9 May 2018

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Liz Chidgey, Independent Chair of Southend-on-Sea LSCB

Dear local partnership,

Joint targeted area inspection of the multi-agency response to child sexual exploitation, children associated with gangs and at risk of exploitation and children missing from home, care or education in Southend-on-Sea

Between 19 and 23 March 2018, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue services (HMICFRS) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to these related areas of risk to children and young people in Southend-on-Sea.[1] This inspection included a 'deep dive' focus on the response to children and young people experiencing these vulnerabilities.

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 Southend-on-Sea.

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door', which receives referrals when children may be in need or at risk of significant harm. In this JTAI, the evaluation of the multi-agency 'front door' focused on children at risk of sexual or criminal exploitation, those associated with gangs and those missing from home, care or education. Also included was a 'deep dive' focus on this vulnerable group of children and young people. Inspectors also considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board (LSCB).

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

Partner agencies in Southend-on-Sea have a shared commitment to tackling risk to children and young people from sexual and criminal exploitation, gangs and going missing from home, care or school. Inspectors met with staff across agencies, who are tenacious in their efforts to engage with, and make a positive difference for, vulnerable children and young people.

When agencies have worked collaboratively to tackle risks to specific groups of children, they have used the learning from these focused areas of work well to improve wider services. Strong working relationships between professionals have been a key element when interventions have been successful. However, the contribution that health agencies could make has not been fully realised. There is limited emphasis on their role within the child sexual exploitation action plan and they are not consistently involved in operational meetings to assess risk and to plan interventions for vulnerable children.

To date, the LSCB has not sufficiently fulfilled its role as a 'critical friend' to partner agencies in their work to safeguard children, nor has it exercised sufficient challenge and leadership in relation to how well they are protecting children from the risk of sexual exploitation. The independent chair is aware of these weaknesses and has put in place measures to address them, but these have not yet had a significant impact.

The co-location within the new multi-agency safeguarding hub (MASH+) of health, police and local authority professionals has helped to improve initial decision-making for children. The MASH+ has also been successfully integrated with an existing strong early help offer.

The partnership has a shared commitment to continuous improvement and inspectors found a number of examples of effective practice. Further work by the partnership will be required for this to be consistently achieved for all vulnerable children in Southend-on-Sea.

Key Strengths

- Work in Southend-on-Sea to tackle child sexual and criminal exploitation, gangs and the risks arising from going missing from home, care or school is underpinned by strong working relationships and a shared commitment and drive for continuous improvement. This is reflected in how agencies have used national best practice and local learning to enhance the quality and impact of services. When agencies, particularly the police and local authority, have worked together to tackle the risks for a specific group of children and young people, learning from this joint working has acted as a catalyst to enhance the quality and effectiveness of wider services, for example through building on the success of the adolescent intervention team. This team, originally created to work with a specific group of

young people, has been expanded with additional staffing and made available to all vulnerable young people for whom there are relevant concerns.

- Leaders and managers have created a culture across the partnership in which staff feel supported in working flexibly, collaboratively and 'going the extra mile' by continuing to work with young people even when they may not at first want to engage with the services they are offered. This tenacity is making a real difference for some highly vulnerable children.

- Collectively and individually, agencies have put in place a broad range of awareness raising, education and prevention work with children, families and professionals. This includes: work done by child exploitation and online protection 'ambassadors' with over 1600 teachers and schoolchildren; former gang members providing awareness-raising training with professionals about how to recognise early signs of gang affiliation; and work by a well-established network of 'champions' helping to tackle child sexual exploitation by ensuring that this work continues to have a high profile and by supporting and advising their colleagues to intervene successfully.

- The coordinator for children who go missing and child sexual exploitation practice leads enhance the effectiveness of both individual practitioners and key operational and strategic meetings through providing expert guidance and knowledge of best practice. They act as focal points for information and intelligence. The profile of and leadership provided by the named GP, both within and beyond health agencies, support greater awareness, confidence and the ability of staff to intervene effectively with vulnerable children.

