion gaining five or more GCSE grades A*-C including English and mathematics has remained low at 20%, and are well below that which is expected nationally and that of their peers locally. The rate of progress is not rapid enough to close the attainment gap, and the better progress made at Key Stage 2 for some children is not sustained throughout Key Stages 3 and 4.

90. The quality of personal education plans (PEPs) is poor; target setting is insufficiently clear to drive progress effectively, with few targets being specific or measureable enough to monitor progress. Timescales are often unclear, with many actions simply being reported as 'on-going'. Young people's views are not well or consistently recorded.

91. The Anti-Bullying strategy, which includes cyber-bullying, ensures foster carers and residential workers have training to enable them to support children and young people when they encounter discrimination or bullying.

92. Thorough procedures are in place to ensure that any looked after children missing from education are identified quickly and appropriate action is taken to establish their whereabouts. Procedures to assure the quality of alternative educational provision are insufficient, particularly for those children placed outside of the local authority area. Virtual school staff do not visit providers prior to a child being placed and quality assurance procedures are not well defined. Arrangements for the transition of young people into post-16 education and training are not good enough. Young people are not helped to explore sufficiently the whole range of post-16 options.

93. Children and young people have not had their health needs identified and met because initial health assessments of children becoming looked after have often not been completed in a timely way. This has improved during 2015, from 21% in January to 80% in May. However, this improvement needs to be built on and maintained. The high turnover of social workers has been a particular factor behind initial health assessment requests not being sent to the designated doctor within 28 days, and consent not always being sought from parents.

94. Children and young people's emotional and mental health needs are not sufficiently recognised or addressed. Where strengths and difficulties questionnaires are completed for children they are not scored and are not used

to identify young people's emotional needs or gaps in services. Child and Adult Mental Health Services (CAMHs) are delivered by a number of providers and referral pathways are unclear. This means it is confusing for young people, staff, parents and carers to access services. Thresholds and the criteria for transition to an adult specialist service are particularly high. As a result, young people who may need this service are referred back to their general practitioner. Consequently young people experience stop and start assessments and delays in receiving support when they need it. However, children who self-harm are responded to very quickly and appropriately and are seen and assessed by a psychiatrist in hospital.

95. Children looked after are able to get advice and support from a specialist nurse who provides contraception services. The Youth Drug and Alcohol Project (YDAP) is a team of qualified drugs workers providing a service for all young people aged 10-18 who require specialist advice and support to help overcome problems or difficulties relating to drugs or alcohol. YDAP have a link worker specifically identified to work with local authority children's homes. Training on sexual health matters and drug and alcohol issues is regularly provided to foster carers.

96. Tier 3 CAMHS for children and young people with serious mental health difficulties is overwhelmed by the number of referrals it receives. Children wait for up to up to three months to receive a service. Staff in universal services and targeted services lack skill and confidence in dealing with emotional and mental health problems and so refer almost all cases into specialist services. This means that some children receive a mental health service unnecessarily and the service cannot focus on those children most in need. Children looked after receive a degree of prioritisation and have a separate referral pathway but this still lacks sufficient responsiveness. Care leavers are not given priority by the service and do not have a separate referral pathway.

The graded judgement for adoption performance is that it is inadequate

97. Children do not achieve permanence quickly enough. The adoption scorecard (2011-14) reports that it takes 654 days from the point at which a child becomes looked after to them moving to an adoptive family. This is 107 days away from meeting the national threshold target, 77 days longer than statistical neighbours and 26 days longer than the England average. Local authority data show a significant improvement in performance for 2014-2015, which has seen the number of days drop from 599 in 2013-14 to 484.

98. The time taken to find an adoptive family is also too long. The adoption scorecard (2011-14) reports it taking on average 240 days, which is 88 days

away from meeting the national target, 52 days longer than statistical neighbours and 23 days longer than the England average. The local authority again report improved performance for 2014-15, down from 215 in 2013-14 to 201 days. While timeliness against the main two indicators in the adoption scorecard is showing improvement, Sunderland is still not achieving the national thresholds targets for either indicator.

99. Opportunities to put in place concurrent arrangements are being missed. There is no foster to adopt policy and carers are not being actively recruited. The local authority recently identified a worker within the Permanence Team to be a Foster to Adopt Champion but it is too early to assess any impact of this development.

100. Systems are not in place to ensure that permanence planning happens by the time of the second children looked after review. In the cases seen by inspectors, formal discussions had not taken place by this point. Importantly, this means that valuable time is wasted during which contingencies could be explored and profiling work started. Added to this, the progress of children who require a permanence plan is not being tracked. The Permanence Monitoring Group, which used to meet regularly to perform this function, has not met for 18 months.

