The sexual exploitation of children: it couldn't happen here, could it?

This thematic inspection was commissioned to evaluate the effectiveness of local authorities' current response to child sexual exploitation. The report draws on evidence from inspection and case examination in eight local authorities and from the views of children and young people, parents, carers, practitioners and managers. In addition, themes from the aligned inspections of 36 children's homes and the collation of findings from the 33 published inspections of services for children in need of help and protection, children looked after and care leavers and reviews of Local Safeguarding Children Boards contributed to the findings.

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Contents

Executive summary

Professor Alexis Jay's report into the sexual exploitation of children in Rotherham was a wake-up call for every professional working in the field of child protection. The catalogue of abuse and abject failings across agencies has understandably prompted a great deal of soul-searching by those charged with keeping young people safe and by the wider public.

While those who have worked in children's services for many years will testify that child sexual exploitation is far from a new phenomenon, what has changed is the level of professional and public awareness generated by a series of high profile investigations and criminal trials. Cases in Rotherham, Rochdale, Derby, Oxford and other towns and cities have uncovered not only the previously hidden scale of the problem but also a particular pattern of abuse involving predominantly White British girls as victims and gangs of predominantly Asian heritage men as perpetrators.

As Professor Jay made clear, faced with this type of offending pattern, senior leaders must show political and moral courage. They must never allow misguided fears about offending cultural sensitivities to get in the way of confronting child sexual exploitation wherever it occurs. However, child sexual exploitation takes on many forms. It is not just confined to particular ethnic groups or parts of the country. It is inherently dangerous for any child protection agency to assume that they need not worry about this type of child abuse because the stereotypical offender or victim profile does not match their own local demographics. As others have pointed out, the sexual exploitation of children can take place anywhere.

Ofsted therefore set out at the start of this autumn to build up a clearer picture of how well local authorities and their partners are carrying out their duty to prevent child sexual exploitation in their area, to offer protection to its victims and to pursue and prosecute its abusers.

Based on a wide range of available evidence, including the voice of more than 150 young people, it was clear to inspectors that many authorities have been too slow to face up to their responsibilities or to implement the statutory guidance issued to them five years ago.

Until very recently, child sexual exploitation has not been treated as the priority that events in Rotherham and elsewhere strongly suggest it should have been. As a result, local arrangements to tackle the problem are often insufficiently developed and the leadership required in this crucial area of child protection work is frequently lacking.

Indeed, as our findings show, part of the problem lies in the fact that some professionals have simply failed to properly apply child protection processes to young people at risk of being sexually exploited. This is one important reason why the prevalence of child sexual exploitation is still not well understood, even in places that have experienced high profile cases.

Most authorities are only now starting to get a handle on the extent to which child sexual exploitation is happening in their area. A number have only begun to address the issue at a strategic level in the last 12 months.

In those authorities where child sexual exploitation has had a higher priority, the local strategy is better developed with links to other key strategies relating to issues like gangs, licensing and how personal, health and social education is being taught in schools.

Senior leaders and local politicians tend to have greater insight and understanding of this complex issue in areas where this has been given greater priority. Elected members are now scrutinising and challenging the work of the professionals, tackling the problem more than in the past.

In too many instances, Local Safeguarding Children's Boards (LSCBs) have shown poor leadership. They have failed to adequately challenge slow progress in developing both child sexual exploitation strategies and meaningful action plans.

On the frontline, inspectors came across examples of excellent practice as a result of the skills, knowledge and expertise of individual professionals working within the local partnership. Conversely, some individual care plans drawn up to protect young people from sexual exploitation are ineffective, leaving those young people exposed to risk of harm. In too many local authorities, management oversight is not robust enough to drive forward individual plans or to monitor their impact.

Partnership action is often disjointed, which means that opportunities are being lost for a more cohesive approach to child sexual exploitation. In too many areas, progress has been hampered because partnerships have failed to define what management information is required from each agency and how this will be effectively shared to build a picture of child sexual exploitation in the locality. The way in which data is collected by many police forces does not allow for the effective collation of reported crime and prosecutions that are specifically linked to child sexual exploitation. This means that the information that the police share with their partners is of limited value.

Specific training on child sexual exploitation, while generally of good quality and useful for those who have received it, is not reaching everyone who needs it. As a result, many of those working with some of the most vulnerable children are not equipped to identify and respond to the signs of sexual exploitation.

What inspectors did find in the eight local authorities inspected was a wide range of initiatives aimed at increasing young people's understanding of child sexual exploitation. Several local authorities have developed specific campaigns to raise awareness of this issue. Some of this work is being delivered well through schools. A number of local authorities are developing a more targeted approach to engage those young people perceived to be harder to reach and more vulnerable, for example those in care.

At the same time, every authority has taken some steps to increase the wider community's awareness of child sexual exploitation, including through effective engagement with faith and community leaders. However, in most cases, the approach has tended to be ad hoc and reactive rather than proactive.

Some areas have not made use of the full range of powers available to them to disrupt and prosecute perpetrators.

In areas where there have been high profile criminal investigations, the experience has galvanised the local authorities and their partners into trying to ensure that past failings are never repeated. Such resolution was not apparent in other local authorities.

It is a concern that, nearly two years after Ofsted published a report on looked after children who go missing; many local authorities are still failing in their duty of care to this group of vulnerable children. Not all children who go missing from home or care get good support on their return. Not enough local authorities are systematically making the connection between child sexual exploitation and children who are missing from school.

Many organisations have had to act decisively to learn the lessons from recent cases and to apply their increased understanding to ensure that this type of sexual abuse is dealt with more effectively. Ofsted is no exception. Child sexual exploitation is something inspectors now focus on much more closely under the arrangements for inspecting local authority child protection and looked after children's services that came into effect a year ago.

It is hoped that the findings of this in-depth thematic inspection will further strengthen the understanding of both leaders and frontline practitioners so that children at risk of being sexually exploited can be assured of the support and protection that they deserve.

Key findings

Strategic leadership

- Local authorities and their partners are still not meeting their full responsibilities to prevent child sexual exploitation in their area, to protect its victims and to pursue and prosecute the perpetrators.
- They have been too slow to meet their statutory duties, despite being issued with guidance to do so over five years ago. Two of the local authorities inspected do not yet have a child sexual exploitation strategy in place. Half have no action plan.
- Local arrangements, where they do exist, are poorly informed by local issues and self-assessment. They do not link up with other local strategic plans.

- Specific training, where it exists, is of good quality and gives staff confidence in their ability to identify and respond to child sexual exploitation. However, it is not always reaching those that need it most.

Performance management

- Local authorities are not collecting or sharing with their partners the information they need in order to have an accurate picture of the full extent of child sexual exploitation in their area. As a result, they cannot know whether they are making a positive difference in the prevention, protection and prosecution of child sexual exploitation.
- Not all local authorities and LSCBs evaluate how effectively they are managing child sexual exploitation cases. This means that findings are not used to improve future practice.

Raising awareness

- Local authorities and partners are successfully using a range of innovative and creative campaigns to raise awareness and safeguard some young people at risk of child sexual exploitation.

Findings from practice

- Local authorities and police do not always follow formal child protection procedures with children and young people at risk of child sexual exploitation.
- Screening and assessment tools, where they exist, are not well or consistently used in some local authorities to identify or protect children and young people from sexual exploitation.
- Plans of how local authorities and their partners are going to support individual children and young people at risk of or who have been sexually exploited are not robust. Plans specifically for children in need are poor. Child protection and looked-after children plans vary in quality. In most of the case files reviewed, there was no contingency plan in place for if the initial plan was not successful.
- Local authorities are not keeping plans for children in need under robust review. This leaves some children in a very vulnerable position without an independent review of their changing circumstances and needs.
- Management oversight of cases is inconsistent and is not strong enough to ensure that cases are always being properly progressed or monitored in line with the plan.
- A dedicated child sexual exploitation team that is solely responsible for the case does not always ensure that children receive an improved service. Where specialist child sexual exploitation support is provided in addition to the allocated social worker, there is more evidence that children are being better supported.

Disrupting and prosecuting perpetrators

- Not all police and local authorities are using their full range of powers to disrupt and prosecute perpetrators. Where they are using their powers well, they are effective in disrupting criminal activity. However, low numbers of prosecutions are achieved in comparison to the number of allegations made.

Missing children

- Too many children do not have a return interview following a missing episode. This means that local authorities and police are missing opportunities to effectively protect these children and young people and to gather intelligence to inform future work.
- Local authorities are not cross-referencing information and soft intelligence relating to children who are frequently absent from school with their work with children at risk of child sexual exploitation.
- Even when the correct protocols are used, too many children still go missing.

Recommendations

All local authorities should:

- ensure that managers oversee all individual child sexual exploitation cases; managers should sign off all assessments, plans and case review arrangements to assess the level of risk and ensure that plans are progressing appropriately
- ensure that every child returning from a missing episode is given a return interview. Local authorities should establish a set of practice standards for these interviews and ensure that these are consistently met. Information obtained from the interviews should be centrally collated and used to inform and improve future operational and strategic activity
- ensure that schools and the local authority cross-reference absence information with risk assessments for individual children and young people
- establish a targeted preventative and self-protection programme on child sexual exploitation for looked after children.

