2 August 2019

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Paul Weatherstone, CEO, National Probation Service
Paula Mead, Independent Chair of Northumberland Safeguarding Children Board

Dear local partnership

Joint targeted area inspection of the multi-agency response to child exploitation in Northumberland

Between 17 and 21 June 2019, Ofsted, the Care Quality Commission, HMI Constabulary and Fire & Rescue Services and HMI Probation carried out a joint inspection of the multi-agency response to children experiencing or at risk of sexual exploitation and those experiencing or at risk of criminal exploitation in Northumberland.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Northumberland.

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door' that was particularly focused on children at risk of sexual or criminal exploitation. Also included was a 'deep dive' focus on this vulnerable group of children, where these issues were known to be of concern. Inspectors also considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the Northumberland Safeguarding Children Board (NSCB).

The inspectorates recognise the complexities for agencies in intervening to help children who are at significant risk when they are affected by child exploitation.

The safeguarding agencies in Northumberland demonstrate a strong commitment to working together to safeguard children. They have made changes in response to findings from previous inspections, including Ofsted's focused visit in February 2018, which looked at the effectiveness of the front door arrangements to protect children. A specialist child sexual exploitation worker based in the multi-agency safeguarding hub (MASH) has had a positive impact on practitioners' understanding of and

response to the risk of sexual exploitation. Several agencies, including health and education, are represented in the MASH. This aids information-sharing and joint planning to reduce risks to children. Following challenge from the NSCB, a review of the processes for return home interviews has led to changes which are beginning to have a positive impact on informing safety plans for children.

The recognition of and response to children at risk of sexual exploitation is embedded in practice. However, the understanding of other forms of child exploitation is limited. Multi-agency training has not yet had a consistent impact on improving practice. Screening tools are not yet fully effective in identifying risks of child exploitation.

Partners acknowledge that they are at the start of their journey to understand the prevalence and risk of child criminal exploitation in the area and that, while they have processes in place to ensure individual children are safeguarded, more needs to be done at a strategic level to further develop plans. There is more to do to ensure that the workforce understands how to recognise and respond to the risks to children of criminal exploitation and to ensure such risks fully inform safety plans.

Key strengths

- The MASH has effective systems in place which ensure that new concerns about children are responded to in a timely manner. In the main, thresholds are understood, and the risk of significant harm is identified. Timely strategy meetings are held and include the right professionals. This aids decision-making.

- Daily multi-agency meetings in the MASH ensure timely information-sharing and analysis of risk. Co-location in the MASH of relevant safeguarding agencies, including health, education and the youth offending service (YOS), facilitates the consideration of the needs of the whole family. High-quality information is provided by the police in child concern notifications (CCNs). Risks to children are clearly articulated. CCNs are routinely uploaded to the electronic patient records system used by the 0–19 health visiting and school nursing service, which supports primary health services to consider children's vulnerabilities.

- The introduction of a child sexual exploitation practitioner in the MASH has been instrumental in raising the quality of risk assessment and safety planning for children who are identified as being at a high risk of sexual exploitation. Practitioners are increasingly considering extra familial risks to children in relation to sexual exploitation.

- Child protection (section 47) enquiries are prompt and social workers see children alone. Social workers engage with children in a sensitive way to support them to

tell their story. When children are at significant risk, there is timely escalation to initial child protection conferences.

- The NSCB undertakes regular multi-agency audits. A multi-agency audit in December 2018 into the safeguarding of disabled children led to the consideration of sexual exploitation being incorporated into all assessments. These assessments would have been further strengthened by consideration of criminal exploitation. Multi-agency audits completed by the partnership reflected the areas of development identified by inspectors during this inspection.

- The NCSB receives a wide range of performance data, which it interrogates and uses to provide appropriate challenge. For example, an audit which focused on the application of thresholds within the MASH, in recognition that section 47 rates were high, found that thresholds were understood. This demonstrates that action is taken to understand practice and to inform action to improve.

- There is a strong focus on ensuring that children can participate in and influence their own plans and the development of services. Children's voices are well represented in the records of the children's drug and alcohol misuse service, SORTED, and in those of the YOS. Children's health records are enhanced by using their actual words and contain powerful records of their experiences. The partnership regularly engages with children to seek their views and understand what is important to them, for example consultation to inform the priorities in the children and young people's plan.

