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London Borough of Bexley

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 11 March 2014 – 2 April 2014

Report published: 23 May 2014

The overall judgement is **requires improvement.**

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

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

The effectiveness of the Local Safeguarding Children Board (LSCB) is **inadequate**

The LSCB is not demonstrating that it has effective arrangements in place and the required skills to discharge its statutory duties.

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

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Section 1: The local authority

Summary of key findings

This local authority requires improvement and is not yet good because

1. Services for safeguarding children and young people in Bexley have improved since they were judged to be inadequate in 2012. During this inspection no widespread or serious failures were identified by inspectors that currently left children being harmed or at risk of harm. However, progress has been very slow and the quality of services is still too variable.
2. Until the middle of 2013 children were still not being properly helped and safeguarded. This was mainly because many social workers and managers had left Bexley and it has proven difficult to recruit high quality staff to replace them.
3. The local authority and its partners have been working hard to improve services, and progress began to be made from the middle of 2013, but this progress needs to be maintained. The local authority has been able to recruit many more permanent social workers and managers, along with many agency workers who have worked in Bexley for a long time and help to improve the lives of children and young people.
4. Children and young people, their parents and carers and people who work for other organisations that help children told inspectors that they did not get a good service from Bexley in 2012 and much of 2013. However, they all said that this had begun to improve towards the end of 2013 and has continued to get better this year.
5. Inspectors found that there are a lot of services in Bexley that help children and their families when they are in need, but some are not yet working well together. Bexley is bringing these early help services together, but this is at a very early stage.
6. When children need help, the local authority and partner agencies have to decide if they should get involved. Bexley set up a new triage system in June 2013 to decide when to assess who needs help. This is now much better than it was last year, but the quality of decision-making by managers needs to improve. Referrals to social workers by partner agencies do not always have good information as other agencies do not always understand the thresholds to receive social work help.
7. Social workers talk to other partner agencies and assess what children and their families need to help them. Inspectors found that the quality of assessments by social workers and the plans that they make with other partner organisations need to be better.

8. Most of the time social workers and partners work together well to identify and agree how best to protect children and young people who are at risk from adults, although sometimes discussions do not involve all the people who have information. Sometimes the plans to protect children are not clear enough or help is not provided where abuse is not found but families still need support.

9. Most children and young people who may be at risk of harm are well protected in Bexley, but inspectors still came across a few cases where the arrangements to protect children were not good. Some plans to protect children are not clear enough or help is not provided when families need support.

10. Meetings to discuss how best to protect children, called child protection conferences, are held regularly and all the right people attend, but children who could attend to give their views are seldom invited, so plans are not as good as they could be. Also the views of young people and their carers are not always sought or used to help Bexley to improve its services.

11. Children who cannot live with their families are looked after by Bexley. For many children, the local authority takes too long to make permanent plans for them. Some looked after children cannot return to their families and are able to be adopted. Bexley has been too slow in finding adoptive parents for many of these children.

12. Many children and young people who are looked after by Bexley have had several changes of social worker, but now most children and young people who met with inspectors said that they like and trust their current social worker.

13. When children leave the care of Bexley, plans for helping them to become independent or to find employment or training are not good enough. Although some care leavers have apprenticeships outside of the council, few get apprenticeships with the local authority.

14. The number of children and young people who are known to be privately fostered is low. Recently Bexley has tried to make people aware that they need to inform the authority when a child is being privately fostered, but this has not resulted in many notifications.

15. Recording of their work by social workers and managers is not always up to date or clear. A new electronic recording system has been introduced recently. Information is still being uploaded to the new system, but while it is being established it is not possible to be sure that the information on it is accurate.

16. Managers in children’s social care services do not routinely audit the work done by social workers to understand and improve its quality.

The local authority has the following strengths

17. Children and young people are regularly being visited by their social worker. They are seen alone where appropriate so that they can say what they want to say and they are beginning to form better relationships with their worker.

18. Many looked after children now receive good direct work from their social workers and feel happy and stable where they are living, either with foster carers or in residential homes.

19. Care leavers have good access to accommodation, support for their physical and emotional health and information about what they can receive, including financial support. Most of them who spoke to inspectors said that they are supported by and get on well with their personal advisors, but not so well with their social workers.

20. Foster carers and adopters are well supported, prepared and trained to care for the children and young people who are placed with them.

21. Contact between looked after children and people who matter to them is sensitively and carefully arranged.

22. The local authority is working well with the courts and partners to reduce the time it takes for courts to be able to make decisions about children and their families.

23. Multi-agency meetings to discuss adults who may pose a risk to children, and children who may be at risk from issues such as domestic violence, going missing or child sexual exploitation are held regularly. These discussions and the plans that are made help to protect those children and their families.

24. Leaders in Bexley are committed to improving the lives of children in the area and the services that are provided to them. Substantial additional money has been given to children's social care services by the local authority to improve its work.

25. Leaders and staff in Bexley are committed to their role as corporate parents for looked after children and try to meet and hear the views of children and young people to make sure that the service they provide improves their lives.

What does the local authority need to improve?

Priority and immediate action

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

Areas for improvement

27. Ensure that the thresholds for access to children's social care services are clear, understood and consistently applied by all relevant agencies.
28. Ensure that all children who meet the threshold for a single assessment by children's social care receive a timely assessment that is of good quality.
29. Ensure that all case files for children and young people have an up to date chronology that reflects significant events in their history, and that this is used to inform planning and risk assessment.
30. Work with the police to ensure that police notifications are timely and are robustly risk assessed.
31. Ensure that all strategy discussions are informed by the involvement of all relevant professionals, have a clear rationale for decisions and are well recorded, with clear timescales for action.
32. Ensure that child protection conference minutes and the outline child protection plans are distributed promptly to conference members and are used to measure progress against the plan.
33. Ensure that young people have an opportunity to attend their child protection conference where it is appropriate for them to do so and that an independent advocate is available if they require one.
34. Ensure that the needs of all relevant children in a family are considered in child protection conferences and core groups.
35. Systematically collate learning from complaints and representations from children and young people, parents and carers and service users to inform and improve service delivery and development.
36. Ensure that assessments and plans are consistently of a good or better quality, with a clear focus on the needs, risks and strengths of children and their families, and the expected outcomes.
37. Ensure that services for children on the edge of care are co-ordinated and delivered effectively, and evaluate their impact on preventing some children from coming into care.
38. Evaluate the impact of family group conferences in preventing or reducing the need for children's social care intervention with children and families.
39. Ensure that all looked after children and young people know the name and contact details of their Independent Reviewing Officer and what their role is,

and have an opportunity to form a consistent and stable relationship with them.

40. Ensure that Independent Reviewing Officers understand the wishes and feelings of children and young people and provide robust challenge to all agencies involved in their care to ensure that children's needs are met.
41. Ensure that looked after children have access to timely treatment from the Child and Adolescent Mental Health Services.
42. Ensure that all looked after children are supported to make good or better progress in each key stage of their education.
43. Ensure that all looked after children are provided with regular and timely dental checks, and immunisations.
44. Ensure that children and young people are able to form trusting and continuous relationships with their social workers through a stable staff group, and avoid children experiencing too many changes of worker.
45. Maintain an effective adoption tracker, and challenge staff where timescales are not met and plans are not implemented.
46. Fully implement the adoption action plan and provide comprehensive reports of progress or barriers for leaders and senior officers.
47. Maintain and enhance training for children's social care workers alongside adoption workers to reinforce the importance of a joined up approach to permanency planning.
48. Provide a full range of options for care leavers to develop and extend their skills to secure employment, education and training, including better support for young people to access apprenticeships, work placements and vocational training.
49. Extend the focus of the virtual school to ensure that young people over 16 years old get the best opportunities to develop and extend their education and employment options to improve their life chances.
50. Improve the quality and effectiveness of pathway plans to support care leavers to develop their independence and transition to adulthood.
51. Ensure that the electronic case and performance management systems in children's services are robustly implemented and that all staff ensure that their records are up to date and are located within one electronic system.
52. Ensure that the social care workforce is sufficiently stable, experienced and skilled to deliver high quality services to children and their families.
53. Ensure that the human resources support for specialist children's services is focused on recruiting and retaining good quality social workers and managers and provides support for operational managers to develop and retain staff.
54. Improve the consistency and quality of management oversight, direction and supervision of front line staff in all social work teams.