Local authorities and partners should:

- develop and publish a child sexual exploitation action plan that fully reflects the 2009 supplementary guidance; progress against the action plan should be shared regularly with the local authority Chief Executive, the LSCB, the Community Safety Partnership and the Police and Crime Commissioner
- ensure that information and intelligence is shared proactively across the partnership to improve the protection of children in their area and increase the rate of prosecutions

- consider using the available child sexual exploitation assessment tools to improve risk assessments of children and young people in their area; where these are in place, they should be used consistently by all agencies
- ensure that sufficient appropriate therapeutic support is available to meet the needs of local young people at risk of or who have suffered from child sexual exploitation, including care leavers
- make sure that local strategies and plans are informed by the opinions and experiences of those who have been at risk of or have suffered from child sexual exploitation
- enable professionals to build stable, trusting and lasting relationships with children and young people at risk of or suffering from child sexual exploitation
- consider how effective local schools are in raising awareness and protecting children at risk of or who have suffered from sexual exploitation.

LSCBs should:

- ensure that the local authority and its partners have a comprehensive action plan in place to tackle child sexual exploitation
- hold partners to account for the urgency and priority they give to their collective and individual contribution to the child sexual exploitation action plan
- critically evaluate how effective the activity and progress of each of the LSCB members is against the action plan and publish these findings in the LSCB annual report
- ensure that all partners routinely follow child protection procedures for all children and young people at risk of or who have suffered from child sexual exploitation
- ensure that partners meet their statutory duties in relation to children returning from missing episodes where child sexual exploitation is a potential or known risk factor
- ensure that all partners carry out their responsibilities as defined in the locally agreed threshold document, which sets out the different levels of provision offered to individual children and young people at risk of or who have suffered from child sexual exploitation in the area, based on their individual needs
- ensure that an appropriate level of child sexual exploitation training is available to all professionals in the local area who require it; specialist training should be targeted on those working with children and young people at risk of or suffering from child sexual exploitation; attendance for both should be monitored with follow-up action taken where professionals fail to attend
- evaluate the impact of training with a focus on how it makes a positive difference to keeping children and young people safer
- include information relating to child sexual exploitation activity in their performance framework - this should enable a clear understanding of how

prevalent child sexual exploitation is in their area and how effectively agencies are responding.

Ofsted should:

- ensure that child sexual exploitation is considered within the safeguarding sections of all future inspection frameworks and across all remits
- continue to sharpen the focus given to child sexual exploitation in all children's services inspection frameworks, including the review of Local Safeguarding Children Boards.

The government should:

- review and update the 2009 Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children so that it reflects recent research, good practice and findings from child sexual exploitation reviews and criminal investigations
- develop a national data set that requires local authorities, the police and their partners to report on all prevention, protection and prosecution activity relating to child sexual exploitation in their area to a standard format - this should include information on both missing children and looked-after children moving into and out of the area
- require every police force to collate information specifically on child sexual exploitation, including the number of crimes reported, the level of disruption activity undertaken and outcomes, including cautions and prosecutions.

Introduction

1. The sexual exploitation of children and young people is a form of sexual abuse. It is not new. What is new is the level of awareness of the extent and scale of the abuse and of the increasingly different ways in which perpetrators sexually exploit children and young people.

2. Professor Alexis Jay's[1] enquiry into historical child sexual exploitation in Rotherham identified failures on the part of care professionals and those working in the criminal justice system to recognise that some children and young people were at risk or victims of child sexual exploitation. Too often, children and young people who had been sexually exploited were wrongly labelled as 'promiscuous' or considered to have made a 'life style choice' and were engaging in 'risky behaviour' or had 'consented' to sexual activity.

3. The Department for Education defines child sexual exploitation as follows:

> 'Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.'[2]

4. The Office of the Children's Commissioner[3] found that at least 16,500 children and young people had been identified as being at risk of child sexual exploitation between April 2010 and March 2011. In addition, during a 14-month period between August 2010 and October 2011, 2,409 children and

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[1]Professor Alexis Jay OBE, *Independent inquiry into child sexual exploitation in Rotherham (1997–2013),* Rotherham Borough Council, 21 August 2014; www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham.

[2] *Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children,* Department for Children and Families, August 2009; www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance.

[3] *I thought I was the only one. The only one in the world*, Office of the Children's Commissioner Inquiry into Child Sexual Exploitation in Gangs and Groups*(CSEGG)*, Interim Report, November 2012; http://www.childrenscommissioner.gov.uk/content/publications/content_636.

young people had been confirmed as being victims of sexual exploitation in gangs and groups. The report warned that the scale of abuse was likely to be much larger. The report also found that, although the majority of victims of child sexual exploitation lived at home with their families, victims of sexual exploitation were disproportionately represented in residential care.

5. The Home Affairs Committee report[4] makes clear that:

> 'this is a crime that can happen anywhere. Belatedly, agencies have made positive steps to try and improve the situation but there is no doubt that both in terms of support for victims and prosecution of offenders, a postcode lottery still exists and agencies are still failing to work effectively together.'

6. Children who are missing from home, school or care are at greater risk of sexual exploitation. The Children's Rights Director[5] suggested that children and young people's behaviour is influenced by both 'push' factors they are running from and 'pull' factors they are running towards.[6]

7. Poor emotional health, self-harm, drug and alcohol misuse, exposure to bullying and violence, poor social work assessments and plans that result in unsuitable, distant or unstable placements all increase the likelihood of children and young people going missing from care.

8. Child sexual exploitation can have a devastating impact on the social integration, economic well-being and life chances of young people. Difficulties faced by victims of child sexual exploitation include isolation from family and friends, teenage parenthood, failing examinations or dropping out of education altogether, unemployment, mental health problems, suicide attempts, alcohol and drug addiction, aggressive behaviour and criminal activity.[7] Child sexual exploitation can also have a profoundly damaging effect on families and communities.

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[4] *Child sexual exploitation and the response to localised grooming* - Second Report of Session 2013-2014, Home Affairs Select Committee, 5 June 2013; http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhaff/68/6802.htm.

[5] *Running away: young people's views on running away from care* (120022), Children's Rights Director, Ofsted, October 2012; www.ofsted.gov.uk/resources/running-away-2012.

[6] *Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children,* Department for Children and Families, August 2009; www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance.

[7] *I thought I was the only one. The only one in the world*, Office of the Children's Commissioner Inquiry into Child Sexual Exploitation in Gangs and Groups*(CSEGG)*, Interim Report, November 2012; http://www.childrenscommissioner.gov.uk/content/publications/content_636.

9. Around 40% of child sexual exploitation victims are caught committing offences, a proportion much higher than in the general population.[8] Some victims of sexual exploitation are being punished by the criminal justice system for crimes they have committed in relation to their exploitation instead of being helped.[9]

10. Statutory guidance emphasises the importance of an integrated and three-pronged approach involving prevention, protection and prosecution.[10] Local authorities, as the lead statutory agency, are responsible with their partners for ensuring that guidance is implemented.

11. Although LSCBs should be considering the effectiveness of the partnership response to child sexual exploitation. research published in 2011 found that:

> 'only a quarter of LSCBs in England are implementing the guidance; young people, their families and carers received awareness raising in less than half of the country; the prosecution of abusers is rare; and, where criminal proceedings take place, young people's experience of court is intolerable.'[11]

12. Findings from research, enquiries and inspections conclude that for children looked after by local authorities, good care is fundamental to keeping children and young people safe. The basic principles of good practice are reflected in Ofsted's inspection frameworks.[12] They are identified as follows:

- listening to children and young people
- visiting regularly and getting to know them well

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[8] UCL, Jill Dando Institute of Security and Crime Science, *Briefing document: CSE and youth offending*. London: UCL, 2011.
[9] *Out of place: The policing and criminalisation of sexually exploited girls and young women,* Howard League for Penal Reform, July 2012; www.howardleague.org/report-sexually-exploited-girls/.
[10] *Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children,* Department for Children and Families, August 2009; www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance.
[11] Sue Jago, with Lorena Arocha, Isabelle Brodie, Margaret Melrose, Jenny Pearce and Camille Warrington*, What's going on to Safeguard Children and Young People from Sexual Exploitation? How local partnerships respond to child sexual exploitation*, University of Bedfordshire, October 2011; www.beds.ac.uk/__data/assets/pdf_file/0004/121873/wgoreport2011-121011.pdf.
[12] *Framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers (single inspection framework) and reviews of Local Safeguarding Children Boards* (130216), Ofsted, June 2014; www.ofsted.gov.uk/resources/framework-and-evaluation-schedule-for-inspection-of-services-for-children-need-of-help-and-protectio.
Inspection of children's homes: framework for inspection from April 2014 (100195), Ofsted, March 2014; www.ofsted.gov.uk/resources/inspection-of-childrens-homes-framework-for-inspection-april-2014.

- ensuring access to accurate information about children and young people
- responding quickly to emerging difficulties
- ensuring effective management oversight
- good training and challenging and reflective supervision for professionals
- good commissioning arrangements
- good assessments and care planning for children and young people
- good joint working and information sharing across services

13. Research evidence suggests that perpetrators of child sexual exploitation are typically White men. The next largest group of perpetrators are likely to be from a minority ethnic background.[13]. Stereotypical assumptions about the ethnic identity of those involved in sexual exploitation, whether as exploiters, abusers or both, or about the victims of child sexual exploitation are dangerous and must be avoided. It is, however, imperative that

> 'the issue of race, regardless of ethnic group, should be tackled as an absolute priority if it is known to be a significant factor in the criminal activity of organised abuse in any local community'.[14]

Senior leaders and elected members in local authorities and across partnerships have to show the political and moral courage to confront and tackle child sexual exploitation wherever and however it occurs.