- The partnership has put in place a framework of meetings and procedures that have the capacity to support effective sharing and analysis of data and intelligence. Within this framework, data and intelligence have been used well to support planning for individual, and some groups of, children as well as to target disruption activity. Pre-tasking and pre-multi-agency child sexual exploitation (MACE) meetings use a helpful breadth of information and intelligence to identify which children could most benefit from consideration at MACE. These meetings are generally well attended by a broad range of relevant professionals.

- The quality and timeliness of decision-making has been enhanced by the new MASH+, co-locating health, police and local authority professionals. Decisions are well matched to risk and need for almost all children. Staff working in the MASH+ value the benefits that co-location provides for swifter and more joined-up decision-making. In particular, strategy discussions are now almost always attended by a health representative alongside the police and local authority, and this is supporting better-informed decision-making. This was an area for development noted at the local authority's last inspection in 2016.

- An existing strong early help offer has also been further enhanced through co-location with MASH+. This supports swift and appropriate decisions for those children referred to MASH+ who may best benefit from an early help response and for those referred for early help whose level of need may warrant a statutory social work assessment. Young people's drug and alcohol services play a particularly effective role within the early help offer. This shared early help offer is further bolstered through the co-location of the 'volunteering matters' project.

- The commissioning and provider landscape is complex in Southend-on-Sea. The new Public Health and Integrated Commissioning Quality and Governance Group is aimed at strengthening quality and service delivery across universal, targeted and specialist health services. This partnership of local authority and CCG commissioners seeks to make best use of local resources, although it is at too early a stage to have had a significant impact to date.

- Well-focused work by the local authority has achieved improvements in key aspects of safeguarding services for children. These include the timeliness with which assessments are completed and the frequency with which children are seen. Strong system-leadership by the deputy chief executive has been a significant factor in engaging partner agencies in the creation of MASH+ and in the continuing development of a strong early help offer.

- A whole-council approach and the additional scrutiny and impetus provided by an improvement board has helped the local authority make progress and maintain its focus on areas of practice that are not consistently good, such as the quality of assessments and plans. Good corporate and political commitment to enhancing services to children is evident in the significant investment involved in putting in place a new electronic case recording system.

- A well-thought-out approach to performance management supports frontline managers with accurate reports of performance in their teams, helps middle managers to understand and drive up performance and gives senior managers a clear line of sight to strengths and weaknesses in quality and performance. Investment in additional management capacity has strengthened decision-making. While not all oversight is of a consistently high standard, managers generally provide appropriate case direction and avoid delays in most children's cases.

- The local authority has a considered and well-targeted approach to workforce development. Training priorities such as assessment and decision-making, or, more recently, the work to support restorative approaches, are linked to identified organisational priorities and areas for development. Training is used well to enhance the quality of practice and improve outcomes for children.

- Successful recruitment in the last year has enabled the local authority to reduce its reliance on agency staff and reduce staff turnover. At the time of the inspection, there was only one social work vacancy. This has helped reduce social

workers' average caseloads and means that they are now able to visit children more frequently than a year ago. This in turn means that children are more likely to build relationships of trust with their workers that make a difference to their lives.

- The use of child sexual exploitation risk assessments is well embedded within social work teams. These assessments are completed for most children who could benefit from them. Most are updated when children's circumstances change, giving an up-to-date picture of risk to inform safety planning for the child.

- Children with complex needs and those at risk of child sexual exploitation, going missing and wider child exploitation benefit from intensive and targeted support from workers with specialist expertise. Work is reflected in children's records, and professionals generally know them and their families well.

- The local authority has a good understanding of patterns of attendance in schools within the borough. Data management and analysis relating to attendance and persistent absence is strong, informing actions undertaken each half term, and each week for children looked after. A dedicated working group focuses on direct work with specific children and settings. Exclusions, reduced timetables and persistent absentees are scrutinised closely and, when problems are identified, support and challenge to specific schools or settings are effective.

- The local authority maintains a record of children who are electively home educated (EHE). Any families known to local authority children's services who choose to home educate their children are visited swiftly to assess how well children are safeguarded. Staff use the fair access panel to ensure that places can be accessed in mainstream schools if this is appropriate. The authority has pro-actively provided training in the primary and secondary curriculum for parents of EHE children and has also liaised with both Ofsted and the Department for Education about possible unregistered schools in the borough.

