London Borough of Barking and Dagenham

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: 29 April – 22 May 2014

Report published: 7 July 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 care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.		
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 **requires improvement** The LSCB is not yet demonstrating the characteristics of good.		

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

Contents

Section 1: the local authority

Summary of key findings

This local authority requires improvement and is not yet good because

1. Too many children experience the trauma of being removed from the care of their parents by the police. This often takes place before enough information has been gathered from other agencies and family members. This was an area for improvement at the last inspection in 2012.

2. The thresholds for children with lower levels of need are not sufficiently understood or applied by all agencies. Although the guidance provided is clear, agencies are not always clear about when a child may be identified as 'in need'.

3. Agencies working with families in the area struggle in responding to the fast and significantly changing demands of the population and the rapid growth in the number of young children in the borough. This is leading to high pressure and workloads across the key agencies.

4. Some assessments focus too narrowly on immediate presenting concerns about children and fail to explore all potential risks and needs. Social workers do not always assess the impact of all aspects of parents' behaviour on the children. This means that children's needs may not be fully identified or met.

5. Only a small number of children and young people who are privately fostered are known to the local authority, despite active work by the local authority to find out about these arrangements.

6. Some children in need and some who are looked after wait too long to be seen and spoken with by a social worker, which affects the timeliness of assessing and addressing their needs.

7. The very low and reducing level of police attendance at child protection conferences means that sometimes decisions about children's lives are made without all key agencies considering the full information within the meeting.

8. The views of children are not recorded well enough. As a result, children's plans do not always reflect their wishes and feelings or what they would like to see changing in their lives.

9. Some child protection and child in need plans are too focused on adult needs rather than those of the child and do not address all areas of identified need. Some child in need plans are not followed through quickly enough.

10. Oversight, guidance and direction by managers are not ensuring that enough assessments and plans are good.

11. The transfer of information about families between teams and services is not consistently well managed and, in some cases, this means that children and families do not engage with services or do not receive timely help.

12. A significant number of children with previous plans for adoption have not achieved this. While many of these children remain in stable placements as a result of changed plans, these do not involve legal permanence.

13. Formal plans for young people leaving care are not well focused and do not identify their long-term hopes and aspirations. Although reduced, a high proportion of these young people continue not to be in education, employment or training.

14. Elected members have not been providing the challenge and leadership needed to drive forward the necessary changes and improvements across the whole service.

15. Although the local authority monitors performance, qualitative information is not being well used to support service development and drive improvement. Not all services are being evaluated through audit. This means the local authority does not yet have a full understanding of the impact all services have on children.

The local authority has the following strengths

16. Early help services support large numbers of children and their families. Purposeful work with vulnerable families leads to improvements for most children, such as increasing school attendance and the early provision of support for very young children with additional needs.

17. Social workers appropriately challenge parents of children who are the subject of a child protection plan if they do not engage with services. When families are not making the progress needed, decisive action is taken to protect the child, including escalation into public law and transition to a safe and settled future.

18. Help and protection services are responsive to families' diverse needs. Inspectors saw examples of proactive, skilled social work sensitive to children's needs, giving parents a clear understanding of what is expected of them. Social workers are creative in the ways in which they engage and communicate with children. These include observations and other work with pre- or non-verbal children.

19. The range of services targeted at children who are on the edge of care are effective and make a positive difference in many individual cases. Family group conferencing supports children and families well.

20. When needed, legal and social care services work constructively and effectively together at all stages. The average duration of care proceedings within the family court is improving, despite an increase in the number of proceedings.

21. Assessment and support for carers is of a high quality, meaning that children can be placed safely with skilled and well supported carers. Placements are well supported by the local authority, resulting in positive attachments and high levels of stability. The use of special guardianship has increased and there is a low rate of placement disruption.

22. Case conferences and other formal meetings are effective in ensuring the engagement and participation of families. Parents' attendance at conferences is good and their feedback is routinely collected. Almost all parents told inspectors that they had been helped to understand the concerns for their child.

23. Agencies share information quickly and effectively to make sure those children at risk of child sexual exploitation and those who go missing from home, care or education get a well-co-ordinated response.

24. The Adoption Panel is well managed and chaired, supported by a stable and experienced adoption team. Post-adoption support is also a strength and is valued by those who have used the service.