101. Some of the work within the Permanence and Adoption teams is of a good standard. Care Plans are clear and focused, Child Permanence Reports are well written and regularly updated and children benefit from good quality life story work. Social workers and social work assistants in the Permanence and Adoption teams are knowledgeable, experienced members of staff who have manageable caseloads. However, the current team manager of the Permanence Team does not have the required three years' experience within adoption work to be able to sign off key documents, such as the child permanence report. There is also a lack of appropriate management oversight in case records where management decisions and the rationale behind decisions are not routinely recorded.

102. The adoption service works creatively to find carers for children. If an in-house match cannot be found, profiles are shared with members of the North East Consortium, the Adoption Register is accessed and paper and online publications are used. The local authority has also held a number of events where information about children has been shared with prospective adopters. Sunderland is currently assessing 14 adoptive households. The local authority has a well-established two-stage assessment process and the vast majority of assessments take place within timescales. Adopters spoke positively about the training they had received.

103. Currently, adopter recruitment is on hold. It is not clear why this decision had been taken. The local authority does not have in place robust management arrangements to ensure that there are sufficient adoptive carers in the future.

104. While children in Sunderland wait too long to be adopted, the local authority is successful at securing adoption for a significant number and range of its children looked after. The Adoption Scorecard reports that from 2011-14, 21% of the children who left care were adopted; this is good performance against the England average of 14%. Further, of the children aged five and over leaving care, 9% are adopted, performance which is higher than statistical neighbours by three percentage points and higher than the England average by four percentage points. For 2013–14, eight sibling groups were placed together and there were no sibling groups placed apart where the assessment was for them to be placed together. Good performance was sustained in 2014-15 with the number of older children and sibling groups adopted increasing over the previous year. The number of children adopted from ethnic minority backgrounds is extremely small with only one child being adopted in the last year.

105. Social work assistants produce good quality life story work for adopted children. Later life letters are written and life appreciation days are taking place for the majority of children.

106. The Adoption Panel has an experienced chair, is properly constituted and takes place when required in order not to hinder the progress of cases. However, the agency decision maker is not making decisions within timescales, leading to delay at a critical point in the child's journey.

107. Two, of the current five, children waiting to be matched have been subject to unnecessary delay as a result of medical information not being provided in a timely way. These issues should have been picked up by the family finding tracker meetings, which monitor the progress of children waiting to be matched.

108. Too many children have experienced adoption disruptions over the last 12 months. This has seriously impacted on their ability to secure a permanent family. Four placements have broken down, two during introductions and two shortly after the children had joined their prospective adoptive families. Inspectors noted in all of these cases, poor matching, inadequate preparation and insufficient management oversight. In three of the matches that broke down, activity events (meetings that both children and adopters attend) were used. The local authority needs to reassure itself that this tool is effective. The learning from these placement disruptions has not been used to inform improvements in practice.

109. There is currently no waiting list for adoption support and there are 11 packages of support ongoing. Post-adoption support offered lacks depth, providing no CAMHs support for adopters and professionals dealing with challenging and complex family issues. Currently there are three full-time adoption support workers providing practical assistance and some low level emotional support. These workers have completed only 18 assessments since March 2014. Managers accept that there is a significant gap in both the range

of post-adoption support on offer and its take up despite the capacity available within the service. A scoping exercise is due to take place to consider the best way to meet the needs of adoptive families in Sunderland, while also ensuring value for money.

110. The annual adoption report does not provide a sufficiently analytical account of the work being undertaken within the service or by the Adoption Panel. This means that the Corporate Parenting Board is limited in the extent to which it is able to understand what has taken place and hold staff to account. For example, the 2014-15 report contains only data on the number and range of children who have been adopted and adopters approved. This information is not placed within the context of a service struggling to get children adopted quickly enough, support and maintain children in their adoptive placements and recruit sufficient adopters.

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

111. Care leavers and young people preparing to leave care are being failed by this service. The local authority fails to support these young people in some of the most basic ways. The outcomes for young people leaving care are extremely poor as a result of this failure.

112. Care leavers spoken to by inspectors were unhappy that they could not go in the building where the leaving care team is based to visit their support workers, meet up with each other or drop in for advice. When this was pointed out by inspectors, the local authority took immediate action to change this so that young people can enter the building. This situation has contributed to the poor performance of the service in keeping in touch with care leavers, especially those who do not consistently have access to a mobile phone. Sunderland is currently in contact with only 30% of care leavers. This is 75 of 252 young people who are relevant, former relevant or eligible, which is a decline from 52% in the previous year. This is an exceptionally low number and represents a very serious failing.