- Essex Police's commitment to protecting children from harm is clear. Through well-focused intelligence work and strong leadership, the police have successfully engaged partner agencies and secured sufficient resources to identify and enhance the safety of some of the most vulnerable children in Southend-on-Sea. The force's 'plan on a page' sets out clear priorities and a drive to protect children from sexual and criminal exploitation, gangs and the risks arising from going missing. Training has a strong emphasis on the sexual and wider criminal exploitation of children. All frontline officers have been provided with a vulnerability guide to assist in the identification of children at risk.

- The force has an open approach to improving their responses to the sexual and criminal exploitation of children. A 'health check' conducted by the national working group has highlighted the Southend-on-Sea community policing team

hub approach to supporting vulnerable young people as a model of good practice. There is positive partnership outreach and disruption work between the team and the street engagement service. Rolling out an operation targeting people involved in drug-related crime (Operation Raptor) has strengthened the ability of agencies to combat the exploitation of vulnerable children, particularly through 'county-lines' drug running and by gangs. Inspectors saw examples of good practice by officers, including detailed and child-focused referrals through the national referral mechanism (NRM). Learning from national best practice, good use is being made of civil orders, such as community protection notices and child abduction warning notices (CAWNs), to safeguard vulnerable children.

- In the last 18 months, the police have been instrumental in raising awareness of modern slavery and human trafficking. Training a significant number of frontline professionals has led to the identification of more children who are criminally exploited and trafficked, with 20 referrals of children to the national referral mechanism in the past year. Relevant investigations reflect a shift from treating children as criminals to recognising their vulnerabilities and the wider context that may be leading to their offending behaviour, such as coercion or criminal exploitation by others. This shift in focus has also led to the force's missing person policy being amended, so that children who are regularly going missing are considered for referral to the NRM because of the potential for trafficking.

- The youth offending service (YOS), national probation service (NPS) and community rehabilitation company (CRC) staff have a good understanding of child sexual and criminal exploitation, gangs and the risks arising from going missing from home, care or school. This is supported by strong management oversight and supervision and is underpinned by the effective range of awareness raising and education across the partnership. Inspectors saw a significant amount of diversion work being successfully undertaken through the YOS triage programme and relatively low levels of young people subject to statutory supervision.

- Within NPS, case managers have a good understanding of escalation procedures, and inspectors saw examples of appropriate and informed professional challenge by probation officers when the MASH+ had not initially accepted referrals about children for whom there were safeguarding concerns. A good level of information-sharing in the early stages of the multi-agency public protection arrangements (MAPPA) process is helping to ensure robust risk management planning at the pre-release stage when there are child protection concerns.

- Health commissioners and providers take an active part, alongside other statutory agencies, in shaping local arrangements for protecting children and young people at risk of exploitation or abuse. A number of health partners are well engaged in work to implement the recently revised child sexual exploitation action plan, while others contribute to the various local child exploitation joint working forums.

- Effective information sharing and handover of care between different health practitioners, teams and services is crucial as children move through childhood and towards adulthood. This challenge is understood well by local leaders, who are making good progress in some key areas to ensure local health practitioners are alert to and better recognise risks to children and young people. The introduction of the Child Protection Information System in the emergency department at Southend University Hospital (SUH) and the 'flagging' of children at risk of sexual exploitation on information systems are important developments in raising the profile of children who are or may be vulnerable to harm or poor health outcomes. This means that relevant practitioners are aware of risks to young people's sexual health and can take prompt action to ensure that they are appropriately recognised, addressed and monitored.

- The emotional well-being and mental health service (EWMHS) has effective systems for referral to children's social care. The quality of referrals is steadily improving. EWMHS works well alongside the early help team, providing consultation advice, contributing to joint assessments and ensuring that children with increasing needs and behaviours of concern can promptly access services. The EWMHS adds value to the work of other teams such as the YOS and the young people's drug and alcohol team. This has led to improvements in the timeliness of access to specialist help for children with complex needs. EWMHS practitioners have been trained in evidence-based approaches to supporting children exposed to harm through sexual or criminal exploitation.