55. Ensure that a robust performance management and quality assurance framework is implemented, including routine auditing of the quality of practice and management.
56. Ensure that all children's services data are accurate and systems are established to check the accuracy of the new electronic database and case recording system while it is being developed and embedded.
57. Implement a commissioning sufficiency strategy for looked after children to ensure that future plans are informed by robust analysis of current and projected needs.
58. Ensure that the views and experiences of children, young people and their carers are actively sought and are used to inform service improvements.
59. Ensure that children's social care services is an effective learning organisation that considers and responds to learning, research and feedback about the quality of provision.
60. Ensure that the combined roles of Director of Children's and Adults' Services can be effectively delivered and that a robust 'test of assurance' is undertaken in accordance with statutory guidance.

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Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

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

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

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

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

The inspection team

Lead inspector: Pietro Battista

Team inspectors: Jansy Kelly, Shirley Bailey, Linda Steele, Stephanie Murray, Christine Williams, Pamela Blackman, Wendy Ratcliff and Fiona Parker.

Information about this local authority area[2]

Children living in this area

- Approximately 54,000 children and young people under the age of 18 years live in Bexley. This is 23% of the total population in the area.
- Approximately 18.7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 13.8% (the national average is 18.1%)
  - in secondary schools is 11% (the national average is 15.1%).
- Children and young people from minority ethnic groups account for 26% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Black/Black British and Asian/Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 15.9% (the national average is 18.1%)
  - in secondary schools is 11.4% (the national average is 13.6%).

Child protection in this area

- At 1 March 2014, 1,457 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,827 at 31 March 2013.
- At 1 March 2014, 247 children and young people were the subject of a child protection plan. This is an increase from 218 at 31 March 2013.
- At 1 March 2014, three children lived in privately arranged fostering placements. This is a reduction from 13 at 31 March 2013.

Children looked after in this area

- At 1 March 2014, 260 children were being looked after by the local authority (a rate of 48 per 10,000 children). This is an increase from 256 (47 per 10,000 children) at 31 March 2013. Of this number:
  - 111 (42%) live outside the local authority area

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[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- 21 live in residential children's homes, of whom 90% live out of the authority area
- A small number live in residential special schools[3], all of whom live out of the authority area
- 183 live with foster families, of whom 31% live out of the authority area
- A small number are placed with parents, none of whom live out of the authority area.

- In the last 12 months:
  - There have been 21 adoptions
  - 28 children became subject of Special Guardianship Orders
  - 164 children have ceased to be looked after, of whom 5.5% subsequently returned to be looked after
  - Eight children and young people have ceased to be looked after and moved on to independent living
  - No children and young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of Bexley's safeguarding arrangements was in July 2012. The local authority was judged to be inadequate.
- The previous inspection of Bexley's services for looked after children was in July 2012. The local authority was judged to be good.

Other information about this area

- The Director of Education and Social Care, who is responsible for Adult Social Care and is the Director of Children's Services, has been in post since April 2011.
- The chair of the LSCB has been in post since June 2013.

[3] These are residential special schools that look after children for fewer than 295 days per year.

Inspection judgements about the local authority

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

61. During this inspection no widespread or serious failures were identified by inspectors that left children being harmed or at risk of harm. However, the pace of change in improving the provision of help and protection to children in Bexley has been too slow. Many of the inadequacies that were identified in the Safeguarding and Looked After Children inspection of July 2012 have not been addressed quickly enough. The local authority acknowledges that prior to June 2013 the impact of improvement actions on frontline practice was not sufficient. Improvements to practice have become more visible, particularly in the last three months, but these have yet to be sustained.

62. When children are first identified as needing help in Bexley, professionals know who to go to for advice about how to support families to prevent concerns escalating. A wide range of innovative early help services has been established. These services are being evaluated individually using feedback from parents, practitioners and partners in order to measure impact. These projects are highly valued by parents, children and professionals. For example the Sisters Project, a programme for black women who were not born in England, provides education, companionship, and advice about domestic abuse, parenting and children's health.

63. Early help services in Bexley are undergoing significant transition. A new 'Thriving Families' service combines services to children and adults with schools, health, police and adults' services to provide joined up support to families with a range of needs up to the children's social care threshold. One prototype team is in place, with a clear plan to gradually expand and develop the service. The local authority and partner agencies recognise the need to strengthen the multi-agency early help provision. An early help strategy has been implemented to guide the development of services.

64. Changes in the coordination and provision of targeted early help services are welcomed by professionals from partner agencies, as currently some early help services are difficult to access due to stringent thresholds and significant demand on their services. This leads to delays in some families receiving the help that they need, with professionals making referrals to a range of services in the hope that one will offer help.

65. Significant numbers of staff across partner agencies have been trained to undertake common assessments, but the number of assessments remains too low and the reason for this is not understood by partners. Those families who are being supported through the common assessment framework (CAF) receive helpful intervention at the right level and parents engage well in assessments and 'team around the family' meetings. Where concerns increase or are not resolved at the CAF level, these are appropriately stepped up and referred to children's services in most cases.

66. Except in urgent circumstances, partners complete an interagency referral form which enables clarity of information sharing and requires issues of consent to be addressed. Decisions about contacts and referrals are made within the local authority children's services triage team by qualified and experienced workers.

67. The threshold for referral to children's social care services is not consistently applied by partner agencies. Approximately two thirds of all contacts or requests for services to children's social care do not progress to a referral, and this increases work pressures within the triage team. Of 19 contacts seen in the triage team where there was no immediate risk of harm, a third that should have progressed to assessment were closed inappropriately, resulting in children not receiving help at the right level or as quickly as they should.

68. Capacity issues within the police have resulted in delays of up to a week, and sometimes longer, in referring children who live in households where there has been a report of domestic abuse. This has the potential to leave children at risk of harm.

69. Prompt, effective action is taken in almost all cases when referrals are received that meet the threshold for a child protection enquiry. Of 71 child protection cases seen by inspectors, two were identified where children were left in situations of potential significant harm. In these cases the local authority took prompt action to protect the children.

70. Inspectors saw no examples of children and families being subjected to child protection investigations unnecessarily. Child protection investigations are undertaken by suitably qualified social workers following information sharing at a strategy discussion. The majority of strategy discussions are between police and children's social care and do not routinely involve discussions with other key agencies, particularly health services. Records of strategy discussions and decisions vary too much in quality. Too many lack detailed planning and in some cases the rationale for single agency investigation was not clear.

71. The local authority has adopted a single assessment framework, with timescales proportionate to the complexity of assessment required. However, managers do not consistently record at the beginning of the assessment how long assessments should take and it is not clear if the time taken is determined by the needs of the children. As a result it is not possible for managers to identify whether there is undue delay in undertaking assessments or meeting the needs of children and young people.