- Weekly multi-agency meetings by the Northumberland Adolescent Service actively engage the specialist expertise of a variety of services to further identify current and changing risks and support proactive management of children's health and care needs.

- Children who require therapeutic support receive a timely response from the sexual abuse service, with positive engagement and focus on building children's emotional resilience.

- Political support from elected members has ensured that resources for children's social care have been protected. Senior managers have worked hard to improve workforce stability. The introduction of assistant team manager and advanced practitioner posts, as well as retaining social workers who undertake their assessed and supported year in employment within the authority, is contributing to a more stable and increasingly experienced workforce. The number of social workers has increased in the last two years, and social workers describe their caseloads as manageable. Social workers receive regular supervision and management oversight of their work.

- The NSCB receives comprehensive performance data that enables it to understand the prevalence and incidence of episodes of going missing and to provide appropriate challenge. This is being further strengthened through the use of a visualisation tool so that data can be interrogated and mapped to support the prediction of children going missing in the future and plan preventative action. It is too soon to demonstrate the impact of this tool. However, it demonstrates the partnership's proactive approach to improving scrutiny and challenge.

- Information-sharing agreements between most of the safeguarding partner agencies enable appropriate exchange to inform plans and work together to protect children from exploitation. For example, cases that are open to the YOS are flagged on the local authority record system, and this aids information-sharing between the agencies. Furthermore, the police notify the YOS about all children who come to their attention. The co-location of the YOS within the Northumberland Adolescent Service also promotes speedy information-sharing across specialisms and access to relevant specialist services. However, the lack of information-sharing agreements between GPs and Northumberland, Tyne and Wear NHS Foundation Trust and the MASH risks delays in the identification and coordination of key information to support comprehensive analysis of risk and safety planning.

- All general practices and schools in Northumberland routinely receive information through Operation Endeavour, an initiative about children who are missing. This initiative strengthens information-sharing about children and families of concern, as many children who are missing may not be known to early help services or children's social care. The appointment of a specialist MASH education worker further supports information-sharing with schools, appropriately informing analysis of risk and planning for children. Harm reduction work has been proactive as a result of the shared approach of partners recognising the vulnerability of children and underlying concerns. Inspectors saw examples where schools had passed intelligence to the police as a result of their vigilant observation of who children were associating with outside of the school.

- Through the interrogation of data on children who are missing, the NSCB challenged the low take-up of return home interviews (RHIs) and a review of the process was undertaken. As a result, there are new procedures in place (May 2019) and this is leading to an improved understanding of both risk to the individual child and risks to other children. The partnership has recognised the importance of a significant relationship between a trusted adult and child. As a result, the youth service now leads on undertaking RHIs, partly as children are often already known to workers. Inspectors saw some cases where child-focused planning in response to missing episodes was supporting children to maintain significant relationships with practitioners, and this contributed to their safety

planning. However, safety plans do not consistently address the risk for children with missing episodes known to be at risk of criminal exploitation.

- The missing, slavery, exploitation and trafficking group (MSET) has been in place since March 2019. It aims to provide a structured response, through the sharing of information, to reducing the risk of all forms of child exploitation. This replaces the previous risk management group. The new arrangements are aligned with other local authorities in the region and Northumbria Police, who chair all the groups. Intelligence is mapped to create a detailed picture of risk to individual children and associated vulnerable people. The MSET process has supported active disruption operations, including a multi-agency operation that took place over a weekend. This has had a positive impact on reducing the number of episodes of children going missing in one locality. This relatively new process has been successful in reducing risks for some children.

- Effective targeted work on disruption has included a focus on the night-time economy, including hotels and fast food outlets. Other strategies have included the use of child abduction warning notices, making training on recognising the signs of child criminal exploitation compulsory for taxi drivers before they can receive a licence, and the provision of training on child protection issues for housing and trading standards staff. This has directly resulted in referrals being made when risks of exploitation have been recognised by taxi drivers and hoteliers. Neighbourhood policing teams are trained and tasked in problem-solving and youth engagement. They work directly with other professionals to support and assist vulnerable children and take proactive action against those considered to pose a risk to children.