- The Safeguarding Children Forum and regular safeguarding newsletters produced by the clinical commissioning group (CCG) help reinforce expected standards of practice, and keep GPs informed about changes to local multi-agency arrangements and priorities. Learning events facilitated by the named GP, supported by safeguarding leads in other agencies, are highly rated. Inspectors observed one such event, which was effective in raising awareness about the experiences, care pathways and services available to children exposed to sexual abuse and exploitation. The development of health safeguarding champions in some services (including GPs and EWMHS) is having a positive impact on building the confidence and competence of the local workforce.

- Although areas for further improvement remain, local health agencies have taken action to address all recommendations for improvement identified in the CQC's previous inspection reports and have provided assurance to their trust boards and the LSCB that actions have been completed. For example, the co-location of health practitioners within the MASH+ provides prompt feedback and updates to case-holding health professionals about the outcomes of referrals. This has supported an improved standard of practice and levels of involvement in safeguarding children work since the last CQC inspection.

Case study: effective practice

Strong partnership working and a timely response tailored to the individual needs of a child have ensured that he is safer from harm. Risk, not only to him but also to the wider public, has been tackled effectively. He has built a relationship of trust with key professionals, providing a platform for further progress.

A 14-year-old has repeatedly gone missing. He has suffered from criminal exploitation and is at risk of sexual exploitation. A 'team around the teen', made up of four key professionals from his school, the police and the local authority, has created a tight network around him. This team of professionals has responded flexibly and creatively to reduce emerging risks before he suffers further harm. A recent example of this is when he was believed to be in possession of a knife. He had already been charged on a previous occasion with carrying a knife. When it was discovered that he was concealing a knife in his bedroom, it was recovered by the police officer known to the child during a well-co-ordinated joint visit with the adolescent intervention team worker.

Areas for improvement

- The current child sexual exploitation action plan, strategy and guidance documents are clear, up to date and contain specific actions, but are still very new and at too early a stage to have had a significant impact. It is not clear how local information, audit and scrutiny have underpinned the strategy, and some elements of the local approach are not as advanced as they could be. For example, work with local taxi drivers remains at an early stage of development. The focus on the contribution of health agencies is not strong enough. The strong working relationships that have underpinned much of the progress that has been made in developing and improving services for vulnerable children have not consistently been matched by an equally strong strategic drive and organisation. For example, Essex police produce an annual thematic assessment on a range of topics, with the current 2018/19 child sexual abuse and exploitation document providing not only national and county level information, but also the local Southend-on–Sea context. However, it was accepted by the partnership that the inclusion of broader partnership data would have benefited the report and assisted in the development, commissioning and targeting of services across the wider partnership.

- The implementation of MASH+ from December 2017. Not all partners are clear about the recent changes to systems and processes at the front door and not all partners have a sufficient understanding of the role of MASH+. Joint working between health practitioners and other agencies is not consistently strong,

particularly outside of the MASH+, where health engagement is continuing to improve. This has limited the speed and quality of information sharing for a few children. This lack of consistency and clarity about role and process and information sharing and engagement limits the collective ability of agencies to intervene as early and as effectively as they could with some children. Although the creation of MASH+ has led to an improvement in how well children's histories are recorded and taken into consideration in initial decision-making, inspectors saw some cases in which decision-making for individual children was too focused on the immediate presenting concern that led to the referral, and not enough weight was placed on longer-standing chronic concerns. Although inspectors saw no situations in which this has left children at immediate risk of significant harm, they did see examples of it leading to delay for some children in receiving the right level of services to match their needs.

- Decision-making in child protection strategy meetings is not consistently shared with the agencies in attendance. In a number of children's cases seen by inspectors, decisions about whether or not to commence a child protection investigation or to hold a child protection conference were taken by the local authority after meetings. Without a shared ownership of decisions, actions arising from these meetings are less well communicated and their completion is more difficult to monitor. Significant improvements achieved in the attendance of all relevant services, particularly health professionals, at strategy meetings convened by MASH+ are not as consistently achieved at strategy discussions held later in the process of intervention with children and their families. This has the potential to limit the range of information available and the quality of decision-making.