Methodology

14. This report summarises the findings of a thematic inspection by Ofsted exploring the responses of eight local authorities and their partners to child sexual exploitation.

15. The local authorities inspected varied in size and included counties, cities, unitary and metropolitan areas with a mixture of rural and urban features.

16. Specific findings about how children in residential care are protected have contributed to this thematic inspection via the reports of 36 children's homes inspections. These inspections took place during September and October 2014 using the established framework for the inspection of children's homes.[15]

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[13]Helen Brayley, Ella Cockbain, UCL Jill Dando Institute *Group-Based Child Sexual Exploitation (CSE)* 2012

[14] Professor Alexis Jay OBE, *Independent inquiry into child sexual exploitation in Rotherham (1997–2013),* Rotherham Borough Council, 21 August 2014; www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham.

[15] *Framework for the inspection of children's homes* April 2014

17. Findings in relation to child sexual exploitation from the collation and analysis of 33 published inspections of services for children in need of help and protection, children looked after and care leavers together with a review of the effectiveness of LSCBs under the Single Inspection Framework (SIF)[16] in relation to the response of those local authorities to child sexual exploitation.

18. In total, inspectors:

- reviewed 141 children's cases in detail[17]
- sampled a further 50 cases to consider the decision making in relation to child sexual exploitation at the point of initial referral to children's social care
- spoke with 41 parents or carers
- spoke to 157 young people; these included the subject children and young people in the cases that inspectors reviewed, groups of young people inspectors met with and 47 children and young people spoken to as part of the concurrent children's homes inspections
- spoke to at least 200 professionals in the local authorities inspected, including elected members and LSCB members, local authority and partner agency staff about local commissioning and quality assurance arrangements.

19. The key questions that the thematic inspection considered were:

- Is there effective strategic leadership of the multi-agency response to child sexual exploitation that identifies prevalence, trends, themes and patterns and secures improved outcomes for children and young people?
- To what extent is the LSCB taking account of statutory guidance?
- How effectively are partners sharing information and working together to tackle child sexual exploitation locally?
- Is practice robustly quality assured and is there evidence that this leads to better services for children and young people?

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[16] *Framework and evaluation schedule for the inspection of services for children in need of help and protection, children looked after and care leavers and reviews of Local Safeguarding Children Boards* (130216), Ofsted, June 2013; www.ofsted.gov.uk/resources/framework-and-evaluation-schedule-for-inspection-of-services-for-children-need-of-help-and-protectio.

[17] For each of the children's cases considered, inspectors met with the allocated social worker or team manager and, for some cases, a professional from partner agencies providing multi-agency support to the individual family. Children's cases were selected from data provided by local authorities. Cases selected included children and young people predominantly between the ages of 10- and 18 years, with an over-bias to females, at risk of or who had suffered from child sexual exploitation, those subject to child in need or child protection plans or those who are looked after by the local authority. The cases also included children that who had reported missing episodes from home school or care or where young people were first time entrants to the criminal justice system. A number of the cases examined were recently closed by the local authority.

- What is the extent and effectiveness of local child sexual exploitation prevention work?
- How effective is the local authority and its partners in ensuring that all children and young people at risk of child sexual exploitation are identified at the earliest opportunity?
- Are children and young people, including looked after children, who are at risk of, or suffered from sexual exploitation effectively safeguarded, protected and supported?
- Are commissioning arrangements effectively meeting the wide range of needs of children and young people affected by child sexual exploitation?
- How effective is the local authority and its partners in identifying and disrupting the activities of those perpetrators engaged in child sexual exploitation and in taking legal action against them?

20. Good practice examples are highlighted in this report. These examples illustrate effective practice in a particular aspect of work and are not intended to suggest that practice in the local authority was exemplary in every respect.

21. This report is a collation of themes identified from the range of information gathered and analysed not just from the eight local authorities visited for the purpose of this thematic inspection. Not all findings in this report were evident in each local authority visited.

Findings

22. Six broad themes in relation to child sexual exploitation were identified from the evidence collected:

- Strategic leadership
- Performance management
- Raising awareness
- Findings from practice
- Disruption and prosecution
- When children go missing

Strategic leadership

23. Not one local authority area was found to be responding to child sexual exploitation consistently well across the full range of its responsibilities. Awareness and understanding of child sexual exploitation among senior leaders is beginning to improve. For some, understanding is well developed and this is reflected in the progress that has been made to respond to child sexual exploitation locally. For others, awareness of the issues has only recently been recognised and this is reflected in underdeveloped local arrangements.

Local authority

24. For four of the eight local authorities inspected, high profile joint agency criminal investigations in relation to child sexual exploitation had demanded significant attention from senior leaders across the partnerships. Two of these local authorities were involved in ongoing police investigations at the time of the inspection. This recent activity was the stimulus for senior leaders to begin to drive forward the local response to child sexual exploitation across the partnership in these local authorities. While some evidence was seen of strong multi-agency child focused working as part of these investigations, recent learning was still to be cascaded across the partnership and used to inform action plans going forward.

25. In one of these four local authorities, where chief officers, elected members and partners had experienced a similar high profile investigation resulting in a number of convictions two years ago, there was a strong and active learning culture demonstrated by their commitment to fully engage in both regional and national initiatives to tackle child sexual exploitation.

26. Despite having commissioned a number of independent reviews on the local response to child sexual exploitation, one of these four local authorities is still struggling to fully accept the findings in respect of the scale of historic failings. This is impeding its ability to move forward.

27. In the four local authorities that had not experienced such high profile investigations, the understanding of the local picture by senior leaders was varied. Two of these authorities had proactively and over time developed good multi-agency working arrangements to tackle child sexual exploitation. These authorities could demonstrate a good understanding of the prevalence of and the quality of the local response to child sexual exploitation. They could identify gaps in information and service provision and were developing plans to tackle this. For example, one local authority recognised that too few open cases related to boys who were at risk of or had suffered child sexual exploitation and were developing plans to tackle this.

28. The other two local authorities had only begun to address child sexual exploitation at a strategic level in the last 12 months. As a result, their understanding about the prevalence of child sexual exploitation in their local area was more limited and they had a less well developed response to such incidences.

Elected members

29. Across all eight local authorities, elected members demonstrated a growing awareness in their knowledge and scrutiny of child sexual exploitation work. For some, a rapid acceleration in their awareness has been prompted by local high profile criminal investigations. One lead member for children described this as a 'steep learning curve'. Another had carefully considered the enquiry

findings in another local authority and recently brought some insightful challenge to senior officers across the partnership about the local response. Others demonstrated that they were well informed about what the local authority and partners were doing to identify, prevent, support and protect young people through available services. Importantly, they also had a good understanding of service gaps or under-reporting issues. In these authorities, it is evident that there is political consensus to support multi-agency working, including substantial financial support and resourcing of high profile criminal investigations.

Local Safeguarding Children Boards

30. In local authorities where the LSCB child sexual exploitation strategy was underdeveloped, the financial and resource implications of responding to child sexual exploitation effectively were not known. In these areas, elected members need to urgently improve the quality and level of scrutiny and challenge they provide to ensure that local authority senior leaders and partners are coordinating an effective response to child sexual exploitation for children and young people.

31. Only four of the local authorities and their partners had completed a child sexual exploitation self-assessment in order to benchmark local activity against learning from national research, statutory guidance and recommendations from various enquiries to clearly inform local strategy. Other local authorities use national recommendations and research to inform their strategic planning in the absence of their own operational findings, evaluation, profile and partnership working.

32. Six local authorities and their partners have a child sexual exploitation strategy. In the two remaining local authorities, the strategy is currently being developed. In all the local authorities inspected, a multi-agency sub-group of the LSCB with the specific remit of tackling child sexual exploitation is in place.

33. Three local authorities and their partners have yet to develop a robust action plan to coordinate and drive forward the full range of activity required to respond to child sexual exploitation locally because of their lack of self-evaluation. Another local authority has detailed information about action required but has not collated the findings into a coherent action plan. LSCBs have not challenged the slow progress in developing child sexual exploitation action plans sufficiently.

34. Inspectors saw one excellent example of an action plan. This LSCB child sexual exploitation action plan for 2014-16 was outcome-focused and closely linked to the local child sexual exploitation strategy. It detailed the evidence required to secure desired objectives, timescales for completion and who is accountable for its progress. All actions are rated red, amber or green. Where actions have been finalised, they are signed off and verified. This plan is based on four key borough-wide priorities: prevention, protection, prosecution and public and

professional confidence. This partnership plan is driven by the LSCB child sexual exploitation sub-group, with senior leaders in each agency demonstrating clear ownership of the plan. The sub-group is chaired effectively by the Director of Children's Services.

35. In four of the local authorities and their partners, the absence of a child sexual exploitation action plan and the very recent development of some strategies meant that links to other strategies and procedures were limited. In one authority, the child sexual exploitation strategy had only been approved by the LSCB in July 2014. This meant that all other related strategies pre-dated the child sexual exploitation strategy and made limited or no reference to child sexual exploitation. This was of concern because risk indicators of child sexual exploitation for some vulnerable groups of children and young people were not recognised. For example, in this local authority, procedures for tackling gang activity did not explicitly consider that this vulnerable group could also potentially be at risk of child sexual exploitation or provide information about risk indicators.