72. The majority of assessments demonstrate appropriate analysis of risk and protective factors based on information available and careful observation of children with their families. Assessments take account of the ethnicity of children and their families, with race, culture and language appropriately considered in the large majority of cases.

73. Chronologies are frequently not completed by social workers until after assessments are concluded. They are not routinely updated when the case is

passed on to the locality teams except when court proceedings are considered. Most assessments contain some analysis of family history and inspectors saw some very good examples of analysis of history leading to effective action. However, the relevance of past behaviour of children and families is not consistently considered to inform contingency planning.

74. Many children have experienced frequent changes of worker, often at short notice. This has impacted negatively on the quality of casework and relationships between children, families and staff. Changes in worker are exacerbated by electronic case records often not being complete or up to date, making it difficult for new workers to fully understand what has happened in the case, and for managers to provide effective oversight.

75. Despite changes of social worker, in almost all cases social workers now undertake direct work with children and their families; they form positive relationships with children that help them to express their wishes and feelings. Children are routinely seen and in the majority of visits are seen alone if appropriate, unless parents of children not subject to child protection enquiries expressly refuse consent. Social workers observe pre-verbal children interacting with their families and use this well to assess attachments and general well-being of children.

76. Risk to children who have a disability is appropriately identified and assessed. Children who have a disability or communication difficulties are sensitively helped by social workers to say what they are happy about and what troubles them. However limited specialist direct work resources within the children with disabilities team leads to social workers relying on their own creativity to develop meaningful ways of communication with children. Children with disabilities who are subject to child protection plans are supported and protected well by the children with disabilities service.

77. Most case recording contains evidence of managerial decision-making. It is frequently brief and seldom explains the reasons for decisions that are made. The quality of decision making is inconsistent and in some cases seen by inspectors it was not appropriate or was not made at an appropriate level of seniority. For example, a decision was made to close a case by a team manager when parents had refused to allow children subject to a child protection investigation to be interviewed; this meant that the children were potentially at risk and that more senior managers had no opportunity to oversee the decision.

78. Children 'in need' are being identified appropriately. Half of the child in need plans seen by inspectors were of good quality. Family history was analysed, the views of the children and carers were well-articulated and the needs and risks identified, leading to purposeful and effective action which reduced risk. However, in the other cases, although social workers could articulate well the children's needs and the actions required to achieve the desired outcomes, this was not always reflected in written plans, which were unspecific and often without timescales. In a very small minority of child in need cases seen the quality of social work support was poor, with long gaps between visits and an

overall lack of purpose, leading to slow progress against the plan or an increase in concerns.

79. Managers recognise that the quality of assessments and plans needs to improve and the local authority has taken steps to address this through the provision of risk analysis training. Plans to improve this further through managers undertaking regular case audit and routinely providing reflective supervision have still to be put into practice.

80. Almost all children at immediate risk are protected through the use of emergency powers. However, inspectors identified two cases where children's services should have used emergency powers during child protection inquiries and instead the police used their powers of protection the following day as part of the same investigation.

81. When decisions are made that a child protection conference is required following an investigation, conferences are convened within appropriate timescales. However, the amount of notice given to relevant agencies and parents is often short, which negatively impacts on the quality of information shared. Social work reports to conferences are of an adequate or better quality and provide sufficient information for partners to make appropriate judgements based on an analysis of risk. Some contain detailed chronologies and make reference to relevant research. Conference chairs identified the use of research in reports as unhelpful to parents as it was frequently written in language parents find difficult to understand. The quality of reports from partner agencies is too variable and a lack of a standard format for reports exacerbates this.

82. Conferences are well chaired and structured, and are attended by most statutory agencies. Outline child protection plans formulated at conferences are mostly of adequate or better quality, and are improving. Recent plans seen by inspectors demonstrated sound multi-agency analysis of risk incorporating specific and measurable actions and timescales, including contingency planning.

83. Progress of plans is considered thoroughly at review child protection conferences, with escalation to pre-proceedings agreements under the Public Law Outline or court proceedings when plans have not reduced risk or concerns are increasing.

84. Bexley compares well to similar local authorities and the national average for the proportion of plans coming to an end within two years; 72% of children are subject to a plan for no more than a year. Numbers of repeat plans are low, indicating that the reduction of risk to children is sustained over time. However, in six out of 14 cases seen by inspectors where a recent change of plan was now working well, or the case was being appropriately escalated due to lack of progress, the action should have been taken sooner.

85. Children and young people who are old enough to attend are not routinely invited to conferences and core groups, which take place during school hours. As a result their views are not independently represented or in their own

words. An independent audit recently commissioned by the Local Safeguarding Children Board (LSCB) identified the inclusion of a dedicated section of the meeting to discuss the wishes and feelings of children as an area for development. It also found that in families where there is more than one child, the needs of individual children are not always discussed in detail. These issues were still evident in this inspection.

86. There are frequent delays in conference minutes and outline child protection plans being made available to agencies and parents. This causes difficulties in ensuring that agencies and parents are clear about what is expected of them and that progress against the plan remains the focus of work with the family.

87. When children are subject to a child protection plan they are mostly visited within agreed timescales. It is not always recorded by social workers when children are seen alone and which visits are unannounced. Explicit discussion with children about progress of plans and whether their lives are improving is too variable. The majority of recording shows general conversation with children about their day to day activities and interests. However, some very good examples were seen of children clearly expressing what life is like for them.

88. Effective multi-agency working across police, youth engagement services and health services ensures that individual cases of children missing from home are dealt with promptly, with suitable risk assessments and welfare follow up. The youth engagement service has responded to 97 missing episodes in the last year. Outcomes for the majority of these incidents have been positive. The children missing from education panel proactively follows up each individual child that has been reported missing from education. The education inclusion service is establishing reporting arrangements for all children missing from education in line with new statutory guidance.

89. The local authority's child sexual exploitation action plan is comprehensive. It is in line with arrangements across London and is informed by relevant research. However, it is still in draft form and partners have been slow to put it into practice. There is some good local intelligence based on known activity but current trend data and analysis are underdeveloped. Some effective work with individual children is being undertaken under current arrangements, using appropriate screening tools to identify and respond to presenting risk.

90. Allegations that are made against professionals who work with children are referred to the Local Authority Designated Officer (LADO), who makes prompt and appropriate decisions to hold multi-agency strategy meetings. Meetings are well attended and are effective. However, referrals to the LADO have almost doubled in the last year, which has stretched the capacity of the service. A comprehensive action plan was drawn up by the local authority in October 2013, which assists the LADO to fulfil his functions more effectively, and additional staffing is now in place. However, the quality assurance function of the LADO remains underdeveloped.

91. Victims of domestic abuse in Bexley are given effective help by Women's Aid and the Freedom Programme. Parents spoken to by inspectors said that this

support enabled them to gain greater insight into how domestic abuse has affected their children and to make safe decisions for their children and themselves. The crisis intervention team provides swift and intensive support to families involved in domestic abuse, parental substance misuse and mental ill health. It works well with partner agencies to promote the safety of victims, families and their children.

92. The Out of Hours Service is sufficient to meet demand. The service responds well to requests for urgent intervention, such as providing foster placements for young people aged over 16 who are homeless, or supporting carers to manage crises within their foster families to avoid placement break down. Links with police out of hours are strong, with joint decision making and a swift response to immediate risk within families.