- Seven-minute briefings provide clear and succinct information for practitioners on various topics. Inspectors were given numerous examples of practitioners valuing these, which they said had increased their awareness and understanding of child sexual and child criminal exploitation.

- The partnership has involved children in the development of innovative approaches to promoting public awareness of child sexual exploitation. 'Pass it on' involved children giving information to other children on the risks to them of child sexual exploitation. This has resulted in increased awareness, including an example of a child making a disclosure as a direct consequence of the campaign. While school nurses regularly use the #ItCouldHappenToMe resources, also developed with children, these are not well utilised by other partner agencies, and this is a missed opportunity.

- The YOS provides a varied offer for out-of-court disposals. Preventative intervention diverts children from crime, and, consequently, they do not get a criminal record.

- Probation officers are linked to the local gangs strategy and use intelligence to identify escalating risk and to develop disruption tactics. For example, responsible officers use recall when the person subject to the licence has failed to comply with its conditions and where, in the light of the intelligence and information shared, they are deemed to be a risk to children.

- Practitioners in frontline health services listen to, and take account of, children's views. Children aged 12 and over can speak with their examining clinician alone in the emergency department. Sexual health practitioners routinely speak to children under the age of 16 alone. This means that children who may be at risk of or experiencing sexual or criminal exploitation have an opportunity to speak privately to practitioners about their experiences.

Case study: highly effective practice

The local area has built on the embedded good practice of Operation Encompass by implementing Operation Endeavour. Every school and general practice across the area receives missing children notifications. This initiative strengthens information-sharing about children of concern and has resulted in proactive harm reduction work.

Schools display a good understanding of risks to children of criminal exploitation. They have access to regular and up-to-date training, and can apply this effectively. School staff are proactive in ensuring the risks to children are mitigated while children are in school. Inspectors saw examples of schools being vigilant about who children are associating with outside school and passing this intelligence on to the police and other partners so that appropriate action could be taken.

Areas for improvement

- The need for an intelligence profile of the criminal exploitation of children has recently been identified by leaders in the partnership and commissioned by the police. The child sexual exploitation profile needs to be updated. This means that the ability of the partnership to understand the extent of child criminal exploitation in Northumberland is currently limited. The partnership has recently refreshed its strategy on child sexual exploitation to include criminal exploitation. However, the strategy and accompanying action plan are underdeveloped and are not informed by an up-to-date profile. This means that resources may not be sufficiently aligned to tackling child exploitation.

- The complex needs of children who offend because of child sexual exploitation and/or criminal exploitation are not sufficiently recognised or planned for in the refreshed strategy and action plan. For a small number of children seen on inspection, not all opportunities to consider alternative actions to criminalisation were taken.

- A sub-group of the NSCB has recently had its remit expanded to include all forms of child exploitation and has begun work to expand the existing strategy beyond sexual exploitation. This refocus is relatively new, having begun in March 2019, and while agencies have begun to work on elements of the newly developed strategy, the group plans to develop this further to address gaps as their understanding of criminal exploitation increases.

- Child criminal exploitation is not comprehensively understood by practitioners in all agencies across the partnership. Training, although in place, has not yet had a consistent impact on practice. This means that exploitation, other than child sexual exploitation, may not be recognised or responded to. In some cases, children's records showed that practitioners viewed children's behaviour as part of a lifestyle choice. This limits their ability to see children as victims of exploitation.

- Practitioners' understanding of child criminal exploitation is underdeveloped. Very few social workers had accessed NSCB multi-agency training, and, although they had received the seven-minute briefings, unlike practitioners in other agencies, they had not all read these. There is no formal training for police staff members within the MASH, and their knowledge and awareness of child criminal exploitation is limited. Community rehabilitation company (CRC) staff had not accessed the NSCB multi-agency training, although they had received single agency training on safeguarding.