36. There was little evidence seen of association between key priorities relating to child sexual exploitation in high level strategic plans and those of LSCBs. This lack of coordination between local strategies meant that partnership action was disjointed and opportunities lost for a more cohesive approach to child sexual exploitation. For example, in one local authority, a comprehensive approach to healthy relationships was being promoted through personal, social and health education (PSHE) arrangements in schools. However, very low numbers of school staff had attended any child sexual exploitation training. As a result, there was an inconsistent approach to raising awareness of child sexual exploitation risks through PSHE.

37. The lack of strategic coordination in most of the local authorities inspected meant that good practice was not rolled out across the authority. For example, partnership working between the police, youth services and schools in one specific area had developed group work targeted at girls who were believed to be vulnerable to child sexual exploitation, but this was not implemented in other parts of the same local authority where other young girls were similarly at risk.

38. In authorities where child sexual exploitation is a key priority across the partnership, an holistic approach was being adopted that meant that:

    - related procedures routinely cross-referenced each other and were clear about referral pathways
    - the child sexual exploitation strategy had links to other key strategies, particularly in relation to gangs, domestic abuse, licencing and PSHE in schools

- governance arrangements between the Health and Wellbeing Board, Community Safety Partnership Board and the LSCB were clear in relation to child sexual exploitation.

39. LSCB annual reports routinely referred to child sexual exploitation as part of the board's activity, but the extent of the critical analysis offered was variable. All of the LSCBs regarded child sexual exploitation as a key priority in their business plans for 2014/15, with most identifying the need to review or establish multi-agency action plans.

40. The 33 Ofsted SIF inspections of local authorities and reviews of LSCBs carried out since September 2013 also reported that the performance of local authorities in delivering services to children at risk of or suffering sexual exploitation in response to statutory guidance has been too slow. While statutory guidance was published in 2009, it is clear that many local authorities and their partners failed to recognise child sexual exploitation as a priority.[18]

41. All eight local authorities inspected and their partners through the LSCB have developed multi-agency procedures to support local professionals to respond to child sexual exploitation. In most cases, procedures were of good quality, publically available and easily accessed on the local authority or LSCB website. In almost all of these local authorities, the contents of the procedures appropriately reflected specific child sexual exploitation guidance and research and some had been recently updated to reflect national learning.

42. In three of the local authority areas, partnership working is well established, with evidence that partners are aware of and implement local procedures effectively. However, in five authorities, the inconsistent application of procedures was evident from the interviews conducted with professionals and from the children and young people's cases tracked by inspectors. The extent to which senior leaders across local partnerships could be assured that multi-agency child sexual exploitation procedures were being used effectively was limited, as these areas had conducted little or no quality assurance audit activity and senior leaders could not be assured that multi-agency procedures were being consistently applied in practice.

43. In some local authorities where the circumstances of children and young people did not meet the threshold for child protection procedures, additional procedures had been developed to ensure specific focus was given to the management of child sexual exploitation risks alongside child in need procedures. However, for a small number of children and families who were subject to these two planning processes, this resulted in the holistic needs and

[18] *Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children,* Department for Children and Families, August 2009; www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance.

the sexual exploitation risks to children and young people being seen in isolation from each other.

44. In all eight of the local authorities inspected, specific child sexual exploitation training was available to professionals working with children through LSCB arrangements. However, training was not provided in sufficient volume and was not sufficiently targeted to ensure availability for the range of professionals that need it.

45. Only one local authority required mandatory attendance at training for elected members and practitioners working with children (level 2). In this local authority, all staff were also required to complete a mandatory online training module. Inspectors noted that these requirements ensured that the workforce was particularly well-informed compared with the considerable variability of awareness evident in staff groups in the other local authorities inspected.

46. LSCBs were not routinely monitoring and holding all partners to account for ensuring attendance of their staff at child sexual exploitation training. One LSCB was aware that over a nine-month period there was significant under-representation by school staff on LSCB child sexual exploitation training but had limited impact on improving this situation.

47. Local authorities in almost all areas inspected did not have strategies to target child sexual exploitation training towards specific local authority staff. This meant that staff across a variety of teams, working with some of the most vulnerable children, were not sufficiently equipped to identify signs and indicators of child sexual exploitation.

48. Although the extent of the LSCB evaluation of the impact of such training on practice was variable, staff who spoke to inspectors indicated that training was generally of good quality and had significantly raised their awareness and that they were more confident about their ability to identify and respond to child sexual exploitation triggers. Conversely, staff who had not attended such training spoke of their vulnerability and anxiety about missing opportunities to effectively protect children. In one local authority, staff consistently reflected that their high caseloads prevented them from attending training. This was also acknowledged by senior managers.

49. Alongside LSCB child sexual exploitation training, many other examples of single agency training arrangements were in place. For example, in one local authority, a one-hour workshop was being systematically cascaded to all social work teams for staff who had been unable to attend the LSCB training. The same materials were used to brief elected members and were tailored to provide a workshop for general practitioners (GPs).

50. LSCB training sub-group information routinely identified how many child sexual exploitation specific training courses were run in a year and the numbers of attendees. Some could provide information about the agencies represented.

This information was not used to ensure that training was being effectively targeted.

51. Analysis of SIF inspections of local authorities and reviews of LSCBs since September 2013 indicates that in almost all of the local authority areas the LSCBs had introduced specific training sessions on child sexual exploitation in accordance with statutory guidance. Some local authorities noted that their performance information had shown an increase in referrals to social work services following partner attendance at training, but it was not always clear what, if any, strategy had been put in place to deal with this increase in referrals. Some good practice was seen by inspectors in well performing authorities. In one large authority, the concept of child sexual exploitation 'champions' had been introduced across the partnership. These 'champions' were kept up to date on developments within the local authority, with the purpose of disseminating the information to colleagues and ensuring that all staff were aware of the procedures they needed to follow in the event of child sexual exploitation being identified. Another local authority had made sure that information on child sexual exploitation was a regular feature of the LSCB newsletter, in order to make staff aware of developments in the field.

Performance management

Quality assurance

52. Auditing of child sexual exploitation case files is an area for further development by the local authorities inspected. To date, five of the local authorities inspected have completed single agency child sexual exploitation-specific audits of case work practice. Inspectors found that these audits were of good quality and robustly identified deficits in practice. In two of these local authorities, themed audits of social work practice are well established and findings are routinely collated and analysed, with identified learning continually informing the child sexual exploitation action plan.

53. Senior managers in the local authorities that undertook child sexual exploitation- specific audits were able to demonstrate a stronger grip on practice and were instrumental in developing action plans to improve practice. Three local authorities have yet to undertake child sexual exploitation-specific audits of practice. While these authorities do have generic practice audit programmes, specific learning in relation to child sexual exploitation is limited. This means that senior managers are not provided with a sound understanding of the quality of child sexual exploitation practice or an evaluation of what action is required to improve practice.

54. One local authority acknowledged that their general quality assurance processes were underdeveloped. Notwithstanding this, in response to the

published findings from another local authority review,[19] they had taken very swift action during September 2014 to prioritise an audit of 80 cases where there was a known element of child sexual exploitation. Another local authority demonstrated that findings from an audit in June 2014 revealed a lack of consistency and timeliness in the completion of child sexual exploitation risk assessments, as well as an absence of evidence to show that assessments are multi-agency in nature. This learning was used to revise the multi-agency child sexual exploitation risk assessment tool, which was then re-launched in September 2014. It was too early for inspectors to see the impact of this in practice.

55. Multi-agency auditing of child sexual exploitation across the partnership was less well established. Only three LSCBs had conducted specific child sexual exploitation multi-agency audits. There were observable links between the LSCB child sexual exploitation audit activity and the two local authorities where single agency child sexual exploitation auditing was well established. In one of these, the LSCB had completed a multi-agency sexual exploitation audit in May 2013. They had undertaken a re-audit in 2014 in order to measure improvement in relation to awareness, the quality of preventative services and the response to incidents of child sexual exploitation. Findings showed improved practice across the partnership. These audits have also facilitated improved information gathering and raised awareness of child sexual exploitation when responding to other vulnerable children. For example, the addition of a specific child sexual exploitation question within missing person's interviews means that in this local authority, the risk of child sexual exploitation is routinely considered for children and young people who go missing.

Management information and information sharing

56. All the local authorities inspected and their partners understood and were committed to the need to share information that each agency may hold in relation to child sexual exploitation. In too many areas, however, partners had not defined what management information is required from each agency and how this would be effectively shared to build a picture of the prevalence of child sexual exploitation in that area. This severely limited the partnerships' ability to respond in a planned and strategic manner to child sexual exploitation.