93. Multi-Agency Risk Assessment Conference (MARAC) arrangements are well established. Attendance by most agencies including adults' services is good. Multi-Agency Public Protection Arrangements (MAPPA) follow statutory guidelines, using London thresholds, which are higher than the rest of the country. MAPPA meetings are robustly chaired and are well attended by appropriate agencies.

94. Only three children are currently known to be living in private fostering arrangements. This is a significant decrease, from 13 in 2013. These children are being appropriately monitored and supported by children's services. The local authority has recently taken steps to raise the profile of private fostering arrangements within the area, with information being shared with partners such as schools through leaflets and a regular safeguarding newsletter. This has not yet resulted in an increase in notifications.

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

95. A range of services is available to support children and young people on the edge of care. This includes early intervention support, mediation, the Bexley Youth Advice service and family support workers. These services are planned to come under the umbrella of the Thriving Families Programme. The local authority recognises the challenge and the need for a co-ordinated approach to ensure that early help services are delivered effectively in order to prevent some children from coming into care.

96. When social workers are concerned about the welfare of children, and they are unable to remain in the care of their family, decisions regarding their future care needs are appropriately secured through the legal system. In the majority of cases legal planning meetings are held and make use of historical information to inform decision making. Good use is made of the Public Law Outline (PLO). This means that children and families are clear about what changes are needed, what timescales are involved, and possible consequences should changes not be made. However, in a minority of cases, the need to look after children with parental consent or take legal intervention had not been considered early enough, leaving children in unsuitable situations for too long.

97. Family group conferences (FGC) are well established and are used effectively to explore extended family involvement for children subject to the PLO. Children are spoken to alone by FGC coordinators and are encouraged to attend meetings to ensure that their views and wishes are heard. However, the local authority has not undertaken a formal evaluation of the effectiveness of FGCs since 2011/12, so their impact on outcomes for children is not fully known.

98. A number of panels have been established to track and monitor looked after children's plans and placements. The children's social care and legal panel now provides a more robust tracking system of care proceedings and ensures that the individual needs of children and young people are met, including the use of concurrent and parallel planning. The looked after children's panel reviews the cases of all newly looked after children to ensure management oversight of their placements. However, the majority of children come into care in an emergency situation and are retrospectively presented to the panel. This means that the opportunity to match children to foster carers is limited and as a result some children experience unnecessary placement moves.

99. The Children and Family Court Advisory and Support Service (Cafcass) and the local judiciary report an improvement in the quality of assessments and court reports by social workers. Clear plans are in place to reduce timescales for care proceedings and as a result these have reduced to 37 weeks, although this remains significantly higher than the national target of 26 weeks. For some children this means there is a delay in securing their permanency. Bexley has undertaken a 12 month PLO pilot project with a neighbouring borough. This has proven to be instrumental in reducing timescales and

improving the quality and timeliness of reports to the court. During the inspection the local authority legal advisors reported that the pilot project has recently reduced the length of care proceedings to 23 weeks for those cases within the pilot.

100. In the majority of cases when children and young people are ready to return home from care, the decision to do so is based on an assessment which appropriately considers and addresses risk. However, inspectors saw a few cases where insufficient work and assessment had been completed and services were not sufficiently in place to support the rehabilitation plan. In one case this resulted in a young person returning to care after a short period of time.

101. Children and young people have regular contact with their family and other relatives wherever possible. Suitable contact is also arranged with other people who are important to them. Children and young people's safety is fully considered when contact arrangements are made.

102. Too many looked after children in Bexley have experienced delays in securing timely permanency planning arrangements. Although there has been progress in permanency planning for children, much of this has been since January 2014 and is therefore of limited impact. The local authority acknowledges that there is still work to do in order to ensure that progress is embedded and sustained.

103. The majority of children and young people looked after are placed within 20 miles of their family home and in over half of these cases this is within the Bexley borough. Cases seen by inspectors included some young people who lived out of the area, and who were visited by a regulatory inspector. The young people confirmed that their placement and care plans are in place. They receive visits and support from social workers and are well supported in their health and educational needs. While these young people now feel well supported, they reported that frequent changes of social worker had not provided them with consistency of support.

104. Many children and young people have experienced too many changes of social worker. Some children told inspectors they were unhappy about the frequent change of social workers: 'Just another adult in my life' and 'They did not care about me, they just came and went'. The impact of the frequency of changes means that children have to re-tell their story and form new relationships of trust with their social workers. Furthermore, partner agencies report that the high turnover of staff has negatively impacted on planning for children and young people. For example, professionals have not known who the new social worker is and some health assessments have been delayed because parental consent was not sought in a timely manner by the social worker.

105. Social workers visit children and young people regularly and see them alone, in line with statutory requirements. Despite the number of changes in worker, social workers spoken to during the inspection know their children well, are proactive in representing the views of children and young people and take time to build strong relationships with them.

106. The majority of looked after children have a care plan which ensures that they are cared for appropriately. However, the quality of written plans requires improvement. Plans are mostly satisfactory and appropriately address health and educational needs. In most cases children are placed with their brothers and sisters when it is in all of their best interests to be together.

107. In the majority of cases Independent Reviewing Officers (IROs) meet children and young people before their review. However, a few young people told inspectors that they did not know who their IRO was or what their role was. For some young people this means they do not have a meaningful relationship with their IRO; this relationship is crucial to ensure that their needs and rights are independently represented. In most cases seen by inspectors, reviews of care plans were adequate, with permanence appropriately discussed. Reviews are well attended by all professionals and children's views are represented. However, some care plans lacked vigorous challenge to ensure that the plan is effectively implemented. Carers report that they are involved in meetings and that their views are taken into account. The distribution of some review minutes has been significantly delayed and this negatively impacts on the ability of people who were not at the meeting to know in a timely way what has been agreed and planned.

108. When looked after children go missing an established triage system is used to determine the action to be taken including whether a child protection enquiry is necessary. Robust systems are in place to track and identify individual looked after children who go missing and those who are at risk of sexual exploitation. These children are regularly considered at multi-agency meetings and suitable contingency plans are agreed. Sensitive interviews are undertaken with looked after children when they return to their placements.

109. Looked after children are offered good services to promote their physical and emotional health and wellbeing. The local authority and health professionals have recently implemented weekly tracking of health assessments. This has resulted in 97% of children receiving their health assessments. However, dental checks and immunisation rates at 71% and 77% respectively are below statistical neighbour and national rates. The local authority is working with health partners to improve this.

110. Dedicated specialist Child and Adolescent Mental Health Services (CAMHS) give high priority to assessing the needs of looked after children. CAMHS professionals provide good, timely assessments and support staff and carers. However, the provision of treatment is not as timely. A few looked after children have been waiting a substantial amount of time for psychotherapy. The chair of the Corporate Parenting Board appropriately challenged this and as a result a more creative, flexible approach is being considered as to how services can be delivered to ensure looked after children are not waiting for treatment. However, this is not yet in place. The CAMHS team jointly delivers the KEEP programme (Keeping Foster and Kinship Carers Supported), which enhances the skills of foster carers in responding to children's behavioural and emotional difficulties. Support services for young people for their drug and alcohol abuse are provided by CAMHS.

111. Children who are looked after make good progress in their education in some key areas. However, 27% of young people currently in Key Stages 3 and 4 are not making expected progress. The virtual school provides effective challenge to schools to ensure that appropriate action is taken to improve individual outcomes. All looked after children attend schools which are judged good or better by Ofsted.