- When children missing from home and care are found, most are offered a return home interview. In some examples, well-focused and recorded return home interviews were used to help make sure that children and young people were receiving the services that best matched their individual needs. For example, learning from one interview led to a child's case being escalated from early help to a statutory social work service, while for another young person it identified peer groups, associates and patterns of behaviour that are helping professionals identify possible triggers for future episodes of going missing. However, while the majority of children and young people who have been missing from home or care are given the opportunity of a return home interview, the quality of information gathered and recorded is not consistently good. Further understanding and development of child-focused approaches are needed to ensure that individual children and young people's needs and voices are effectively sought and used to inform future planning to keep them safe.

- The diversity of children's identities and needs is not always understood and worked with to a consistently high standard. A lack of consistency in this area risks undermining the effectiveness of intervention. For example, some children with complex needs and educational histories who would benefit from having education, health and care plans (EHCP) do not currently have them.

- The conduct of MACE meetings lacks sufficient structure and rigour in considering the risks to individual children. This is also mirrored in the minutes of meetings, which are not consistently clear and sometimes lack relevant details, such as children's ages, while agreed actions often lack specificity and are not always well matched to presenting need. This does not support the tracking of action completion or monitoring of risk as effectively as it could. While a broad range of agencies generally attend, attendance is not always consistent for some key attendees, such as education and health professionals. Stronger connectivity is needed between the sexual health, maternity and EWMHS and the MACE processes to improve the depth of information available from these agencies to support best decision-making for vulnerable children and young people.

- Minutes and plans arising from multi-agency meetings, such as child protection strategy meetings and case conferences, child in need meetings and MACE meetings are not always sent to attendees in a timely manner and, in many cases, are not received at all. As a result, children, their families and the professionals who support them may not be clear about what is expected. This may limit the effectiveness of intervention.

- Although child sexual exploitation risk assessments are well embedded within the local authority, they are not always well used in other agencies. Inspectors found variable levels of confidence and competence in the use of the assessment tool to analyse risk, inform referrals or to escalate or reduce concerns for individual children or young people. Reporting on the use of CSE risk assessment tools within sexual health services is not yet in place to support the monitoring of trends.

- MAPPA meetings are generally only attended by police and NPS and therefore lack the benefit derived from a full multi-agency approach. Local authority staff only attend when there is a specific person already known to them being discussed, and other partners are often absent. This attendance gap has the potential to reduce the breadth of information and intelligence informing planning and decision-making.

- The LSCB has not sufficiently fulfilled its role as a 'critical friend' to partner agencies. Work by the board to assess how well agencies are tackling child sexual exploitation and associated vulnerabilities is under-developed. For example, the LSCB has not carried out any multi-agency audits to assess how well Southend-on-Sea children are being protected from sexual exploitation and it does not have a multi-agency dataset to measure performance in this area. This limits its ability to provide challenge and to drive improvement. The independent chair of the LSCB has recognised these shortcomings and, since taking up her role in early 2017, has worked to put in place structures to improve the functioning of the board. She meets regularly with senior leaders from the local authority and partner agencies and has instigated some positive challenge from the board.

However, these positive changes in the structure and functioning of the board are too recent for the board to add significant value to the work of partner agencies.

- The local authority has worked hard to improve the quality of assessments and plans, and while inspectors have seen the impact of this good work in a number of high-quality assessments and plans, this is not consistently the case. Some assessments lack a sufficiently sharp analysis of children's risks and needs and are not always updated when children's circumstances change over time, while many plans, whether they are for early help, child in need or child protection, lack clarity. Plans are often rather generic, lacking clear identification of risks and the actions needed to tackle them, and do not always sufficiently distinguish between the individual needs of brothers and sisters within larger families. This limits their effectiveness as a tool to monitor and drive progress for vulnerable children and young people.