113. Housing options and choices for young people leaving care are inadequate. Only 60 out of 136 care leavers (44%) aged 19 to 21 years are in suitable accommodation. This is down from 96 out of 147 (65%) in 2013-2014.

114. Some young people told inspectors that they felt unsafe where they live because of anti-social behaviour, threats of violence or because of the poor quality of accommodation. One 17-year-old met by inspectors lives in a shared home whose bedroom has graffiti and damage from the previous tenant. Two young people living in supported lodgings did say they feel safe and happy where they live, however six that are living in or have recently moved on from trainer flats and hostels say that they felt worried and unsafe. They say that the lack of support and the loneliness they felt living on their own made them feel anxious and isolated.

115. Young people do not all know about their entitlements to funding for setting up home, equipment for work and training and they have not been given any information about advocacy or complaints. Young people are expected to fund expensive deposits and bonds on properties of up to £800 from their leaving care grant, which leaves them with little money for the essential items required to set up their own home. The local authority does not have robust commissioning arrangements in place to ensure sufficient high quality, affordable and safe housing for care leavers.

116. Four care leavers have been homeless in the past six months. They have each recently found accommodation but one young person spent three months

'street homeless', while another 'sofa-surfed' for six months. A third young person is living with just basic resources in bed and breakfast accommodation. Senior managers were unaware of these issues. Cases of homeless children looked after and care leavers are not formally reported on a regular basis to the leadership team or the Corporate Parenting Panel.

117. The local authority has insufficient contact with many care leavers and outcomes for them are poorly recorded. As such the service is unable to determine whether care leavers are being supported into employment or training. The number of care leavers not in education, employment or training is 101 out of 136 (74%). This is very high and a deterioration in performance from 57% the previous year. Five young people are recorded as being not in education, employment, or training (NEET) due to pregnancy or parenting and a further four due to illness or disability. Activity information for 193 care leavers (77%) is recorded as not known. The local authority's inability to identify and record care leavers' employment status is a serious failing that prevents action being taken to improve young people's economic well-being.

118. There are no apprenticeships available for care leavers and relationships with the local college are poor. Care leavers attending Sunderland College have no transition arrangements in place, the college is not involved in pathway planning and when problems arise for students such as eviction, it is the college that offers pastoral care and support. Liaison between the virtual head teacher and the college is poor. The college does not receive information from the local authority about things that might impact on young people's future success.

119. Pathway plans are mostly ineffective. The majority seen had important information missing; some had not been started. Those that had did not contain clear goals, expectations or timescales and young people had not been actively involved in developing them. Case recording on care leavers' files is incomplete and does not demonstrate that comprehensive risk assessments have been undertaken. This means that the local authority does not know how many care leavers are at risk from such factors as drug or alcohol misuse and therefore do not know what support they will need to address these needs.

120. The lack of management oversight of cases means that poor practice and drift and delay in progressing plans are unchallenged. Assessments and plans are not dated, signed or reviewed by managers and the promotion of young people's education, employment and training is not discussed with any sense of urgency. Supervision takes place regularly but is not well recorded, reflective or focused on problem solving.

121. The 'Change Council' provides a forum for children looked after but there is no council for care leavers and this means that their thoughts and ideas are not sufficiently heard and responded to. Care leavers said they would welcome a chance to speak to senior managers and to have a say in how services for them are designed and delivered. There is no forum to celebrate care leavers

achievements, they do not receive birthday presents and there are no arrangements in place to ensure that they are not alone at Christmas and other holidays.

122. The leaving care team is stable and many young people have had the opportunity to develop longstanding trusting relationships with their leaving care workers, who they value highly. Some of the team are experienced in working with young people and are able to offer help with practical matters and work to support young people through emotional issues. However, other workers on the team are offering low-level practical support to young people, which is more like a befriending service than a professional leaving care service. Staff do not receive adequate training and development to ensure that they have the skills to respond to young people's needs around mental health and wellbeing, domestic abuse, drug and alcohol use and sexual health.

123. Young people do not always have information about their medical histories or receive a health passport when they leave care. Some young people who spoke to inspectors have recently become mothers but had received little or no information about medical issues that may have been important to know during their pregnancy or post natal period.

124. Responses to care leavers who go missing or are at risk of child sexual exploitation are under developed and uncoordinated. Some examples of good work were seen in individual cases, such as later life letters, one-to-one work to develop self-esteem, breaking patterns of behaviour and giving young people alternatives, but there is a lack of strategy or consistency in approach. These individual cases are not used to build a picture of the risks to young people.