112. In 2013, 20% of looked after children achieved five GCSEs, including English and mathematics. This is an increase from previous years and better than the national rate of 16%. The virtual school accurately identified an attainment gap for white British boys at Key Stage 4 and is addressing this. Personal education plans are used effectively to support the educational and academic progress of young people. The virtual school monitors the quality of plans to ensure that they are used effectively to help young people progress successfully. The pupil premium is used effectively to support looked after children.

113. Children in care are provided with alternative education provision throughPathways Short Stay School, New Horizons Federation. New Horizons works effectively with local schools to ensure that any looked after children at risk of permanent exclusion are offered suitable alternative provision to meet their needs. No looked after child has been permanently excluded in the last five years.

114. Fostering service managers have developed plans to provide sufficient numbers and types of foster carers for looked after children. Eight foster carers were approved last year, although nine left the service to continue to provide care for those children under Special Guardianship Orders. 'Skills to Foster' pre-assessment is regularly undertaken to ensure that people interested in becoming foster carers are clear about the commitment and skills required. A shortage of carers for children over the age of 10 years has been identified by the local authority and has resulted in an appropriately targeted publicity and recruitment campaign. However, the recruitment activity is not fully implemented and, while it is showing potential, the impact on outcomes has still to be achieved.

115. The Fostering Panel meets all statutory requirements. Foster carers in Bexley are positive about the support that the family placement team provides. Training opportunities are targeted at meeting foster carers' own individual needs and the needs of the children that they care for.

116. Delegated authority to foster carers is agreed when children come into care; this is clear, age appropriate and helps children to have as normal an experience of childhood and family life as is possible. For example foster carers can agree for children to take part in social and leisure activities without having to obtain written permission from social workers or parents.

117. The adoption team is responsible for Special Guardianship Orders (SGOs). The use of SGOs in Bexley in the last 12 months has significantly increased from 7% to 18% of the number of looked after children. Prompt viability assessments are undertaken and children placed with family members

maintain their family links and culture. There is no policy in place regarding allowances for children on SGOs; the local authority is aware that this needs to be agreed.

118. Some looked after children are able to have their views heard to help shape the services that are provided to them. A small number of children and young people who are on the Children in Care Committee (CICC) contribute well to the corporate parenting forum and have engaged in the recruitment and training of social work staff. The CICC representatives recognise the difficulty of getting the views of the wider looked after children population, and are developing ways to improve how information is shared and how the views of other children and young people are heard, for example, through developing a new website for looked after children.

119. The National Youth Advocacy Service (NYAS) provides an advocacy service for looked after children and care leavers. However, this is too limited, provided by one part time worker. An Independent Visitors service is available to all looked after children through spot purchasing, although take up of this service has been negligible. The local authority is currently reviewing these services as a result of the low take up.

120. The local authority does not monitor or actively seek to understand themes or issues from complaints from looked after children; this significantly restricts its ability to learn and to develop effective services for looked after children. However, NYAS is offered to all looked after children who wish to make a complaint, ensuring that they have an independent voice and support in the process.

The graded judgement for adoption performance is requires improvement

121. Planning for some children has been too slow, resulting in drift, delay and in some cases missed opportunities for permanency. Some children have waited for many months in temporary arrangements before they move in with an adoptive family who can meet their needs. The average time taken from becoming looked after to moving in with an adoptive family has been increasing over the past three years and is above the national threshold. Some children have been waiting too long before they are matched with their adoptive parents once the Court has approved the plan for adoption.

122. The local authority is now tackling delay, and permanency planning for children is improving. A comprehensive tracker of all looked after children is in place, overseen by senior managers in children’s services. The tracker is updated weekly and is used to inform progress. As a result, inspectors saw improved and timely planning for children since July 2013, with greater impact since January 2014. For example, 30 children were waiting for adoption in March 2013; in February 2014, 41 children were waiting to be adopted, 20 of whom had been placed, and 21 were waiting to be matched. In March 2013 45% of children waited more than 20 months between becoming looked after

and being placed for adoption; by February 2014 only 21% of children waited in excess of 20 months.

123. A small number of children have been placed with foster carers for a long time, in some cases since 2009, with foster carers only now being assessed as adopters for these children. While this may now enable these children to have a permanent plan with continuity of placement, proactive decisions for permanency with their current foster carers or alternative adopters should have been undertaken much sooner, reducing drift in care planning and uncertainty for those children. Delay in making permanent plans for some children means that the opportunity for adoption is compromised or even lost as they get older and therefore become more difficult to place.

124. Adoption social workers now chair permanency planning meetings and a family finding social worker from the adoption team attends looked after children reviews. More recently, family finding meetings have been introduced which review and track progress of family finding for children with a plan for adoption.

125. The local authority has good knowledge of the needs of the children who are waiting to be placed for adoption and those who are coming through the care system and requiring permanency. Some success in placing brothers and sisters together has been achieved. Where there are large groups of brothers and sisters with a plan for adoption, the individual needs of the children are considered and, if necessary, difficult decisions to separate brothers and sisters are taken to ensure that the needs of the individual children are met. In these circumstances the contact arrangements are especially important, and inspectors saw some good plans where contact between brothers and sisters had been arranged.

126. The recruitment of prospective adopters is improving. The local target to recruit 25 adopters in 2013–14 has been narrowly missed, with 22 new adopters recruited. The service is ambitious and has set a target to recruit 50 new adopters in 2014–15. The local authority is confident that this will be achieved as 30 prospective adopters are currently being assessed. Joint work with the other local authorities in the south east consortium has resulted in recruiting adopters from more diverse backgrounds, including same-sex couples, enabling a wider choice of placements. Three foster carers are being approved as 'fostering to adopt' carers, offering a completely new resource for children, including those children subject to concurrent plans. Adopters spoken to confirmed that they had actively chosen Bexley because of the welcome and information that they had received when making initial enquiries to adopt. They said that the process of assessment is working well, with second stage assessments being completed within six months.

127. Improved access to training for both adopters and social workers has been in place in the last 12 months, including training on attachment and loss, and life story work. Three excellent life story books were seen by inspectors. Managers confirmed that a backlog of life story work has now been cleared as a result of this work being outsourced to another agency. Social workers are

now trained to complete the work. Life story books and welcome books from adopters were also seen, which have been invaluable in helping children settle into a new adoptive family and understanding their personal background and history.

128. From a previous position of no disrupted adoptive placements, there have been two disruptions since October 2013, one in the last few weeks. The local authority is reviewing these cases to understand what could be done better to avoid disruptions in the future.

129. There is an appropriately constituted adoption panel with an experienced panel chair, who confirmed that the local authority has successfully implemented the new adoption guidance, including the new templates for reports. The quality of reports has improved, along with a reduction in the timescales for assessment and an increase in the numbers being approved. Prospective adopter reports seen during the inspection were of good quality, detailed and analytical; the reports enable the panel to make secure recommendations to the Agency Decision Maker.

130. The adoption panel chair meets with members of the local authority and is aware of the priorities to increase the number of children placed for adoption in a timely way. The chair of the panel and the Agency Decision Maker acknowledge that although progress has been made there is more to do to ensure that timeliness and permanency plans are in place for children, and that children are considered at an early stage when they become looked after. This was not always evident when sampling review minutes.

131. Adoption support is provided by a principal social worker with a remit to further develop the service. A second worker deals with birth records, adoption counselling and letter box contact. Adopters reported that they have been well supported by the adoption social worker in organising support for their adoptive children, including therapy and entry into appropriate schools. Adoption support plans seen by inspectors were comprehensive and clearly identified the support to be provided, including financial support for children and adopters.