25. Care Leavers feel well supported and prepared for independence by their allocated workers. Young people report that training programmes are valued and the service overall is very accessible and welcoming.

26. Leaders have a clear picture of the current pressures faced by front-line practitioners. Strategic bodies, such as the Children's Trust and the Health and Wellbeing Board, have a shared understanding of these pressures. Extra staffing has been recently agreed to help children's social care meet its responsibilities.

27. The Local Safeguarding Children's Board learning and improvement framework has developed good communication from front line practitioners across the key agencies. This is an effective approach to understanding what is happening on the ground.

What does the local authority need to improve?

Areas for improvement

28. Ensure that sufficient checks and enquiries are undertaken before any unplanned removal of children from their families. This concerns the exercise of police powers of protection. This was an area for improvement in the last inspection.

29. Improve the quality of referrals to children's social care by partner agencies to ensure that timely and appropriate decisions are based on all relevant information.

30. Ensure that child protection strategy discussions are focused on all children in families, are clearly recorded, have engagement from all relevant agencies and identify clear and achievable outcomes.

31. Ensure that all key information is shared and considered at initial and subsequent child protection conferences through regular attendance by all key agencies.

32. Ensure that assessments include children's wishes and feelings, provide a thorough consideration of parenting difficulties, their impact on the child, and a full analysis of risk.

33. Ensure that all children are seen in a timely manner, assessments are timely and thorough, and written plans consider all areas of need and identify the outcomes sought.

34. Introduce a permanency policy that emphasises parallel planning from the earliest point when children become looked after, as well as tracking of the timescales for individual children with a plan for adoption.

35. Further develop consultation arrangements for children in care, including through increased representation of looked after children in the children in care group.

36. Improve the quality of planning towards adulthood for those leaving care, with a greater focus on those not in education, employment or training, or with other vulnerabilities.

37. Continue to improve the opportunities for young adults leaving care to continue living with their carers as part of 'staying put' arrangements.

38. Develop and implement medium and long-term strategic service plans that fully take account of known and estimated increases in amount and type of demand for the whole range of services for vulnerable children.

39. Strengthen management oversight, including oversight of plans by conference chairs and independent reviewing officers, as well as formal social worker supervision, to reduce drift or delay in assessments.

40. Ensure that corporate parenting responsibilities are fully understood by elected members to achieve greater awareness and accountability across the local authority.

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 5 of Her Majesty's Inspectors (HMI) from Ofsted and two associate inspectors.

The inspection team

Lead inspector: Brendan Parkinson, HMI

Team inspectors: Mike Ferguson, Wendy Ghaffar, Graham Tilby, Penny Fisher (HMIs) and Sara Goodinge and Nick Stacey (associate inspectors)

Information about this local authority area

Children living in this area

- Approximately 56,200[2] children and young people under the age of 18 years live in Barking and Dagenham. This is 29% of the total population in the area.
- Approximately 34.9% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 22.2%[3] (the national average is 18.1%)
  - in secondary schools is 25.5%[4] (the national average is 15.1%).
- Children and young people from minority ethnic groups account for 62%[5] of all children living in the area, compared with 25% 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 (2011 Census). Black African (24%) and White Other (11.2%) are the largest minority ethnic groups in the Barking and Dagenham school population (School Census 2014).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 48.3% (the national average is 18.1%)
  - in secondary schools is 37% (the national average is 13.6%).
- This area has seen a large and continuing increase in children and families population in recent years. Those newly arriving are from a wide range of ethnicities, cultures and religions, with many children and families whose first language is not English.

Child protection in this area

- At 29th April 2014, 2,065 children had been identified through assessment as being formally in need of a specialist children's service. This is a slight decrease from 2,161 at 31 March 2013.
- At 29th April 2014, 328 children and young people were the subject of a child protection plan. This is a significant increase from 200 at 31 March

[2] GLA 2013
[3] Spring Census 2014
[4] Spring Census 2014
[5] LBBD age 0 to 17 years BME (including White Other) 2011 Census

2013. However, the child population has risen from 20% to 30% of the population in a very short time, so the numbers are proportionate to the population and the socio-economic demography.