Leadership, management and governance	Inadequate

Summary

Senior managers and elected members, including at the very highest levels in the council, have not ensured that children and young people receive services that keep them safe. They do not ask the right questions or undertake the right activities to have a good enough understanding of frontline practice and have not put in place the necessary improvements. There has been a serious failure in governance and this has led to broad and deep inadequacies in services for the most vulnerable children.

In the year before the inspection, two independent reviews commissioned by the local authority reported significant failings in services for children and young people similar to those identified during this inspection. Despite these reports, there remain serious and widespread failings in local authority services that potentially leave children unsafe. The local authority has not been able to ensure that all children and young people who need one have a social worker who sees them regularly, an assessment of their needs and a plan aimed at improving their welfare. Decision making for children is often unclear and many children and young people experience delays in receiving help.

Performance management and quality assurance processes are poor, based on often unreliable data, and do not always focus on services and areas of practice in greatest need of improvement. Learning from audits, the complaints process and feedback from children, young people and their families are not used to understand the quality and impact of services and to drive improvement planning. Scrutiny by elected members lacks rigour and has had little positive impact.

The local authority is not meeting its responsibilities as a corporate parent. The needs of children looked after and care leavers have not been adequately analysed or met. A sufficient range and quality of placements has not been provided; both placement stability and the percentage of care leavers in suitable accommodation have declined over the last year. Outcomes for care leavers are particularly poor, with less than half in suitable accommodation.

The local authority and partner agencies do not have a shared, up–to-date strategic plan that sets out their priorities for children, how they will be delivered and how impact will be measured. The Children's Trust has not met since May 2014 and no successor forum is in place to act as a focus for the multi-agency planning and delivery of services for children and young people. A 'framework of cooperation'

outlining how partner agencies will work together and a new safeguarding joint strategic needs assessment (JSNA) were both finalised in May 2015. These are positive developments but too new to have had an impact on improving the range and quality of services.

Services for children and young people missing from home or care, missing from education or at risk of child sexual exploitation are insufficient and poorly coordinated. Data and intelligence about young people are not adequately collated and analysed to inform service development and planning for individual young people. A March 2015 review of services for children and young people at risk of child sexual exploitation commissioned by the local authority identified significant weaknesses in the existing strategy and action plan.

The local authority is aware of the need to recruit and retain staff, to provide better support and to develop their skills. Despite some success in recruiting permanent staff, an on-going reliance on interim and agency staff, including at senior management level, has led to continuing instability. Plans to support and develop the skills of staff through the appointment of a chief social worker, the roll out of a 'Back to Basics' training programme and other measures are too recent to have had a measureable impact on improving practice.

Staff morale in Sunderland is low. During the course of the inspection, staff reported feeling frustrated and unsupported because they were not able to provide adequate services to children and families.

Inspection findings

125. The most senior managers and political leaders have failed to ensure that children in Sunderland are supported, protected and cared for appropriately. There are widespread and serious failings in services to the most vulnerable children and young people. Despite a commitment from both political and strategic leaders to making improvements, many of the shortcomings found by inspectors were the same as those identified in the two independent reviews commissioned by the local authority in 2014. The local authority has not shown sufficient leadership, management, impact or pace in understanding, tackling and improving these failings so that outcomes for children and young people improve.

126. Frontline and strategic managers have been unable to ensure that all children who need one have a social worker. Nor have they been able to make sure that vulnerable children's needs and the risks they face are assessed and reduced through prompt and good quality support. Inspectors saw many examples of children and young people who either did not have a social worker

at all or who did but were not being seen regularly and where work was not being done to improve their lives. This is not safe for children and young people. There are not enough frontline managers and this combined with a lack of stability arising from the high number of interim-managers means that there is insufficient management oversight to provide consistent, guidance and scrutiny of practice. As a result, decision-making for children and young people is not always clear, consistent or timely.

127. Managers at all levels have failed to provide the necessary structure, oversight and support to enable social workers to do an effective job. This has a direct impact on the quality of services received by children and their families. In talking to inspectors, social workers in Sunderland variously described the service as 'firefighting', 'overwhelming', 'dangerous', 'unsafe' and 'chaotic'.