132. Adopters who spoke to inspectors confirmed that they were aware of their entitlements, including how to make a complaint. Adopters were very positive about the adoption service, which has experienced fewer changes of staff than in some of the locality teams. This has meant that adopters often rely on the adoption social worker for support if the child’s social worker is unavailable or is new to the child.

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

133. Many care leavers are well supported by their personal advisors. Academic and wider success is celebrated, and young people feel proud of their achievements, including their ability to sustain relationships, support others

and make good progress toward successful independence, including parenthood.

134. One care leaver stated, 'My personal advisor is like the mum I never had', and this effectively captures the views of many care leavers about the care, guidance and support that they receive from their personal advisor. Many however, have mixed experiences of the support that they receive from social workers as they approach leaving care. Not all young people are allocated a personal advisor by the time they are 18 years old. In some cases, care leavers saw a number of personal advisors in a short time span, giving them no opportunity to form a trusting and helpful relationship.

135. Pathway plans vary too much in quality. Plans generally lack focus, particularly in relation to education and employment options, and they fail to sufficiently identify risks to young people. Young people say that pathway plans vary in their usefulness, for example, one young person told inspectors he was asked to complete his pathway plan with his foster carer without suitable support or guidance.

136. Care leavers have good access to services that support their health needs, including regular medical checks and a health passport which sets out all their health history. This provides effective guidance on future health issues, including sexual health and the dangers of substance misuse. The looked after children nurse is proactive and flexible in her approach to ensure that all care leavers address their health needs. Bexley Youth Advice, a one-stop shop, offers young people a range of accessible and helpful advice and guidance. Care leavers have good access to counselling through the Youth Engagement Service and the response from CAMHS is timely and supports young people to improve their mental health.

137. Effective and productive partnerships with a range of supported accommodation providers enable care leavers to have good access to accommodation that meets their individual needs. Care leavers report that they are living in safe and appropriate accommodation. This ranges from 'staying put' with foster carers to managing their own tenancy.

138. The local authority has developed an effective system to ensure that all care leavers are offered a suitable tenancy when they reach 18 years old, if this is appropriate for their needs. The authority makes a direct offer of a property, taking into account any identified risk factors. The authority has reciprocal arrangements with other boroughs to offer tenancies for those young people who wish to be housed outside the borough. This results in the vast majority of young people taking up their own tenancy by the time they are eighteen. As a result, almost all care leavers are living in suitable accommodation and are appropriately supported.

139. Only a small number of care leavers benefit from some effective work by the local authority with education partners. This includes the local college, which offers bespoke programmes tailored to individual needs and language programmes for those young people whose first language is not English. Job Centre Plus is now able to identify care leavers and is offering a much more

bespoke service, which recognises that many care leavers are very vulnerable and require additional support in seeking and securing suitable long-term employment.

140. The local authority and its partners have been slow to assist those care leavers with significant barriers to learning to find suitable options for future education, work experience and apprenticeships. The local authority has only recently begun to consider offering regular work placements specifically for care leavers to assist them in developing skills for employment. They have offered between 40 and 50 apprenticeships across the authority for a number of years, but only two care leavers have ever successfully completed one of these apprenticeships and gone on to find suitable employment. Around 37% of care leavers over the age of 19 are not in suitable education, training or employment.

141. While educational plans are prepared for young people over the age of 16 who are preparing to leave the care system, not enough of these plans are of sufficient quality to assist young people to improve their educational and academic prospects. These plans lack focus, are extremely brief and do not systematically include the views of young people. For those care leavers with identified challenges to their learning, personal education plans fail to clearly identify how their support needs will be effectively met. This contrasts markedly for those children up to the age of 16, where the virtual school very effectively monitors education plans to ensure that realistic but stretching targets assist young people to achieve.

142. For those care leavers who progress into higher education, Bexley provides a good package of support, including assistance with fees and support with accommodation during the holidays if required. Care leavers say that they value the financial and emotional support they receive and that it is helping them to achieve. Bexley is currently supporting 17 care leavers in higher education.

143. Care leavers are well informed about their legal entitlements and financial support available to them. Useful information is provided by the Children in Care Committee who endeavour to make sure all care leavers are informed about the Bexley Pledge, setting out the 10 promises that are made by Bexley Council to all looked after children.

Leadership, management and governance require improvement

144. The local authority knows its strengths and areas for development. Following the issue of an improvement notice by the Department for Education (DfE) in October 2012, the local authority and its partners have been working to a comprehensive improvement plan. Timescales for this plan have been extended beyond an initial twelve month period, to allow for the local authority to radically change the structure and operation of children’s social care services. This restructuring has also resulted in delay in securing and evidencing improved social work practice with children and their families.

145. Demonstrable improvements in the delivery of safeguarding services began in June 2013 and became more evident from autumn 2013. Many positive plans, procedures and practices have been very recently implemented and are still to demonstrate positive impact for children and their families. Little has been embedded or sustained for any significant period. Services for looked after children and care leavers have deteriorated since their last Ofsted inspections. Adoption services were assessed as good in 2009 and looked after children services were assessed as good in 2012. In the past six months these services have also begun to gradually improve.

146. The pace of improvement has been too slow. Elected members, the Chief Executive and the Director of Children's Services recognise the need to secure and sustain improvement. They are committed to maintaining the Safeguarding Improvement Board and enhancing its role, and increasing the effectiveness of the Local Safeguarding Children Board through additional resources for performance management and monitoring.

147. The targeted improvement in children's social care services has been underpinned by a substantial additional investment of £5.2m by the local authority. These monies have been used to enhance children's services such as increasing the number of social work posts, thereby reducing caseloads from an average of 35 in July 2012 to an average of 20 in January 2014, and creating specific posts within children's social care services to support quality assurance and performance management. Substantial amounts have been used to fund the significant number of agency staff currently employed in the service and to increase the social work and management complement.

148. Robust action has been taken by managers to support or move on those staff who have struggled to meet the practice standards required.

149. The chair of the Safeguarding Improvement Board identified in her update to the DfE in October 2013 that relationships between the local authority corporate centre and children's social care services have been strained by the demands of the improvement programme. Since then they have been working together more closely, for example over the recruitment of social care staff.

150. Local authority elected members, the Chief Executive and senior officers are clear about their respective roles, and clear lines of accountability are in place to ensure that they effectively discharge their individual and collective responsibilities. The combined role of the Director of Adults' Services and the Director of Children's Services has been subject to a limited evaluation of the possible impact of combining these functions, called a 'test of assurance'. However, this has not been formally reviewed since first being agreed in November 2010, despite the significant pressures resulting from the Ofsted inspection findings in 2012.

151. Elected members and senior officers demonstrate a clear understanding and recognition that, although services for children and young people have begun to improve within the past few months, they still have a long way to go. Leaders maintain an awareness of social work practice through a variety of sources, including routine shadowing of social workers, seeking opportunities

to speak directly with young people through the Children in Care Committee and working with colleagues from other local authorities to compare practice standards. This knowledge is used to set high standards and expectations for the quality of practice in children's social care services, although members and senior officers acknowledge that such standards are not consistently being met.

152. Improvement in operational management direction and oversight of practice in children's social care services has been too slow. Evidence of management oversight of practice has only begun to improve over the past six months and it is still not consistent across the service. A number of cases were identified through this inspection where the local authority had to take corrective action to secure the welfare of individual children and to review operational management decisions; in a very small number of cases children had been left at potential risk. The findings from the local authority audit of cases for this inspection were agreed by inspectors in the majority of cases. However, in some cases the findings were over-optimistic.