57. Across the eight local authorities inspected there were considerable variations in the way in which locally held child level data was shared, collated and analysed to identify the prevalence of child sexual exploitation. As a result, the prevalence of child sexual exploitation is not well understood. In the absence of a nationally agreed data set for child sexual exploitation, each local authority with its partners are at different stages in their understanding of the prevalence

[19] Professor Alexis Jay OBE, *Independent inquiry into child sexual exploitation in Rotherham (1997–2013),* Rotherham Borough Council, 21 August 2014; www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham.

of child sexual exploitation in their area. Even in those authorities that collected data, the data only relates to children who are known to them and already receiving a service. Arrangements to collect information about a full range of children and young people who are at potential risk of child sexual exploitation were not well developed. For example, information about children and young people who were absent for short periods of time during the school day was not centrally collated and analysed. The better performing authorities were aware of information gaps and are developing measures to tackle this.

58. Police management information systems did not allow for the accurate collation of reported crime and prosecutions that related specifically to child sexual exploitation. For example, while many are able to report on the numbers of sexual abuse crimes reported and prosecuted, these figures are not broken down to provide information on the proportion that relate specifically to child sexual exploitation. Similarly, a wide range of crimes are associated with child sexual exploitation but these cannot be identified from the total numbers of crimes. This means that the management information the police share with partners has limited use.

59. Not all the local authorities were able to identify how many cases had been referred to children's social care due to concerns about child sexual exploitation. Where this could be identified, follow-up action in each case could not always be demonstrated. For example, one local authority was able to determine the numbers of cases that progressed to a referral but were unable to identify the outcome following referrals. Another local authority was able to identify all cases that had progressed to a child protection section 47 enquiry and, where a single assessment had been completed, whether child sexual exploitation was a risk factor. However, none of the information was analysed and aggregated to identify the outcomes for young people in these cases.

60. Procedures in another local authority required child sexual exploitation cases to be flagged on the child's record. This enabled the local authority to extrapolate how many children and young people are subject of intervention at any one time. However, this process was not used consistently, resulting in inaccuracies in the information collated.

61. Some local authorities hold multi-agency child sexual exploitation meetings, but the purpose of these varies. In one local authority, a monthly multi-agency meeting is held to consider individual plans for young people, but opportunities to share and analyse soft intelligence were not well developed. This meant that the partnership's collective knowledge of the local profile was weak. In other local authorities, proactive weekly multi-agency meetings are held to share up-to-date information, including intelligence, to inform a partnership approach to disruption activity.

62. Only a small number of local authorities were able to demonstrate that they had well established, effective systems to collate, analyse and use intelligence to its best effect. In one local authority, an experienced and knowledgeable

police data analyst produced a comprehensive child sexual exploitation profile and regularly interrogated police and partner intelligence to keep the profile updated. However, even in this local authority, data was not complete, as intelligence drawn from children who go missing from care, home and school was not integrated with existing child sexual exploitation data.

63. The lack of an agreed national performance data set means that the true extent of, and response to, child sexual exploitation is uncertain. As a result, local authorities are not held to account effectively for the performance of the partnership approach to child sexual exploitation at a local, regional or national level.

Commissioning

64. Child sexual exploitation was identified as a priority in a range of strategic documents seen during the inspections, although only a small number of local authorities were able to demonstrate that their Joint Strategic Needs Assessment made any specific reference to child sexual exploitation. Few were able to show that child sexual exploitation was a key priority in relation to commissioning intentions at a strategic level or that there was any recognition of child sexual exploitation in their sufficiency strategies of places to live for children looked after.

65. Information and data were rarely used to inform the commissioning of services for children and young people who are at risk or have suffered from child sexual exploitation. As a result, commissioning arrangements for such services were often fragmented. Poor analysis of the data and information that were available was a missed opportunity to evaluate and understand whether services were making a difference to children and young people who have suffered child sexual exploitation or to determine future commissioning requirements and priorities.

66. In one local authority, effective joint partnership working arrangements had led to the development of a comprehensive service specification to commission the multi-agency child sexual exploitation team. The specification, developed in partnership with health partners and the police, was clearly informed by the child sexual exploitation strategy and action plan. Commissioning arrangements provided for ongoing performance monitoring, routinely reported to the LSCB, to ensure compliance and provide evidence of the child sexual exploitation team's impact in reducing risk experienced by young people.

67. The commissioning of children's homes or secure placements for children at risk of or subject to child sexual exploitation were undertaken in all local authorities through spot purchasing arrangements. From the children's home inspections completed, it was evident that commissioners are not always holding providers to account or purposefully monitoring the contracts for individual placements or services. Children had experienced multiple placement moves and risks remained unaddressed due to poor placement planning and poor

commissioning of an initial placement that was failing to meet the needs of the young person.

68. In the cases inspected, many examples were seen where children who had been missing from a children's home had not been given a return home interview by a professional who was independent of the children's home.[20] This is despite a number of authorities commissioning a service to undertake return interviews from a provider, usually from the voluntary sector. Children's homes did not escalate this non-compliance with the contract and commissioners did not sufficiently challenge the provider or contract manager. As a result, children and young people were not receiving the service that had been commissioned for them. The intelligence from such interviews, which could have been used to help safeguard children now and in the future and to support the potential prosecution of offenders, was lost.

69. Inspectors saw some good examples of individual commissioning arrangements in place where young people had been involved in the procurement of services. In three local authorities, there was clear evidence that the views of young people had been instrumental in designing, developing and delivering a child sexual exploitation service, as well as other examples of young people influencing a wide range of materials to raise awareness of child sexual exploitation in their communities.

Raising awareness

Children and young people

70. All eight local authorities recognised the importance of trying to prevent child sexual exploitation in the first instance by engaging with children and young people and raising their awareness of child sexual exploitation. Evidence was seen by inspectors of a wide range of initiatives aimed at helping to keep children and young people safe, by increasing their knowledge and understanding of child sexual exploitation and building their resilience.

71. Some local authorities were making good use of DVDs, videos and theatre productions to raise awareness of, and generate debate and discussion with young people about, child sexual exploitation. In one local authority, the play 'Chelsea's Choice' had been staged in all the secondary schools in the area. Two other local authorities had commissioned a theatre company to deliver 'Somebody's Sister, Somebody's Daughter', a powerful drama about sexual exploitation and street grooming, to secondary school children. In one of those authorities, the play had been watched by around 1,400 pupils, who spoke very positively about the impact that it had had on them:

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[20] *Statutory guidance on children who run away or go missing from home or care*, Department for Education, January 2014; www.gov.uk/government/publications/children-who-run-away-or-go-missing-from-home-or-care.

'It puts you in their shoes.'

I felt really bad for the victims; it made me want to do something to help them.'

In the other local authority, where it has been seen by over 3,200 Year 10 students, it led to 12 young people disclosing that they had been, or felt that they were at risk of being, sexually exploited.

Oldham

Keeping Our Girls Safe (KOGS) is a voluntary sector organisation that runs group workshops and one-to-one programmes to educate and inform young people. These issue-based workshops use art, dance, drama, film and photography to allow young people to explore sensitive subjects and provide them with the tools to make positive lifestyle choices. Topics include grooming, sexual exploitation, healthy relationships, domestic violence, self-awareness, self-esteem and confidence.

72. Several local authorities had developed specific campaigns to raise awareness of child sexual exploitation. In one, a 'Know This Isn't Love' campaign has been delivered through religious and cultural groups, while another ran a 'Supporting #1' campaign using a short film developed with young people. Another local authority had organised a series of 'awareness and promotional events' that reached 250 young people between July and September 2014.

73. Much of the awareness-raising work in relation to child sexual exploitation was being delivered through schools. Some local authorities are beginning to use PHSE more effectively to deliver key messages about child sexual exploitation and safe relationships and to give young people the chance to explore the issues. However, what young people told inspectors would suggest that the content of PSHE varies. One young person said, 'In my school we learn a little bit about it, but not much. It's mostly "don't talk to strangers".'

74. In one local authority, a guidance document had been developed specifically for headteachers, designated safeguarding leads and PSHE coordinators. It provided schools with practical advice and tools to manage and support children at risk of child sexual exploitation. In another, a voluntary agency had been commissioned to contribute to PSHE by organising drop-in sessions in secondary schools, supporting young people with sexual health issues, raising awareness of child sexual exploitation, undertaking one-to-one work and providing training for parents.

75. Several young people told inspectors that they thought awareness-raising should start sooner.

'No-one said anything about it until I went to secondary school; I never heard anything about child sexual exploitation when I was eight or nine.'

The same message was delivered by young people who took part in a Takeover Day organised by another local authority. While most of the local authorities inspected were targeting their awareness raising activities at older children, two local authorities were working with primary schools. One local authority has started to roll out 'Crucial Crew', an interactive safety game, across all of its primary schools. Another has commissioned the UK Safer Internet Centre to raise awareness of online grooming with primary school children.

76. A number of local authorities were developing a more targeted approach to engage those young people who are perceived to be harder to reach and more vulnerable. In one local authority, the multi-agency child sexual exploitation team had organised a workshop with the lesbian, gay and bisexual community and organised a specific piece of work targeted at care leavers. In another local authority, inspectors saw evidence of staff based in the pupil referral unit demonstrating considerable imagination and persistence in working with young people who are hard to engage resulting in increased awareness and resilience and a reduction in risk-taking behaviours.

Parents and carers

77. In six local authorities, parents and carers were able to access information about child sexual exploitation either via the LSCB website or generic leaflets, posters or publicity campaigns.