- The MASH receives referrals from partner agencies through a variety of formats, which means there is no single consistent approach. This means that trigger factors that present when a child is at risk of exploitation may be missed. In some cases, referrals from the probation service failed to analyse risks posed by an adult to the child. Key information about restrictions, for example about contact an adult may have with a child, was absent. Inspectors saw better quality referrals submitted on the multi-agency referral form, which included a clearer analysis of risk and impact on the child. The partnership recognises these shortfalls and is planning to review the referral process.

- Strategy discussions are not always held when risks of increasing harm have been identified. This relates specifically to concerns referred to children's social care about children who are already known to them. This means that opportunities are missed for partners to share information, and for this to be used to inform planning to reduce the risks for children. When strategy meetings are held, they

do not always clearly identify the rationale for decision-making, and actions to keep children safe are not always sufficiently explicit.

- Assessments where exploitation is a factor are mostly timely. However, they are of a variable quality. Some do not include sufficient consideration of wider family and community networks. There is an overreliance on parents' self-reporting at times, and this is a missed opportunity to understand children's networks of support more thoroughly.

- Children are discussed at multiple meeting processes, for example in strategy meetings, MSET, core groups and MASH daily meetings. The outcomes of these meetings are not always sufficiently clear or visible on children's records. This means that there is no one single coherent plan that addresses needs and mitigates risks for children. Not all appropriate agencies are represented at meetings. For example, the CRC is not always invited to submit a report or attend child protection conferences, and sexual health staff had not attended MSET meetings, although a plan is now in place for them to do so. This means that not all the relevant information that is gathered within the multiple meetings is considered in children's risk assessments and plans.

- The MSET processes require further development to ensure that all children are identified when they are at risk of criminal exploitation. Not all practitioners are able to fully identify the risk of child criminal exploitation, and this is impacting on their ability to complete the screening tool. A focus on the risk of child sexual exploitation means that some children who may be at risk from other forms of exploitation are scored as being at a low risk of harm. For some children, this can mean that risk of harm from exploitation is not sufficiently well considered.

- Management oversight in children's social care, although frequent, is not consistently effective at driving timely progression of plans. Social workers do not always receive enough critical challenge to ensure that they sufficiently explore and analyse the underlying risk factors for child exploitation. Inspectors also found that there was insufficient management direction in some police investigations relating to criminal exploitation of children, and this contributed to cases not progressing.

- When children display harmful sexual behaviour, this does not always prompt the initiation of the MSET process because the management of the case is considered in terms of harm posed to other children rather than the harm the child may be experiencing themselves.

- Northumberland has a high rate of permanent exclusions from schools. The NSCB receives a comprehensive suite of performance data, including data on children missing education, children who are electively home educated and exclusions.

However, the board has not challenged agencies to further understand any links between increased risk to children permanently excluded and their vulnerability to exploitation. Following this inspection, it now plans to do so.

- Not all practitioners across the partnership understood that any child may be at risk of exploitation, not just those who score highly on vulnerability checklists. This means that early warning signs may not be noticed for those children who do not have existing vulnerabilities.

Case study: area for improvement

Indicators of criminal exploitation are not well understood by practitioners. In some cases, practitioners view children's behaviour as part of a lifestyle choice and this limits their ability to consider children as victims of exploitation. Management oversight, although frequent, does not provide sufficient challenge to address this.

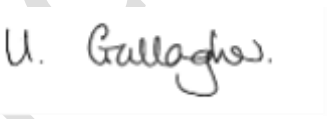
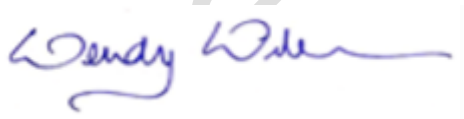
Missing, slavery, exploitation and trafficking screening and risk assessment processes are not fully utilised in order to understand the risk of exploitation, and the changing dynamics of risk factors are not considered in all cases. This means that the safety plan for children does not always mitigate against all risk, as it is not understood or identified fully enough.

Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, YOS, the police, the clinical commissioning group and health providers in Northumberland. The response should set out the actions for the partnership and, where appropriate, individual agencies.[1]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 11 November 2019. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Yvette Stanley National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary and Fire & Rescue Services	**HMI Probation**
 Wendy Williams HMI Constabulary and Fire & Rescue Services	 Helen Davies Assistant Chief Inspector

[1] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.