128. Senior managers do not have a good enough understanding of practice. The role of performance management in understanding and improving practice is under-developed and the data that support performance management are not reliable. Performance reporting does not focus sharply enough on key weaknesses in services. Senior managers have not established a performance culture in which the analysis of performance is informed by managers and social workers. As a result, performance information is not used as a practical tool to improve services and develop practice. During the course of the inspection, and in response to feedback from inspectors, the local authority took some immediate steps to improve both the quality of data and how it is used to monitor and improve practice. Although positive, these are only the first steps in ensuring a robust and effective performance management system are developed to help improve outcomes for children and young people.

129. Leaders and managers also lack a good enough understanding of the quality and impact of work with children and young people, because the use of audits is weak. Although the local authority is beginning to undertake both case and thematic audits, this is a new development. Case audits began in January 2015 and have not had an influence on improving practice and outcomes for children and young people. The local authority has not made best use of those audits it has undertaken. Learning has not led to subsequent actions plans or training to improve practice or any assessment of their impact. Qualitative information from audits, complaints and feedback from children, young people and their families has not been adequately gathered, analysed and linked to performance data to give the rounded picture of the quality and impact of practice necessary to drive successful service improvement.

130. Political leaders do not have a strong enough grasp of children's experiences outcomes. Although they express a strong commitment to the welfare of children and young people, and have backed this with increased funding at a time of significant financial pressure, they have not been successful in improving services. Elected members scrutiny of children's services has not been rigorous or tenacious enough to have a positive impact on outcomes for children and young people. A new safeguarding committee, created to

scrutinise the implementation of the local authority improvement plan, met in February and March of this year but is too new to have had an impact.

131. As a corporate parent, the local authority has not analysed, prioritised and planned sufficiently to improve outcomes for children looked after and care leavers. Corporate parenting board members cannot give clear evidence of how or where they have made a positive difference for children. The 'Change Council' (children in care council) is underdeveloped. The local authority has not done enough to involve children and young people, leading to low attendance by children and no representation from care leavers. There are no mechanisms in place for the corporate parenting board to seek the views of the wider children looked after population.

132. The 2013–16 sufficiency strategy does not adequately address the 20% increase in the number of children looked after over the last year. The strategy has a much stronger emphasis on describing existing services rather than on analysing need or planning for the future. Consequently, in-house and commissioned placements do not provide a sufficient range and quality of placements to meet the needs of children and young people. This lack of focus on key priorities is also reflected in the paucity of 'edge-of-care' provision, such as a family group conference service, and in the lack of enough good quality housing or an apprenticeship scheme for care leavers. Better placement provision, where it does exist, is driven by strong needs assessment and contract and compliance arrangements, for example through consortia arrangements with other local authorities and for some young people permanently placed in out of city placements. Notably the voice of children and young people is also much more evident in placement planning in these cases. Bringing together commissioners and social care staff at children in care panels is a positive new development but too new to have had a significant impact.

133. The absence of a current priority-based multi-agency plan to deliver services for children is a significant gap and multi-agency governance arrangements lack clarity and accountability. Without such a plan, and an effective forum or board, underpinned by operational delivery plans and focused reliable performance data, agencies are not collectively achieving the best for children and are not able to hold each other to account effectively or to measure outcomes achieved for children. A 'refresh' of the Children And Young People's Plan 2010–2025 carried out in 2014 does not update the plan but rather provides a brief explanation of some key national and local legislative, policy and practice developments in the intervening four years. Delivery plans for key priorities have not been developed in the interim and the performance framework developed to measure impact has not been used. The children's trust has not met since May 2014 and no successor body is in place. A 'Framework of Cooperation' between the Health and Wellbeing Board (H&WB), Sunderland Safeguarding Children Board and Sunderland Safeguarding Adults Board (SSAB), which also envisages the Children's Trust (subject to review) becoming an advisory group to the H&WB, was drafted in May 2015 but is yet to be agreed.

134. The Safeguarding JSNA of May 2015 adds to the overarching JSNA. It provides a much stronger focus on children and young people and identifies 11 appropriate areas of unmet need and service gaps, including CAMHS and developing CSE services. It is however too new to have had impact, lacks analysis and does not focus on some services areas in need of significant development, including services for children missing from home or care and care leavers.

135. The voluntary improvement board established by the local authority has been important in starting to build the improved relationships between the local authority and partner agencies that are a necessary starting point for good inter-agency working. However, the lack of engagement in this process of some key agencies such as the police and general practitioners limits joined-up improvement planning. As with wider partnership working, scrutiny within the improvement board is under-developed and improvement planning is not sharply focused on clear priorities or underpinned by robust plans for operational delivery and impact assessment. Consequently the local authority's own assessment of progress presented to the June 2015 meeting of the improvement board is that less progress has been made than was expected.