- At 29th April 2014, 14 children lived in a privately arranged fostering placement. This is an increase from 12 at 31 March 2014 and an increase from 7 at 31 March 2013.

Children looked after in this area

- At 29th April 2014, 450 children are being looked after by the LA (a rate of 82 per 10,000 children). This is an increase from 420 (76 per 10,000 children) at 31 March 2013. Of this number:
  - 298 (66%) live outside the local authority area
  - 17 live in residential children's homes, of whom 15 (88%) live out of the authority area
  - 1 lives in residential special school[6], which is out of the authority area
  - 367 live with foster families, of whom 240 (65%) live out of the authority area
  - 17 live with parents, of whom 8 (47%) live out of the authority area
  - 19 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 22 adoptions
  - 28 children became subjects of special guardianship orders
  - 269 children have ceased to be looked after, of whom 9 (3.3%) subsequently returned to be looked after
  - 54 children and young people have ceased to be looked after and moved on to independent living
  - 23 children and young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The previous inspection of Barking and Dagenham's safeguarding arrangements and services for looked after children was in July 2012. The local authority was judged to be Good for safeguarding and Adequate for services for looked after children.

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

Other information about this area

- The Director of Children's Services has been in post since September 2009.
- The chair of the LSCB has been in post since August 2011.

Inspection judgements about the local authority

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

41. High numbers of families experiencing early help services report that it has made a positive difference to the lives of their children. Children's centres in the borough, pivotal to the early help offer, are considered by inspection to provide outstanding services. Early help is effective for most children, particularly in identifying additional needs and improving school attendance.

42. The common assessment framework (CAF) is well established and used by a range of agencies, and particularly well by schools. Assessments are generally good and lead to effective team around the child meetings and outcome-focused action plans. There are fewer than expected referrals made by adult oriented services, such as substance misuse and mental health services. Additional links have been recently introduced to address this, but it is as yet too early to see their impact.

43. The local authority quality assures and reviews early help work to ensure that, within the context of the challenging demography, the right families are targeted for early help, although the numbers rise continuously. New impact measures are being introduced using the implementation of an electronic CAF, to enable a more accurate overview of the effectiveness of every early help plan initiated as well as a dedicated early help evaluation service.

44. Systems to track pupils who have moved out of the borough or are not on a school roll meet statutory requirements and are effective. The local authority has gone further in also collating information on children and young people not accessing full-time education. The quality of alternative provision for those children not in mainstream provision is good.

45. Thresholds for those most urgently in need of protection are well understood by the main statutory agencies in the area, enabling consequent response by social care to be effective. However, the application of thresholds for other children in need are less well understood and less effectively applied by agencies.

46. When children are referred to children's social care, those at immediate risk of harm are identified quickly and receive a timely and appropriate response. Information sharing between agencies and professionals is timely and effective within the 'triage' and multi-agency safeguarding hub (MASH). The recent co-location of children's social care, health, the police, including a child sexual exploitation officer, and multi-agency panel (MAP) coordinator, is effective in supporting all key services to be fully informed and involved in plans for these children.

47. Decisions about actions to ensure children's safety are taken promptly. The MAP coordinator ensures prompt access to early help, supporting agencies to

initiate early help assessments. Performance in relation to repeat referrals within 12 months of a previous referral is very good, and below the national average, indicating that when children are referred to children's social care they receive a service that meets their needs.

48. High numbers of domestic abuse notifications are made by the police each day and are screened in the MASH. Those referrals sampled by inspectors in the MASH evidenced good, timely information sharing, a good analysis of risk and consideration of historical factors recognising the potential physical and emotional risks to children. A domestic abuse risk assessment tool is used by senior social workers within 'triage' and MASH to assess and to inform safety planning. This is used effectively to ensure that children are protected. Management decisions at this initial stage are well recorded, analytical and included detailed direction to social worker's about next steps in safeguarding the child.

49. In all cases seen by inspectors, parental consent had been appropriately sought prior to referrals being considered by the MASH. Where child protection concerns are identified and parental consent cannot be obtained, referrals still progress through the MASH, ensuring that information is shared in a timely manner. Non-social care professionals can seek advice and support and clarification from a qualified social worker in the MASH and 'triage' services. Professionals told inspectors that they welcome this, ensuring that safeguarding expertise informs decision making.