- Although qualitative information from audits, peer reviews and other sources are used successfully by the local authority, such as in the development of the MASH+ and in monitoring the impact of improvement actions, there remains room for further improvement. Information from audits is not aligned closely enough with and included in performance documents. This would enhance the understanding of their quality and impact of practice, while the audits themselves lack a sufficiently sharp focus on identifying specific areas for individual or service improvement. In addition, the quality and impact of practice could be further enhanced through making better use of children's feedback.

- While the supervision received by social workers from their managers is regular, it is too often focused only on process and action completion. Supervision records lack sufficient focus on the lived experience of children and on giving workers the opportunity to reflect on the progress that children are making. This means that social workers do not always receive the clarity of guidance required to ensure that work with children is progressed as quickly and as well as it might be.

- The decision to use the HOLMES (Home Office large major enquiry system) to manage a recent operation to protect children from criminal and sexual exploitation and to disrupt the actions of perpetrators came as a result of difficulties in managing an operation with similar characteristics in the past. However, the information gathered was not routinely transferred to the main police computer systems and was therefore largely inaccessible to frontline officers who cannot access HOLMES. Although mitigated to some degree by the use of markers on the police national computer, which alert officers to a potential risk, this does not provide officers and staff with the detail needed to fully inform their decision-making.

- Greatest value is not currently being achieved from the community safety hub's very positive work in engaging children and young people and disrupting perpetrator activity. Officers do not receive training about statutory processes

before they attend partnership meetings such as child protection conferences. This limits their understanding of the procedures and processes involved and thus the potential effectiveness of their contributions. At present, the team does not have a broader investigative capability. This limits the benefit drawn from the team's particular role, for example the potential to map locations and numbers of young people and persons of interest to help target services.

- Current structures in Essex Police mean that it can be difficult to direct resources when intelligence received at a force level requires action at a local level. This may limit the timeliness of some interventions with vulnerable children. The force has recognised these limitations and has begun a review.

- Senior leaders in Essex Police have worked hard to improve responses to the sexual and criminal exploitation of children and young people, to gangs and to children who go missing. However, although current meeting structures provide a generally good level of strategic oversight, higher-level meetings could benefit from an overview and qualitative assessment of tactical delivery to provide reassurance that the strategic drive of the organisation to effectively safeguard vulnerable children is being translated into effective delivery at the frontline. A recent bid to introduce a dedicated audit team may provide a suitable framework for such a development.

- The force's approach to children detained in custody, who are often vulnerable and have complex needs, is not consistent. A recent review by a continuous improvement team found that requests recorded by custody staff to submit a notification to the local authority's children's services were not being actioned. This inspection found that this continues to be an area for development. Opportunities to provide intervention for children and young people are not consistently being taken at this early opportunity.

- The quality and timeliness of notifications that are submitted by frontline officers and staff to the local authority are inconsistent. The decision for these notifications to be submitted directly, without the need for supervisory oversight, was intended to ensure that they were submitted as quickly as possible. However, the current process has gaps in both compliance and quality. This means that some children may be left in need or at risk of harm without those agencies who could intervene having been informed. Although there are safety nets in place that significantly reduce the chances of vulnerable children being missed by agencies, such as the daily 'vulnerability meeting' in MASH+, it is clear that the notification system is not working as well or as consistently as is needed.

- Information from multi-agency meetings and panels is not always recorded on police systems in a timely and consistent fashion. This means that multi-agency decisions are not always visible to frontline officers and so their ability to respond effectively to safeguard children is limited.

- The lack of a current NPS office or formalised reporting facilities in Southend-on-Sea means that there are inconsistencies in the management of offenders and presents challenges to successful multi-agency working.

- While it is positive that a number of health organisations use a shared electronic recording system, with some health practitioners having read-only access to each other's records, key gaps remain in information governance and information-sharing protocols to enable MASH+ practitioners to have timely access to relevant information held by other health partners, including sexual health services, EWMHS and GPs.

- Joint protocols for information sharing and joint working between the EWMHS and school nursing service are not yet in place. This limits the ability to share information that could support better early identification of changes in young people's emotional health and well-being, including risks of going missing or vulnerability to exploitation or gang involvement.