153. Staff in children's social care services consistently report a change from June 2013, when operational and senior managers began modelling a culture of high expectation and high support. Staff articulate that the new locality team model and line management arrangements are clear, managers are now accessible for daily advice and guidance, staff have lower caseloads and there is a less reactive management style that enables them to plan more effectively for children. This was evidenced throughout the inspection.

154. The quality of supervision of social workers is too variable. Too many records poorly record case direction or the rationale for decision making. A small number of supervision files did include reflective supervision and consideration of welfare and training needs of the staff. Many staff do not currently have their personal development assessed or planned with their manager and the health check completed by staff in January 2014 identifies that only 66% of staff received timely supervision. The high turnover of staff and managers has delayed productive supervision for some staff; in a small number of cases this has negatively impacted on the planning and review of progress for children.

155. Performance monitoring and reporting do not effectively combine quantitative information with qualitative information gained through user

feedback, analysis of complaints and direct consultations. Since March 2013 a performance reporting framework has been in place. However, this is still being developed alongside an ongoing process to ensure full confidence in the data through developing reliable and accurate inputting, reporting against the new electronic case system and completing the migration of records from the former system. Manual systems continue to be employed to assist operational managers in managing their services.

156. Routine auditing of cases by managers across children's social care services has not been embedded into core business, and plans to deliver this have been too slow in development. The practice of auditing is now being developed across all social work teams, with the first audits taking place in the

duty and assessment team in December 2013. The findings from this audit are currently being collated and therefore the learning and impact on practice improvement cannot be determined. The local authority has also started to undertake a monthly review of the quality of CAFs. However, an action plan from these reviews which identifies areas for improvement has not been developed.

157. More permanent staff and agency workers of a higher calibre have been recruited over the past nine months following a targeted recruitment campaign in April 2013. However, agency workers still occupy 47% of roles across the social work teams, including some key operational management posts. This lack of stability has negatively impacted on the quality and continuity of the social work service received by children and their families, and has also caused difficulties in communication for some partner agencies. The local authority is trying a variety of approaches to secure a more permanent workforce, including direct engagement with neighbouring authorities and recruitment agencies, and supporting five social work assistants to gain social work qualifications.

158. Recruitment to permanent posts has been slow, and has been adversely impacted by tensions between the local authority corporate centre and children's social care services. The DCS has negotiated the temporary appointment of a specialist social care post to better target recruitment to the needs of the service.

159. Slow recruitment to permanent posts since 2012 has also negatively impacted on the degree to which the workforce is appropriately trained and how learning is maintained in the organisation when staff leave. Agency staff have access to training alongside permanent staff. Core training, such as risk assessment, working with hostile families and courtroom skills, has continued to be delivered to social workers over the past 12 months, and staff state that the training is of good quality. However, due to previous experience of trained staff and managers leaving the local authority, the authority set a target of having at least 50% permanent staffing before delivering their on-going training plan to managers, in order to ensure the learning is maintained within the service.

160. The local authority has improved its work with strategic bodies, including the LSCB, the Health and Wellbeing Board and the Children and Young People's Partnership to ensure that safeguarding children is a clear priority for all. Commissioning in Bexley has been enhanced through the jointly funded health and children's social care posts within the integrated commissioning unit (ICU) since January 2013, and also through the complex cases panel where funding is agreed across health, education and children's social care for those children with the most complex needs. Providers of the broad range of commissioned services are effectively held to account through contract management that includes routine feedback from providers regarding the outcomes for individual children and findings from 'secret shopper' visits. The ICU is currently implementing a new outcome and incentive-based commissioning model.

161. Appropriate targets are in place to secure the sufficiency and range of foster care and adoptive placements for children and young people. However, the commissioning sufficiency strategy in relation to looked after children does not yet allow the local authority to be confident that they are commissioning the correct range of placements against a robust analysis of current and projected need.

162. Early help services are undergoing major reconfiguration and the local authority and partners plan to invest significantly in the new Thriving Families service. While all professionals spoken with during this inspection are optimistic about this new service, the full programme is not in place nor evaluated, and therefore the impact for children and their families cannot be assessed.

163. The most recently published Joint Strategic Needs Assessment (JSNA) for 2010/12 was reviewed in 2012/13. In 2013 a new JSNA was commissioned and is currently in draft. Useful information has been obtained during consultations to inform future commissioning of services for children and young people. For example, consultation with parents about short breaks provision and consultation with young people from the youth council took place as part of the development of the Thriving Families Programme.

164. A high level of enthusiasm and commitment is demonstrated by leaders and senior managers to corporate parenting, with effective engagement of young people as members of the corporate parenting forum. The forum has effectively championed the needs of looked after children in some areas; for example, it works well with schools to minimise exclusions, and there have been no permanent exclusions of looked after children for the past five years.

165. Young people representing the Children in Care Committee (CICC) told inspectors 'As a unit our voice is heard'. They are routinely involved in interviewing staff and provide induction training for new social workers to help them to understand the experience of children looked after and care leavers. The Lead Member, chair of the Overview and Scrutiny Committee and the DCS engage with children and young people in order to understand their experiences of services and life more generally through both formal meetings and informal contacts within the looked after children homework club. The CICC representatives acknowledge that the voice of looked after children and care leavers is currently limited to their relatively small group. They have begun some proactive work more recently to ensure that the wider group of looked after children get an opportunity to voice their views and concerns through newsletters and surveys and they are developing a new website. The outcome from this work is still to be established.

166. The local authority cannot be sure that it is developing services that respond to the needs and views of children and their families and, with the exception of the CICC, Bexley's Children's Parliament and the Youth Council, the voices of children and their parents and carers are not sufficiently captured or used to shape service development.

167. Senior managers in children's social care services have a clear understanding of the strengths and areas for development across the service, although strategies to ensure that the local authority becomes a learning organisation are not sufficiently embedded. Managers demonstrate a commitment to hearing the views of workers through direct feedback in open surgeries, but systematic learning through group case discussion and use of research has not been embedded within teams across children's social care services. Disruption meetings, although helping individual young people and carers, are not being used to inform service improvements. There is an understanding of, and management of, complaints to the local authority as a result of a complaint system being established in April 2013. However, the learning from these is not being effectively considered and disseminated to enable the service to improve.

168. No serious case reviews have been undertaken in the area since the last Ofsted inspection in 2012. A number of serious incidents have been raised by partner agencies at the LSCB serious case review sub-group which, appropriately, did not result in the LSCB commissioning a serious case review.

Ofsted

What the inspection judgements mean: the local authority

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

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

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

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

Section 2: The effectiveness of the Local Safeguarding Children Board

The effectiveness of the LSCB is inadequate

Priority and immediate action

169. Ensure that the lead role of the LSCB in safeguarding is clearly established across Bexley and that governance arrangements within the board and with other key strategic bodies are clearly described and understood.
170. Ensure that the extensive LSCB work programme is rationalised and is robustly implemented and monitored.

Areas for improvement

171. Ensure that the LSCB effectively undertakes monitoring and quality assurance of multi-agency safeguarding practice.
172. Ensure that multi-agency audits are systematically undertaken in relation to key local safeguarding issues identified by partners and agreed by the board and that learning from these is actioned and carried forward into subsequent audits.
173. Ensure that safeguarding data and information from all partner agencies are robustly analysed and that trends, issues and the implications for multi-agency safeguarding practice are fully assessed.
174. Ensure that all operational groups of the LSCB have clear terms of reference and work programmes that are manageable and are co-ordinated with the LSCB work programme.
175. Ensure that audits to establish whether partner agencies are appropriately engaged in safeguarding are promptly undertaken and that the findings from these are acted upon.
176. Ensure that multi-agency safeguarding training is fully reviewed to meet current needs and that methods to evaluate the impact of this training on improving safeguarding practice are developed and implemented.
177. Ensure that work to capture the voice of children, young people and service users is carefully considered and is sensitively and systematically introduced.
178. Ensure that the annual report analyses the activity and the impact that the Board and its partners have on outcomes for safeguarding children.