50. Some recorded referral information fails to include details of family and addresses, or fails to clearly identify concerns. While the quality of many cases was clear, detailed and specific to the child as well as identifying risks, some do not include this key information. This results in a significant amount of time being spent subsequently identifying the level of concern before being able to progress these referrals.

51. Almost all strategy discussions are undertaken only between the police and children's social care. Cases that may benefit from a multi-agency meeting do not always have one. These discussions take place only in the most high risk or complex cases, such as child sexual exploitation. Many strategy discussions are poorly recorded, with most limited to the decision to proceed with child protection enquiries. Few strategy discussions record concerns and risks to the child and none identify agencies' actions and responsibilities.

52. Referrals progress rapidly to the duty and assessment teams and are allocated promptly to qualified social workers. At the time of the inspection there were no unallocated social care cases. While there are no delays in dealing with those seen as most at risk, children with lower levels of need are transferred and allocated within the duty and assessment teams and experience delays in being seen. This does not compromise children's safety but does result in delays in assessing other needs.

53. Child protection enquiries are timely and conducted by suitably qualified and experienced social workers. Children are seen and seen alone for the purpose of child protection enquiries, and in the majority of cases these interviews are well recorded and detailed.

54. The out of hours' service is recognised by the local authority as having had insufficient capacity to respond to all urgent needs. A very high proportion (43%) of children becoming looked after are taken into care during the out of hours period. While many children are appropriately returned to live with their families, they are subject to the traumatic experience of being removed from home and coming into an unplanned care placement. The re-commissioned out of hours service (in partnership with three adjacent boroughs) is yet to show impact or the effectiveness of the changes made.

55. The quality of assessments is variable with many being good, child-focused assessments that are timely, comprehensive and consider the child's history. A small number of assessments seen focused primarily on the presenting problem, not sufficiently addressing or evaluating all areas of potential risk and need. Assessments completed and authorised have shown a very large increase, from 1,271 in 2012–13 to 2,760 in 2013–14. This has contributed to a reduction, albeit slight, in timeliness of completion of assessments, dropping from 77% in 2012–13, to 71% 2013–14, which is below the national average.

56. The high volume of work and the introduction of a 'single assessment' approach has had an adverse impact on quality. Many practitioners seen did not readily understand or apply this new approach. Also, assessments that feature parental domestic abuse, substance misuse and mental health issues do not always fully analyse the impact of parental behaviours on children.

57. In most cases seen, social workers were able to evidence effective engagement with children and young people, including in large families, resulting in good outcomes. Children are seen, and seen alone at all stages of involvement. Creative methods of engaging and communicating with children to gain their wishes and feelings about changes needed to improve their safety and support are used well. However, this work was not consistently well recorded.

58. Plans are regularly reviewed, and performance is above the national average. This is in the context of a substantial increase in the number of child protection plans in a short time, from 200 in 2012–13 to 317 in 2013–14. Targeted work by the Child Protection Reviewing Service (CPRS) has been effective in ensuring child protection plans do not drift. The number of children who had been on a child protection plan for more than two years has reduced from 8% in 2012–13 to 3.8% in 2013–14, below the national average. This very good performance is supported by a significant reduction in those who are the subject of plans for more than one year.

59. The quality of written plans is variable. Plans were in a format that is easy for parents, carers and young people to access, clearly identifying what changes

are needed by when. Most child protection plans seen were good, with clear actions, responsibility and timescales for outcomes recorded, and have contingencies if the plan is not successful. However, some plans seen by inspectors were too brief, did not address all areas of concern and were too adult-focused. It was not clear what needed to change or what support the child required.

60. When changes in parenting are not secured, authoritative action is quickly taken. Parents who fail to engage receive appropriate challenge. In some cases this has resulted in improved engagement by parents and good outcomes for the child. Where this has not happened, matters are appropriately escalated into legal intervention. Many children subject to child protection plans make good progress, as indicated by the low numbers subject to a second or subsequent child protection plan; at 11.5% for 2013–14. This is well below the national average of 15% and is strong performance.

61. Some children subject to child protection or child in need plans experience drift or delay in achieving positive changes. In response to this the local authority has provided additional child protection chairs to ensure that those identified as being 'in need' have robust plans that are regularly reviewed. It is too early to see evidence of impact of these changes.