136. Services for children missing from home, care or education or at risk of child sexual exploitation are insufficient. They lack the joined up approach and impetus that a clear strategy, action plan and robust performance data and intelligence should provide. This is highlighted in a local authority-commissioned review of March 2015 that led to an immediate action plan to remedy deficits in the previous plan and strategy but this is very new and significant gaps remain in the quality, sufficiency and impact of services.

137. Data and intelligence about children missing from home or care, those missing from education and those at risk of child sexual exploitation have not been brought together and analysed to understand prevalence, levels of risk and trends. This means that service planning, training, awareness raising and disruption activity as well as planning for individual children and young people have not been informed by the information available. In particular, intelligence from return interviews carried out with the most vulnerable children, those whose level of need means that they are an open case to children's services, has not been collated centrally to help understand need and plan service developments.

138. There is only one worker, commissioned from the voluntary sector, available to undertake specialist work with young people who go missing or who are vulnerable to sexual exploitation and to provide training and awareness raising to professionals. Consequently, there is a waiting list and young people experience delays in receiving a service. Information in relation to child sexual exploitation and missing episodes is not always shared between different meetings about children. This means that planning for children is often neither well coordinated nor informed by all relevant information, and is consequently less successful than it could be in reducing risk for children and young people.

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139. The local authority recognises that recruitment, retention and workforce development are major challenges and are therefore key priorities. Some success has been achieved in reducing the percentage of the workforce who are agency workers from 30% in September 2014 to 21% in April 2015, and in achieving the target of recruiting three experienced social workers each month since January 2015. However the high percentage of managers who are interim, and the higher concentration and turnover of temporary agency staff in some key teams, remain a very serious issue. The MASH is staffed currently with 37% agency social workers. This means that the stability necessary to build sustained improvement has not been achieved.

140. The local authority has not created the conditions for good social work to thrive. Staff are often not clear about what they need to do, how they need to do it and by when. This is further hampered by a complex and unintuitive electronic case recording system, insufficient and inconsistent management oversight and supervision and very high caseloads, often in the 30s or 40s and even up to 69 in the case of one social worker.

141. The new workforce development strategy underpins a stated commitment to developing and retaining staff but has yet to show significant impact. The efforts of the newly appointed chief social worker to improve communication between frontline managers and staff and senior managers, and to drive up practice standards are well focused but too new to have had an impact. The safeguarding managers and practice champions groups have only started meeting over the last three months. Only one of six modules of the 'Back to Basics' training programme has been delivered to staff so far and risk assessment and 'signs of safety' training is yet to be rolled out.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate.

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.

Executive summary

The Sunderland Safeguarding Children Board is failing to exercise sufficient scrutiny of services for safeguarding children and young people in Sunderland. It has not done enough to evaluate how effectively agencies are keeping children safe or hold partners to account for their practice. It has not provided sufficient leadership and coordination with regard to key priorities including children who may be at risk of sexual exploitation, those who go missing and those who live in homes where domestic abuse is a problem. The board has not undertaken a multi-agency practice audit for over a year. It has not therefore monitored the effectiveness of local arrangements to safeguard children as required under statutory guidance.

The experienced independent chair, appointed in September 2014, has led a comprehensive review of board membership, structure and priorities and there is now a clear commitment at senior leadership level to improving the effectiveness of the board. This has resulted in changes coming into effect in April 2015. These include all board members now being sufficiently senior to be able to commit resources or agree changes to practice in their agencies. However, while considerable development work has been undertaken and a number of initiatives are well underway, these improvements have yet to show a significant impact in ensuring that the LSCB is fulfilling its statutory functions.

Relationships with other statutory boards have until recently remained unclear. This means that the board has had limited impact in ensuring that children's safeguarding issues are prioritised within the work of other boards, such as the Sunderland Safeguarding Adults Board and the Health and Wellbeing Board.

There is a lack of clear links between various planning documents. This means that the board does not have clearly defined priorities or expectations about the quality of

services for children in Sunderland against which it can hold agencies to account. For example, with regard to the provision of early help services, a single, streamlined plan is in preparation but it is not yet complete.

The board's limited resources are overwhelmed by the scale of undertaking 10 serious case reviews (SCRs) in two years, and this has seriously limited their capacity to undertake other activity. Current performance information available to the board is insufficient to allow partners to scrutinise and challenge performance.

Representation by Children's Services at sub-committees of the board has been inconsistent because of both poor attendance and staff turnover. Partners express exasperation at what they see as a lack of commitment and capability at middle management level within Children's Services.