78. One local authority was raising awareness by delivering training specifically to parents while at the same time creating a free online course on 'tackling child sexual exploitation' that parents can access. In another local authority, awareness-raising is given a high priority and includes key rings with details of where to go for help, advice or support. Local parents are also actively engaged in reaching out to other local parents, developing self-help materials and delivering training. A third local authority, in collaboration with Parents against child sexual exploitation (PACE), employs an independent parent support worker based in the dedicated child sexual exploitation team. As well as offering support to parents and carers, the parent support worker helps raise awareness and build parental resilience. Parental feedback, provided to the local authority about this initiative was, positive.

Camden

The parents' council has been very influential in raising awareness of the risks of child sexual exploitation. It delivers community-based training on child sexual exploitation in schools and has also helped to change the way in which internet providers restrict children's access to sites. It has been influential in introducing parental consent forms for internet use in schools as standard across the borough. The parents' council has also focused on hard to reach groups and raised awareness of child sexual exploitation among the Somali community.

79. Not all the local authorities were confident that foster carers were sufficiently aware of the issues relating to child sexual exploitation. Some foster carers have received training that raises awareness and describes the response needed to child sexual exploitation, although this is not routinely available in all the local authorities inspected. One local authority provided specific and targeted training to foster carers who were caring for looked after children involved in court cases. In another, foster carers were included in the same briefings provided to local authority social workers and required to access online training.

80. The 36 children's homes inspections, which were carried out concurrently with the thematic inspection, found that training on child sexual exploitation, customarily delivered by the LSCB, was to be widely available. In almost all the children's homes staff had undertaken training and in some all members of staff had been trained. Inspectors noted the positive impact of training in terms of increased staff awareness of child sexual exploitation and vigilance in keeping watch for potential risks within the children's home. In one local authority, one of the homes' managers had spent the day with the local specialist police team as a learning exercise.

The wider community

81. In general, awareness-raising was not being coordinated or evaluated strategically to ensure that it is appropriately targeted and LSCBs were not consistently providing the leadership required or expected. All eight local authorities had taken some action to increase the community's awareness of child sexual exploitation. However, there were marked variations in the way this was being done. In the absence of comprehensive and robust action plans, there was no sense of drive or purpose in raising wider awareness of child sexual exploitation within local communities.

82. The better performing local authorities were making it clear that child sexual exploitation is everybody's business. This was achieved through well planned and well organised publicity campaigns and the involvement of local media and partners to ensure that local communities and businesses were aware of child sexual exploitation and knew what to do if they suspected that a young person is at risk. Awareness-raising was being targeted at people working in hotels, hostels, taxi companies, licensed premises, restaurants and fast food outlets.

83. In one local authority, all licensed individuals had received mandatory professional training on child sexual exploitation, free of charge, including 1600 taxi drivers. This had helped to generate a real sense of 'buy in' and has extended the intelligence network in a way that is helping to safeguard and protect children and young people at risk of child sexual exploitation.

84. Inspectors also saw some good examples of effective engagement with community and faith leaders and with churches, mosques and madrasas.

However, in most local authorities inspected, the approach adopted is ad hoc and reactive rather than proactive.

Findings from practice

85. None of the eight local authorities inspected were covering child sexual exploitation well across the full range of responsibilities. Analysis of SIF inspections of local authorities and reviews of LSCBs presents a complex picture. The performance of local authorities in delivering services to children suffering or at risk of suffering sexual exploitation in response to statutory guidance has been variable, both between and within the authorities. Some had used quality assurance processes to identify deficits in practice and had action plans in place to address them, driven by a multi-agency child sexual exploitation group. For others, inspection brought appropriate focus to acknowledged deficits and these are now identified as areas for development. The system seen to be failing in only one case and this was in a local authority that was failing generally to provide help and protection to children in need.

86. The thematic inspection reflected the general findings from the SIF inspection. Inspectors saw a wide range of practice within and across the eight local authorities inspected. Some children and young people benefited from highly skilled and knowledgeable practitioners who, with partners, were able to provide well-coordinated packages of support and protection. This contributed to the risk of sexual exploitation reducing and the outcomes for young people improving. Evidence from the case files inspected indicated that for the large majority of children and young people practice was more variable. While risks were appropriately identified for many young people, for others the work to reduce risks was less well focused, leading to inconsistent outcomes. Inspectors found that some plans to protect young people from child sexual exploitation were ineffective, which left children and young people exposed to risk of harm.

Management oversight

87. The key component to effective practice is the quality of management oversight. This is a key finding in most of the SIF inspections and was mirrored in the thematic inspections. In too many local authorities, management oversight was not sufficiently robust or effective in driving forward plans and monitoring the impact of those plans. The quality of supervision offered to social workers in child sexual exploitation cases was seen to be consistently good in only two of the eight local authorities inspected.

88. It was evident from case records in all local authorities that most managers were meeting with social workers on a regular basis to discuss cases. Records did not typically reflect a clear focus on potential risk of child sexual exploitation, consider patterns of behaviour or possible triggers to missing episodes or explore preventative options or the impact of one-to-one work. Some records seen reflected the managers' endorsement of the social work decisions, but revealed insufficient challenge or reflection by those managers.

Identification and assessment of child sexual exploitation

89. All eight local authorities inspected had in place agreed multi-agency threshold documents to reflect the level of intervention required when additional needs are identified within families. All but one made clear reference to child sexual exploitation and the need for a referral to children's social care when concerns are identified by any professional. However, few LSCBs had audited the application of the threshold document in practice. In one local authority, inspectors found a small number of cases of child sexual exploitation that a voluntary agency was working with, without the local authority's knowledge.

90. Young people are not routinely benefiting from multi-agency strategy discussions when risks of child sexual exploitation are identified. Practice is variable within local authorities and managers do not exercise effective leadership or provide consistent clarity about expectations. In two local authorities that both had specialist child sexual exploitation teams, strategy discussions and meetings are used routinely. They usually involved a wide range of relevant agencies and the quality of information-sharing was of a high standard. This meant that the possible child protection risks had been explored in a formal multi-agency forum and that prompt and coordinated actions were agreed at an early point.

91. Not all the local authorities inspected and their partners used specific child sexual exploitation screening or risk assessment tools to support multi-agency professionals in identifying early signs of child sexual exploitation. Where these were used, professionals were better able to articulate the concerns they had about children and young people and to access appropriate services.

92. Specific child sexual exploitation assessment tools were not routinely used in cases where the risk of child sexual exploitation had not already been identified. There is limited evidence to demonstrate that managers are encouraging their use. Systems for implementing and monitoring their use were generally underdeveloped. This meant that local authorities and their partners could not be assured that early signs were effectively identified and responded to for all young people.

93. However, inspectors noted some good practice in this area. For example, in one local authority, a duty social worker received an incident report from the police. Using the child sexual exploitation risk assessment tool to gather and analyse the information known to professionals who knew the young person, the social worker was able to identify risk indicators including unexplained absence from school, use of a mobile phone that caused concern and entering/ leaving vehicles driven by unknown adults. This promptly led them to organise a strategy meeting, which demonstrated the effective use of the risk assessment tool to inform the next steps..

94. In cases where the risk of child sexual exploitation was known, the use of specific child sexual exploitation assessment tools was varied. Where they were

used, they brought additional consideration to the holistic needs of the young person. As a result, plans were usually more focused and targeted at reducing risk for the young person. Conversely, in other cases seen, the absence of robust assessment meant that some young people were left in vulnerable situations and had not received appropriate services and support to meet their needs.

95. Overall, the individual needs of children and young people that arise from their culture and heritage are considered well in most cases. However, in others, a fuller exploration of family history and identity would have led to more effective intervention.

96. In one good practice example, the accuracy of the assessment was assisted by the social worker's research of the young person's culture and country of origin, where the age of consent is lower than the UK. This knowledge was used effectively to inform the analysis. Good use was made of interpreters; the same interpreter was used consistently to assist the social worker in building a relationship with the young person. The social worker was also clearly sensitive to the vulnerability issues associated with the child's age and gender and this again informed the assessment.

97. In some local authorities, assessments and plans are promptly translated into the young person's first language, which allowed them and their parents to read about professionals' concerns as well as hear these through interpreters. One child sexual exploitation project run by a voluntary organisation had developed awareness raising resources such as a Parental Awareness DVD and leaflets available in a number of languages to reflect the diversity of the local community.

98. Other case files inspected, notwithstanding good information being recorded about the young people's ethnicity, identity and faith, were not given appropriate consideration in assessments and the need for an interpreter was not always recognised. This meant that assessments were often superficial, not sufficiently responsive to diversity and did not provide a sound analysis of the full range of potential risks a young person may experience.

99. Structural arrangements differed across the authorities inspected. Four had dedicated child sexual exploitation teams, the other four allocated child sexual exploitation cases across all social work teams.

100. Irrespective of the structural arrangements, some examples of very good excellent practice were seen by inspectors as a result of the skills, knowledge and expertise of individual workers within the partnership. Where specialist workers worked alongside the young person's social worker, assessments and direct work to reduce risks to these young people were consistently more effective. This was in part due to the recognition that significant persistence is needed to engage young people who are at risk of or suffering from child sexual exploitation. The addition of a second worker provided this capacity.

Conversely, in another local authority, senior managers acknowledged that high caseloads prevented social workers from engaging effectively with young people to help reduce the risks to which they were exposed.