- Case auditing and quality assurance of practice in health is not sufficiently strong to support ongoing learning and review and to help benchmark areas where targeted development work is still required. Although there are some good examples of learning and development activity, learning from national best practice has not been maximised.

- Supervision practice is inconsistent across health agencies. Inspectors also found that stronger management oversight is required in a number of areas to ensure that safeguarding referrals are of a consistently acceptable standard, for example with regard to referrals from the SUH emergency department and those completed by GPs. Coverage of level three training within the SUH emergency department and midwifery services continues to be an area for improvement to ensure that NHS trust targets are fully met.

- The knowledge of frontline health practitioners of criminal exploitation and gangs overall is relatively limited. Although SUH has recognised growing risk in this area, it still need to progress its intention to develop a joint pathway for the management and care of children involved with or harmed by gangs.

- Southend-on-Sea has a relatively high number of teenage parents and comparatively high use of emergency contraception and abortions. The child sexual exploitation action plan does not currently contain specific actions that are linked to supporting wider learning from information in this area.

- Children and young people accessing health services do not always benefit from a thorough assessment or analysis of their health needs. Records are often descriptive, lacking analysis of the impact of concerns and vulnerabilities on the child or young person. This limits the opportunity for children and young people

to have their needs fully understood or have the right services involved to appropriately meet their needs and to improve their outcomes.

- NPS court officers use a targeted approach to requesting child safeguarding information relevant to adults appearing before the courts. These are responded to swiftly by MASH+. This allows for appropriate information to inform pre-sentence reports and informs safe sentencing in these individual cases. However, not checking on safeguarding information in all cases means that safeguarding concerns about which court officers were unaware could be missed and so not inform recommendations and sentencing. This is a missed opportunity, particularly in the light of the creation of MASH+ as an enhanced multi-agency 'front door'.

Case study: areas for improvement

A previous lack of sufficiently joined-up working between agencies, weak planning and reactive practice has meant that a vulnerable teenager did not receive the right help and support when needed and agencies had not succeeded in ensuring that she is significantly safer.

The child was supported under a child-in-need plan following concerns about her poor mental health, risks of sexual exploitation and conflict between her parents. A recommendation to convene a child protection case conference was not acted on for several months. During this time, the child had stopped attending school, with little planning for an alternative education provision and no assessment of learning needs. Agencies' practice has been reactive rather than proactive. Not all key professionals have been included in the child's plan and not all of her needs have been addressed. It has taken several months for a multi-agency plan to be formulated, and parenting assessments have not been started. While one key professional has forged a good relationship with the child, much is still unknown about her life and new concerns around exploitation continue to emerge. Although more recent planning and interventions reflect a clearer focus and greater urgency, they have not yet significantly improved the child's safety.

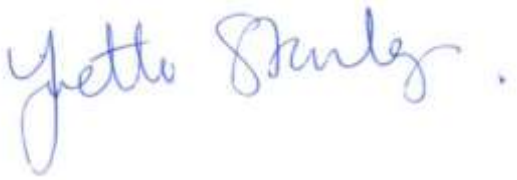
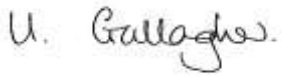
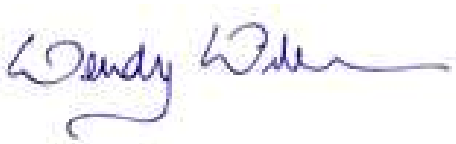
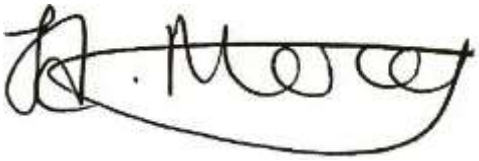
Next steps

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, the clinical commissioning groups and health

providers in Southend-on-Sea and Essex police. The response should set out the actions for the partnership and, where appropriate, individual agencies[2].

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 18 August 2018. 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	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Helen Mercer Assistant Chief Inspector

2 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.