Recommendations

142. Ensure full board approval of agreed priorities and action planning.

143. Ensure that the board is able to effectively monitor the quality and impact of services for children across the partnership.

144. Accelerate implementation of an early help strategy, ensuring that it is consistent with the 'multi-agency threshold guidance' document and then monitor its effectiveness.

145. Review multi-agency training to ensure it supports and promotes front line practice and is able to respond to demand following the imminent publication of a high number of Serious Case Reviews (SCRs); then ensure lessons are learnt and improvements embedded.

146. Agree with partner local authorities on Child Death Overview Panel (CDOP), a coordinated response to the high number of SCRs awaiting publication.

147. Ensure that multi-agency arrangements for the oversight of children missing and at risk of sexual exploitation or trafficking are driven by effective information sharing, performance monitoring, action planning and are strategically coordinated and monitored by the board.

148. Review the resources available to undertake the governance of Multi-Agency Looked After Partnership (MALAP) to ensure a sufficient focus

Inspection findings – the Local Safeguarding Children Board

149. The Sunderland Safeguarding Children Board is inadequate because it is failing to meet its statutory duties and does not provide effective oversight of all areas concerned with children's safeguarding as required by statutory guidance. The board has not had a clear or agreed structure through which to exercise its 'critical friend' role or assure itself that children's safeguarding matters are being given sufficient priority at a strategic level by partners. The board has recently (May 2015) signed off a 'framework of cooperation' with the Sunderland Safeguarding Adults Board and the Health and Wellbeing Board, but this is too new to have had an impact.

150. There is not yet a published strategy for the coordination of early help services in Sunderland and this limits the board's ability to monitor effectiveness and hold agencies to account. The board leadership recognises that the delay in its implementation is having a significant impact on planned improvements in frontline services. A draft strategy document seen by inspectors, is not consistent with the existing 'multi-agency threshold guidance' document and this will need to be resolved prior to publication to avoid compounding an existing lack of clarity among professionals about early help pathways and the threshold for referrals to children's services.

151. The board is not monitoring and evaluating the effectiveness of agencies in safeguarding and promoting the welfare of children, nor has it provided sufficient leadership and coordination with regard to key concerns such as child sexual exploitation and domestic abuse. The board has not received reports from the Local Authority Designated Officer (LADO) for two years and has not received a report on Private Fostering Arrangements (PFA). It has not conducted a multi-agency practice audit for over a year or carried out an audit of agencies safeguarding arrangements under Section 11 of the Children Act 2004 since 2012-13. As a result, it does not have a clear understanding of the quality of services. To address this, the board has recently developed and agreed a performance and quality assurance framework and is undertaking a Section 11 audit. It has also formed and trained multi-agency auditing teams, and produced an auditing pack. However, none of this is yet in use.

152. Poor performance management is a particular weakness of the board. Taken alongside the unreliable nature of much of the data and the lack of multi-agency audits, this lack of oversight means that often poor and uncoordinated safeguarding services are not receiving sufficient scrutiny and challenge of their quality and impact. Board members remain largely unaware of the impact of any development activity and cannot easily evidence progress or challenge delay. The most recent performance report to the board shows a sharp decline in domestic violence referrals. Board members knew this was inaccurate and attributable to human error, but the error passed the board's Quality Assurance sub-committee and was included in the board performance report

twice. The commentary within the board's performance reports is too focused on highlighting trends within the data and lacks sufficient analysis of the impact on children.

153. The board's failure to meet its statutory duties has been recognised and responded to by senior leaders including the local authority's Chief Executive. This led to the appointment of the current independent chair in September 2014 who undertook a comprehensive review and reconfigured the board's governance arrangements to improve its performance. The independent chair now has the confidence and trust of board members in what is a very testing environment for effective partnership working; they describe him as, 'inclusive, engaging and committed to change'. His position as independent chair of the SSAB has led to better integration with adult safeguarding matters and the promotion of a 'think family' approach.

154. The board commissions its core policies and procedures from an independent provider and they are kept up to date with current statutory guidance. Examples were seen by inspectors of effective local policy formation. Coordination between the safeguarding children and adult's boards to coordinate partners approach to Female Genital Mutilation (FGM) has led to a multi-agency group working together effectively to raise awareness of the issue, particularly amongst medical professionals working with parents. A detailed policy has been developed, including a flowchart, to undertake preventive action under child protection procedures where there is a risk of FGM.

155. A number of business plans govern the board's actions but these are not joined up. Following changes to its governance structure, the board has completed and agreed a single, streamlined plan but this is not yet in operation. The streamlined plan's outcome measurements are too centred on the completion of processes, and not sufficiently focused on the quality of practice and how this improves outcomes for children.