Children and young people's voice

101. Inspectors met with a large number of social workers and partners. In almost all cases the social workers were able to speak knowledgeably about the circumstances and risks experienced by children and young people. It was clear that almost all had listened to what young people had to say about their experiences, were able to represent their views well and, where appropriate, sought to act on their wishes and feelings. In some cases, this was clearly reflected in the written records and the way in which workers were able to describe and articulate the key issues; in others, this was weak with very little evidence of the young person's views or feelings being recorded. Young people that inspectors spoke to generally felt supported and listened to by their social worker. One young person said:

> 'she didn't just help me she helped my mum too.'

Another commented:

> 'they have helped clear my thoughts and talked to me a lot to make sure I am safe.'

102. Many children and young people benefited from direct work delivered by a range of professionals, although this was not consistent within or across all eight local authorities. Some young people were effectively engaged in group activities and one-to-one work that helped them to understand their circumstances and reduce risks. One young person spoke to inspectors about how workers had helped her to devise effective 'keep safe strategies' with her mother. Another young person described how group work had been very timely in her case - it had helped her to understand that she was being groomed and workers supported her to break away from this situation.

103. Young people did, however, voice some concerns to inspectors. The most significant of these was about the frequent changes in social workers that many experienced. They told inspectors that:

> 'it is difficult to trust adults'

Changes of social workers compounds this. One young person said:

> 'my social worker does listen to me but I have been in care for nine years and I have had a different social worker for every year. They say you can trust them but... it gets really hard to trust people.'

The effectiveness of plans to reduce the risk

104. In all eight local authorities, some young people known to be at risk of sexual exploitation were being supported as children in need.[21] Inspectors found that child in need plans were often monitored less robustly than child protection or looked after children plans. For example, one local authority was able to identify that most children known to be at risk of child sexual exploitation following an assessment had child in need plans. The local authority's general auditing activity had identified that child in need plans were not rigorous in addressing identified need; some had been periodically reviewed and others not reviewed at all. This meant that young people at risk of child sexual exploitation were not given sufficient priority, risks did not reduce and intervention was often ineffective.

105. Formal review arrangements for children and young people who were subject to child protection plans or who were looked after were given more scrutiny than child in need plans. However, variation in practice, across and within the eight local authorities, meant that this scrutiny did not always ensure that risk reduced for all children and young people. In two local authorities that had child sexual exploitation teams, learning from individual cases was regularly shared within teams, both formally and informally, to improve practice and inform strategic planning. The remaining local authorities did not routinely collate and analyse information about what had worked well for young people or contributed to the reduction of risk in individual cases. As a result, learning from local practice did not inform future strategic direction or operational practice.

Therapeutic support

106. Referral pathways for young people who are at risk of or who have suffered child sexual exploitation to access therapeutic support were not well developed in all local authorities.

107. Inspectors found that in only three of the eight local authorities, partnership working at a strategic level had ensured that responsive services were in place to provide therapeutic support from Child and Adolescent Mental Health Services (CAMHS) to young people who were at risk of or who had suffered child sexual exploitation. In one local authority, CAMHS workers were based in the voluntary sector child sexual exploitation project. This allowed staff and young people easy access to consultation and therapeutic services. In these local authorities, CAMHS was also supplemented by provision ranging from lower level support to highly specialised provision. However, these local authorities were also aware of some delays for young people in accessing appropriate support. Where therapeutic support is an integrated element of the

[21] Children Act 1989, section 17; www.legislation.gov.uk/ukpga/1989/41/section/17.

child sexual exploitation action plan, provision is reviewed and commissioners were held to account for any shortfalls in the provision of services.

108. While an integrated approach to CAMHS provision was not apparent in all local authorities, some areas had made good attempts to secure alternative specialised therapeutic provision for individual young people. In one authority therapeutic support was commissioned specifically to support young people and their families in the run-up to court proceedings. Staff involved in these cases were also able to access therapeutic supervision.

109. The provision of therapeutic support in other local authorities was more fragmented. This often reflected the disjointed partnership approach to child sexual exploitation and a poor understanding of local prevalence. In these authorities the extent of therapeutic needs were not known.

110. In case files inspected, a small number of young people who did not attend initial appointments were discharged from CAMHS with their therapeutic needs left unmet. This demonstrated a poor understanding of the experience of child sexual exploitation and its impact on young people and a failure to recognise the need for services to be persistent in their efforts to engage them.

Disruption and prosecution

111. The absence of a whole-systems approach to child sexual exploitation meant that information and intelligence were not consistently being used to best effect to tackle child sexual exploitation and some areas were not making good use of the full range of powers available to them to disrupt and prosecute perpetrators. The difference between the number of referrals made and the number of subsequent prosecutions was stark across all areas. However, on the occasions that those powers had been used effectively and imaginatively, this had led to success in achieving positive outcomes. The absence of statutory reporting arrangements in relation to disruption and prosecution undermines the ability to monitor activity, provide critical challenge and compare performance across different areas and over time.

Disrupting and preventing the activities of perpetrators

112. Disruption plays a key part in helping to build the trust and confidence of victims, empower others to come forward and encourage communities to report signs of child sexual exploitation wherever and whenever it occurs. However, while two local authorities have adopted a 'zero tolerance' approach to child sexual exploitation and are making full use of the range of policing and other powers available to them to disrupt child sexual exploitation, most are not.

113. In four local authorities inspected, an average of 27 abduction notices had been issued over the previous 12-month period. However, in three other local authorities, only five abduction notices had been issued between them during the same period. In one authority, where 76 children or young people were

identified to be at risk of child sexual exploitation, no abduction notices or criminal prosecutions had been secured in the corresponding 12-month period.

114. Of the eight local authorities inspected, only three had developed an adequate overview of child sexual exploitation in their locality. In those areas there were good examples of appropriately targeted and well coordinated operations involving the police and a range of partners to disrupt the activities of known or suspected perpetrators at both an individual child and at community level. In two areas, imaginative use was also being made of Risk of Sexual Harm Orders (ROSHOs) issued under the Sexual Offences Act 2013 to restrict the activities of named individuals from having contact with children and young people, and of section 19 of the Police and Criminal Evidence Act to seize mobile phones in order to interrogate telephone records and disrupt exploitative activity.

115. Two of the eight local authorities had recently been involved in large-scale multi-agency joint operations resulting in ongoing criminal proceedings. In both cases there was evidence of agencies working together better than they had done in the past, with early indications that this experience was already being used to inform and enhance the current and future collective response to disruption.

116. However, disruption does not depend solely on the police. Most local authorities are beginning to realise the potential of developing a more joined-up approach to disruption through better sharing of information and by making full use of the powers available to the local authority and its partners. This includes better use of enforcement powers in relation to the licensing of taxi drivers and fast food establishments. For the majority, this is still work in the very early stages of development and is yet to have impact.

Rochdale

The local authority has radically changed the way in which information is shared across departments and between agencies in order to facilitate successful prosecutions and support the credibility of victims of child sexual exploitation. A formal data sharing protocol has made that possible and a designated Disclosure Officer based in legal services and acting as a single point of access oversees the process. The Disclosure Officer has contributed to achievement of a number of successful prosecutions and has made it possible to disrupt the activities of other perpetrators.

Prosecuting those who sexually exploit and abuse children and young people

117. In two local authorities where there have been high profile criminal investigations, this experience has galvanised the local authorities and their partners into trying to ensure that past failings are never repeated. There has been a step change in intelligence gathering, information sharing, joint working

and disruption activity, leading to a steady flow of prosecutions. This step change is not apparent in the remaining local authorities inspected.

118. The absence of a consistent approach to the recording and reporting of the range of criminal activity in relation to child sexual exploitation means that it is difficult, if not impossible, to establish a clear picture of activity or draw meaningful comparisons across and between local authority and policing areas. It means that the ability of senior leaders and LSCBs to provide an appropriate level of scrutiny and critical challenge is compromised. It shows clearly that the association between high numbers of children subject to child sexual exploitation and the low numbers of prosecutions is poor and much greater focus and attention is required to narrow this gap.

Rochdale

By harnessing the full range of the local authority's enforcement capabilities, a multi-agency enforcement team is taking disruption to another level. Housing powers are used to enter properties of multiple occupation. Health and safety standards, licensing regimes and anti-social behaviour legislation are all being brought to bear on the perpetrators of child sexual exploitation. This work has resulted in 12 arrests and the closure of three licensed premises.

When children go missing

119. The dangers that children and young people are exposed to when they are missing from education, home or care cannot be underestimated. None of the eight local authorities was using information about children missing or absenting themselves from school effectively to make links with the bigger picture about child sexual exploitation. Children and young people who go missing from home or care do not routinely have return home interviews and even when return home interviews were conducted, the possible risks associated with child sexual exploitation were not always discussed or explored. Information and intelligence from return interviews was not systematically used either to inform the strategic overview or shape operational activity.

120. Analysis of SIF inspections highlights similar concerns. Where return interviews did take place, the information gathered was not always collated and analysed to identify patterns either between individual missing episodes, or with other missing young people. This results in a missed opportunity to provide an effective risk management plan for the individual young person or to intervene early and disrupt the activities of potential perpetrators.

Missing from home

121. All of the local authorities had protocols and policies in place for missing children and young people and most of them had arrangements to carry out return home interviews, usually through a commissioned service provided by

voluntary organisations. However, those arrangements were not being effectively implemented in practice.