Key strengths and weaknesses of the LSCB

179. The Local Safeguarding Children Board (LSCB) is not effective in ensuring that partners always work together to ensure that safeguarding arrangements reduce risk for all children identified as needing assessment, support and intervention. Since the last Ofsted inspection of safeguarding services in

Bexley in 2012 the LSCB has not effectively undertaken its primary role to monitor and evaluate the impact of local safeguarding arrangements. Following the appointment of the current LSCB chair in June 2013, significant deficits in the functioning of the LSCB have been recognised by the Board. An ambitious programme of change and development has been established with partner agencies to tackle the issues through newly established task and finish groups, or re-invigorated LSCB sub groups with revised membership and terms of reference. However, almost all of these operational groups of the LSCB are at a very early stage of development and are not able to demonstrate impact or that they are now effectively progressing the work of the Board.

180. The LSCB chair is highly experienced and is well-respected by all partner agencies. She has actively engaged with all partners to raise the profile of the Board and of safeguarding issues. This has resulted in increased commitment amongst all partners, following a period when most key partner agencies have undergone significant structural and organisational change. Partnership commitment is now more evident in the seniority of agency representatives on the board and on the range of LSCB sub-groups. The LSCB chair has begun to challenge partners to ensure that they actively engage in the work of the LSCB.

181. Governance arrangements within the LSCB and with other strategic groups are not sufficiently clear and do not effectively enable LSCB partners to assess whether they are fulfilling their statutory responsibilities to help and protect children. A draft LSCB governance protocol has been in development since 2013. The respective roles of the LSCB and the Safeguarding Improvement Board have not been made explicit; as a result there is some duplication of roles and confusion amongst partner agencies about the respective roles and responsibilities of these boards. Some agency representatives sit on both boards, which promotes communication but also blurs the respective roles of the boards. This has resulted in the LSCB not taking or being seen to take an effective lead role in safeguarding children and young people. The LSCB chair meets regularly with the local authority Chief Executive, the Director of Children's Services, the chair of the Safeguarding Improvement Board and local authority members and is a member of the Children and Young People's Strategic Partnership. All of these appropriately prioritise the need to safeguard children, but not all have recognised the lead role of the LSCB. The LSCB chair has recently attended the Health and Wellbeing Board, to ensure that issues relating to safeguarding children are considered.

182. The LSCB does not systematically provide robust monitoring and evaluation of the quality and effectiveness of multi-agency safeguarding work. The sub-group of the LSCB tasked with this role has recently developed core child protection and safeguarding data across partners, based on performance information currently collated by individual agencies. The core data are due to be agreed by the LSCB; detailed evaluation of trends, concerns or safeguarding issues has not been effectively undertaken. As a result, LSCB partners are not able to robustly understand the key multi-agency

safeguarding challenges or the impact of the LSCB. Multi-agency audits are at a very early stage of development. Only two multi-agency audits have been undertaken by partners, both in relation to thresholds for access to children's services. However, there is little evidence that the learning from the first audit was effectively used to improve the understanding and application of thresholds by staff of partner agencies. An independent audit of child protection conferences, recently commissioned by the LSCB, does provide a good benchmark for future work, although the draft findings have yet to be fully considered or acted upon by the LSCB.

183. The LSCB is not fully aware whether partner agencies are ensuring that safeguarding is a priority. Section 11 audits are planned for June 2014, but are overdue; the most recent section 11 audits were undertaken in 2011. Promoting awareness of private fostering arrangements has not been sufficiently addressed by the LSCB and there has been a reduction in the number of children known to be privately fostered in the area from 13 in March 2013 to currently three. Partner agencies report that this is an under-representation and believe that other private fostering arrangements have not been notified. In recent months the LSCB has begun to raise awareness amongst partners and the community of the need to report private fostering arrangements; this is yet to have an impact on increasing the number of notifications.

184. The LSCB is at a very early stage of establishing some oversight of the effectiveness of early help to support children and young people. While a range of individual services is provided locally, the early help offer in Bexley is not yet effectively coordinated and some services are being reconfigured. The LSCB plans to include early help developments at its next conference in June 2014 to raise awareness amongst partners. However, there is no early help strategy and the LSCB has not undertaken an evaluation of the sufficiency, range or impact of these services to prevent safeguarding issues escalating or to support children when they are no longer subject to child protection plans.

185. The LSCB child death overview panel effectively carries out its role. Serious incidents are appropriately considered through the serious case review sub-group. However a lack of clarity in the commissioning of the two most recent serious case reviews (SCRs) undertaken in the area resulted in undue delay in the completion of the reviews and in the actions from one requiring significant modification. The LSCB chair and new sub-committee chair have reviewed how SCRs will be commissioned, but this has not been formalised into protocols for the LSCB. Learning from individual management reviews has been disseminated within partner agencies, and multi-agency learning has been recently shared across partners at an LSCB conference, although this conference was significantly delayed. While learning from these SCRs was positively received by those who attended the conference, it is not clear how the learning is being disseminated to staff across the partnership.

186. The LSCB training sub-group has not effectively overseen the delivery or evaluation of the LSCB multi-agency training programme and this has been exacerbated by a training officer not being in post for an extensive period.

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Core multi-agency training has continued to be delivered by the LSCB and does cover a broad range of safeguarding issues, which to some extent has been developed to address local and national emerging issues, including some learning from SCRs. However, the evaluation of multi-agency training is underdeveloped and remains based on questionnaires from training participants, which have not been systematically evaluated or used to inform planning for future training.

187. Voluntary organisations across Bexley are appropriately engaged in the LSCB and in some of its operational groups, and are able to access multi-agency training provided by the LSCB. The first lay person was appointed during the course of this inspection.

188. In recent months the LSCB has begun to drive improvements in the coordination of partnership work for missing children and those at risk of child sexual exploitation. However, the groups tasked to develop multi-agency strategies, intelligence and trend analysis are still at an early stage, and remain more focused on case discussion and support to individual children and young people.

189. The LSCB has very recently started to consider consulting with young people to inform the development of its work. A task and finish group has begun exploring ways of obtaining the views of young people with partner agencies that have experience in this area. However, at the time of this inspection the views of young people or their carers are not routinely captured or considered by the LSCB to help develop its work or understanding of local safeguarding issues.

190. The LSCB annual report provides information about activity undertaken by the board over the year 2012–2013. Although some performance data are included within the report, this is not linked to an assessment of the performance and effectiveness of local safeguarding services or the impact of the Board. The LSCB, through its chair, has recently developed an extensive activity and work programme to address the significant range of areas that require improvement. While all of these are appropriate, they are not systematically well-coordinated and this has resulted in delay or lack of clarity in some work streams, for example in relation to the LSCB oversight of safeguarding of looked after children placed out of the area. The ambitious LSCB work programme, with almost all areas of the work of the Board currently subject to review and redevelopment, is a significant challenge to the stretched capacity of all partner agencies. Whilst the LSCB has a draft improvement framework, this has not been developed across the partnership and has not had any impact.

What the inspection judgements mean: the LSCB

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

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

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

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

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