156. The board's Missing, Sexually Exploited and Trafficked (MSET) sub-committee does not provide the strength of leadership or scrutiny necessary to support a robust and effective multi-agency response to missing children and those at risk of child sexual exploitation. MSET enables known cases of child sexual exploitation to be tracked but does not focus on the children most at risk. Information about sexual exploitation and missing children are not evaluated together to provide an understanding of trends, themes and hotspots. This is a missed opportunity to use intelligence to inform disruption activity, which is underdeveloped, and service planning. Although there has been some ad hoc evaluation of return home interviews, overall evaluation is weak. A recent review by Children's Services of strategy and services available identified an approach to child sexual exploitation that is seriously underdeveloped and not currently capable of safeguarding young people.

157. In response to the unusually high number of serious case reviews (SCRs) following death or serious injury to a child, the board's Learning and Improvement sub-committee streamlined and refined its processes to cope with demand. As a result, it demonstrates improved, decision making, agenda planning, and tracking to ensure that SCRs are completed to their terms of reference. A high number of SCRs has placed additional pressure on board staff, sub-group members, and on resources, limiting the board's capacity to undertake other work.

158. The Learning and Improvement sub-group's six meetings in the last year have been attended by four different Children's Services middle managers. This lack of continuity has led to significant delay in taking steps to ensure that learning from SCRs and other serious cases is effectively disseminated and used to inform practice development.

159. The findings of SCRs are in line with the findings of this inspection. Board members are aware that due to inconsistency, the lessons from SCRs and any consequent changes to frontline social work practice have not had the necessary impact within Children's Services. Service outcomes for children in Sunderland have not therefore improved in line with the lessons identified by SCRs. Repeated challenge from partner agencies using the board's formal escalation process have not led to improved performance by Children's Services in this area.

160. Satisfactory arrangements are in place for the Child Death Overview Panel (CDOP), which is a tri-partite arrangement with two other local authorities. Cases are initially considered by a local child death review panel (CDRP), effectively chaired by the Clinical Commissioning Group's Head of Safeguarding. Scrutiny of LSCB minutes indicates that CDRP provides regular feedback to the board. Current themes highlighted within the CDOP annual report include standard items, such as co-sleeping, road traffic accidents, sudden unexplained deaths, and other local themes such as drowning. Many of the current high number of SCRs are yet to be published and so have not fully impacted on this forum. The current CDRP chair acknowledged that because a number of SCRs are due to be published in the near future, there will need to be effective liaison with partner agencies to ensure that the aggregated findings from these child deaths are used effectively to inform strategic planning.

161. Board arrangements for training are stronger than the board's other statutory functions. A joint committee with the adult safeguarding board oversees the training programme, although this arrangement is recent and proposals for the identification, planning and delivery of joint training are new. Training is administered and delivered by a dedicated board training officer supported by a training pool drawn from the board's partner agencies. A recent, rudimentary training needs analysis (TNA) has provided the committee with a baseline from which to adjust and enhance their training programme. The committee produces a business plan and completes an annual report of its activities.

However, documentation reviewed by inspectors indicates that the TNA was not completed in line with the board's existing business priorities, or its emerging improvement plan. As a result, it identifies a further set of priorities at a time when the board is already overwhelmed by multiple priorities.

162. The boards training budget has considerable demands placed upon it by work arising from the high number of SCRs. This will be a significant pressure going forward.

163. Data collected by the board from training sessions indicates that Children's Services is by far the worst attender, and that children's social workers have the poorest attendance record at board training. This means that partners cannot be assured that the messages from board processes such as SCRs are being heard by frontline workers from the lead agency. The board's Annual Report for 2013-14, published in December 2014, echoing the independent chair's structural review, is a frank analysis of the board's shortcomings and appropriately reads across to the board's improvement plan. However, proper consideration has not yet been given to the resource implications of the board's recent decision to take on governance of the Multi-Agency Looked After Partnership (MALAP). While this shows commendable commitment to the welfare of children looked after, the board needs to be assured that it has the capacity and resources available to ensure that this substantial additional task can be carried out effectively.

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

The inspection team

Lead inspector: Fiona J Millns

Deputy lead inspector: Dominic Stevens

Team inspectors: Gary Lamb, Paula Thomson-Jones, Peter McEntee, Tracey Metcalfe, Susan Myers, Chris Luke, Ian Young, June Cramman, Pamela Blackman

Senior Data Analyst: Peter McLaughlin

Quality assurance manager: Bob Morton

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