122. Too many local authorities were failing in their duty of care to children and young people who go missing. The evidence suggests that, on average, fewer than a quarter of all children and young people who go missing from home in these local authorities had a return home interview. At the time of the thematic inspection, in one local authority alone, 43 children who had previously been reported as missing were waiting to be interviewed by the commissioned voluntary agency. Another local authority had 'RAG'-rated its commitment to 'ensuring the procedure for missing from home, care and education addresses child exploitation and practice is embedded' as red as it was recognised as area where work was still to be done.

123. The situation is compounded by the fact that, in most of the eight local authorities inspected, return home interviews were seen as optional. Many children and young people choose not to accept the offer of a return home interview. Local authorities, or the organisations they had commissioned to carry out return home interviews, were not systematically recording or reporting how many children had declined the offer of an interview or why.

124. In child in need and child protection cases it was often the social worker who was responsible for carrying out a return home interview. Inspectors involved in tracking cases observed that those interviews did not always take place. This is an opportunity lost to gain an independent insight into what is happening for the young person and the risk they may experience when missing from home. From supervision records it was also clear that the factors that might trigger a missing episode were not routinely discussed or explored.

125. Management oversight varies. Some local authorities had put in place arrangements to ensure that senior managers oversee the risk assessment and monitoring of individual children and young people who go missing from home frequently and/or for long periods of time. One local authority had recently established a Missing Panel. This was a multi-agency senior manager meeting where the response to children who go missing from home or care is reviewed to ensure that it responds adequately to the risks identified. Another local authority was in the process of combining two different panels, one that reviews missing children incidents and another that oversees child sexual exploitation work, to provide improved focus on and analysis of the possible links between children and young people who go missing from home and child sexual exploitation.

Missing from school

126. Most of the local authorities inspected were not yet systematically making the potential connection between child sexual exploitation and missing from school, especially when they are in school at the beginning and end of each day and only absenting themselves at times in between. It is also too easy to overlook

other risks, for example street level grooming and/or peer-on-peer abuse or exploitation, that young people may be exposed to when they are absent from school.

127. Only one of the eight local authorities was explicitly addressing information about children missing from education as part of the child sexual exploitation prevention strategy. In that local authority, the education welfare service had access to a 'persistent absence list', which they used to target young people whose pattern of school attendance may indicate other concerns, including a risk of child sexual exploitation. The fact that there was such a list made it possible to combine and analyse data in order to identify trends and patterns and explore possible links to child sexual exploitation or gang-related activity.

128. More typically, as in the case of another local authority, school attendance officers were expected to follow up those young people whose attendance fell below 85%. Most of the local authorities inspected did not have a centrally held database of children and young people with high levels of school absence. This meant that it was not possible to cross-reference that information with information about children and young people known to children's social care at risk of child exploitation or those who have been reported to the police as missing.

Missing from care

129. In each of the 36 children's homes inspected, inspectors considered the quality of arrangements in the home's response to children and young people who persistently go missing and those at risk of child sexual exploitation.

130. The arrangements that local authorities have in place to provide return home interviews for children in care are not sufficiently robust. Despite the best efforts of foster carers and staff working in children's homes, large numbers of missing from care episodes are reported for looked after children. Although inspectors found good evidence of compliance with children's home procedures and protocols in respect of children missing from care and high levels of awareness of the risks of sexual exploitation, this in itself is not enough to protect children and young people who are already vulnerable to the threat of sexual exploitation.

131. Generally, children and young people who were running away were doing so in order to be with family, friends or peers. Inspectors saw many examples of good partnership working that helped to keep children and young people safe. Factors that contributed to success included:

- a well understood local policy and protocol on children missing from care that set the context for individual strategies to keep individual children safe
- a regular pattern of well attended and well recorded partnership meetings to deliver the strategy

- good staffing ratios that allow the home to offer high levels of support in delivering individual children and young people's risk management plans
- a qualified, experienced and stable staff group capable of diverting individual children away from risky behaviours.

132. Conversely factors that had a negative impact included:

- high levels of staff vacancies and sickness that led to the engagement of agency workers unfamiliar with the protocols
- lack of awareness of the role and responsibilities of the child's Independent Reviewing Officer (IRO)
- a mixed age group of residents that led to peer pressure to abscond
- non-cooperative families who harbour the child and do not inform the home of their whereabouts.

133. Almost all of the children's homes inspected had access to current policies, procedures and protocols in relation to children missing from care and staff knew how to apply them. In one local authority, regular meetings were held with children's home managers to discuss safeguarding strategies, creating opportunities to reflect on and improve their practice as well as to discuss and explore 'hotspots' and patterns in missing children episodes across the local authority.

134. However, inspectors saw some cases where not all of the documents were customised, relevant or up to date, making it difficult to be confident that they were being effectively implemented. Examples were also seen of homes that operated as part of a group of services presenting corporate policies that did not always reflect the local situation.

135. Most of the children's homes inspected had established good links with their local police force across a range of issues. In dealing with children who are missing and vulnerable to child sexual exploitation, it is an advantage if the local police force has a specialist team or specific officers dealing with the issue, as they can liaise authoritatively with homes. Some homes were able to demonstrate success in significantly reducing the number of missing episodes through this partnership approach. However, in one policing area where there were good levels of support to local children, the police did not provide a continuing service to those children placed in children's homes from outside the authority. This leaves some of the most vulnerable young people at significant risk in an area of the country that may be unfamiliar to them.

136. In most children's homes, the standard of record keeping in relation to children who persistently go missing was very good. Good record keeping helps to keep children safe. In one good practice example, the inspector noted that detailed records kept by staff, including intelligence about a young person who persistently went missing, were passed to the police who were then able to

check CCTV images, serve abduction notices and secure a conviction of the perpetrator.

137. In most cases, children's homes notify police and social workers of children going missing promptly, thereby facilitating a swift response. There was good evidence of high levels of communication with children's family and friends, with checks being made with them immediately a child or young person went missing. Some of the homes inspected were proactive not just in notifying, but in engaging with, social workers who placed the children in the home to ensure that they were aware of the risks from missing episodes and of any action to be taken.

138. The quality of risk assessments was variable. In one well performing home, the inspector observed that:

> 'each young person has an individual risk assessment and a separate missing from home risk assessment that provides a comprehensive overview of identified behaviours, triggers, warning signs and control measures.'

The manager notified all appropriate agencies when incidences occurred. Elsewhere, and at the opposite end of the spectrum, in the case of a child who had a history of going missing from school and previous placements, the home had completely failed to assess the risk of that young person going missing or put in place a strategy to safeguard them.

139. Regular partnership meetings, either strategy meetings or extraordinary care reviews convened by the child's IRO, contributed to a reduction in the number of times that individual children and young people went missing. In one good practice example, regular strategy meetings underpinned an effective and well-coordinated approach involving a range of partners, which resulted in a significant reduction in missing episodes. However, it is more difficult to organise regular meetings of all appropriate representatives when the home is located outside of the placing authority, particularly where there are substantial distances between the two.

140. In a small number of cases tracked as part of the thematic inspection, the ineffectiveness of strategies for keeping children safe was extremely concerning. In one home, the inspector concluded that:

> 'Safeguarding strategies have not proved effective… they [staff] express an understanding of their role and the actions they need to take in response to… child sexual exploitation in particular… However, the home has not been effective in reducing missing from care episodes in the case tracked.'

In another home, the inspector observed that:

'…missing persons' notifications have been comprehensively documented and shared with relevant agencies. Local policies, procedures and protocols… have been consistently adhered to… The home has been proactive in convening professionals meetings to explore strategies. However, a multi-disciplinary approach to managing and reducing absconding behaviour and associated risks has proved ineffective.'

Conclusion

141. Responding effectively to child sexual exploitation is highly complex. It is a form of child sexual abuse and the consequences for individuals and communities are wide ranging and long lasting. Local authorities cannot tackle child sexual exploitation in isolation. It requires the full commitment of statutory agencies, the voluntary sector and wider communities to make child sexual exploitation everyone's business. As such, it requires leadership by those that can effect change in their own agencies and scrutiny by LSCBs to hold agencies to account for their contribution. This thematic inspection has found that leadership to tackle child sexual exploitation is not sufficiently well developed in all eight local authority areas inspected.

142. Prior to the introduction of the SIF in September 2013, previous Ofsted inspection frameworks had given limited attention to child sexual exploitation. The introduction of the SIF framework has brought more focus on child sexual exploitation and greater challenge to local authorities and LSCBs. Learning from this child sexual exploitation thematic inspection will inform future frameworks and sharpen the focus of existing frameworks.

143. Some of the local authorities that have experienced significant public attention due to high profile cases of child sexual exploitation have begun to learn from the findings of those reviews and can demonstrate progress in some areas, with pockets of good practice being evident. However, most authorities have only recently taken action to determine the extent to which child sexual exploitation is happening in their local area.

144. Children and young people are more effectively protected from child sexual exploitation when LSCBs have an effective strategy and action plan that supports professionals to work together and share information well. This activity, when combined with a whole system approach of awareness raising, the early identification of both victims and perpetrators and disruption and prosecution, is the only route to the effective protection of children and young people from child sexual exploitation in our towns and cities.

Annex A: Local authorities subject to this thematic inspection

Brent
Bristol
Camden
Kent
Luton
Oldham
Rochdale
Rotherham