62. Initial and review conferences are timely and most are well attended by almost all agencies involved, although the police only attend 8% of initial and 1% of review conferences and GPs also do not attend sufficiently. Decision-making is potentially less than robust as a consequence.

63. The quality of child protection conferences observed during this inspection varied from adequate to good. The 'strengthening families' model, aiming to engage families and identify resources and strengths as well as risk, is used effectively in most cases seen, ensuring the participation of families and agencies in assessing risk. Most meetings were clearly guided, parents were supported in understanding the concerns, and were effective in identifying what improvements were needed. Few children attend conferences, although this is beginning to take place through support from the participation team. Advocacy for parents and children attending conferences is available, although not extensively used. While parental feedback is mostly positive, with many reporting that they had been helped to understand concerns, social workers do not always share reports with parents, resulting in less effective parental engagement.

64. In most cases seen, core groups are regular with good evidence of multi-agency involvement in planning, including adult substance misuse services, resulting in better parenting for children. However, the involvement of adult mental health services is limited and, in a small number of cases, several core groups had been cancelled reducing the oversight and drive in implementing plans.

65. Social workers make routine home visits, although the purpose is more often unclear, other than to monitor the child's general well-being. Records do not make sufficient reference to progress against the plan. Transfers of cases between teams are not consistently well managed and, in some cases, the effectiveness of engaging children and their families is not secured.

66. Effective and responsive help and protection appropriate to the diverse needs of families was seen in many cases. For example, a parent's approach to the child's autism, informed by cultural and ethnic factors, was understood well by a social worker, enabling them to engage effectively with the parent. With another family, the social worker showed skill and sensitivity in planning and intervention with an Asian family where there was domestic abuse. An understanding of cultural matters, together with a robust response enabled the parent to engage wider family members, resulting in considerable change and positive outcomes for the children.

67. Multi-Agency Risk Assessment Conferences (MARAC) are well established, with effective contributions from partner agencies, reducing risk through information sharing and action planning. In most cases involving domestic abuse there is effective work in supporting children. Services are available for women and children who have experienced domestic abuse, including a young person's Independent Domestic Violence Advisor. However, the high reported incidence of domestic abuse exceeds capacity, with no local programmes for perpetrators. Out of borough there is also a waiting list for the Everyman programme. This lack of provision contributes to delays in some child in need and protection plans being progressed.

68. Direct and effective work focusing on prevention of abuse, including domestic abuse, is carried out in schools through the ARC theatre group. The group positively engage with young women around sexual violence, domestic abuse and forced marriage. Workshops are provided in schools to promote awareness and signpost young people to support services, with evaluation of the impact of these also being undertaken.

69. Children missing from home and education receive a well-coordinated response through a shared strategic commitment to ensuring harm reduction, with recent strengthening of these arrangements with the introduction of the Multi Agency Sexual Exploitation (MASE) subgroup of the LSCB. Early identification and information sharing on children missing is timely and effective. The daily report of children missing is sent to the MASH and to schools and hospital emergency departments. A dedicated officer in the MASH identifies those at risk of child sexual exploitation (CSE). Reports presented at both strategy and MAP meetings support the planning and delivery of safeguarding interventions. This was effective in cases tracked by inspectors, with good identification of risk at an early stage.

70. Systems tracking pupils who move out of the borough or are not on a school roll meet statutory requirement and are effective. There are currently only a

low number (18) of children whose whereabouts are unknown. The local authority goes further, coordinating information on those currently not accessing full-time education. The tuition service provides good quality alternative provision commissioning and quality assuring other specialist provision within the borough.

71. Children missing from home, education, care and those who are home educated are all followed through a regular multi-agency meeting, with actions set and tracked. Active enquiries and plans are made with all key agencies half-termly. This involves good information sharing and timely responses. Children missing from home who do not have a social worker are tracked through the restorative mediation and family group conferencing (FGC) team. This service is proactive in making contact with children and their families to offer support. The strategic leads of children's services, education, health and senior police officers meet on a termly basis to discuss individual high risk cases, monitoring patterns and trends. Data on missing children is also considered by the performance management sub-group of the LSCB. The effectiveness of these arrangements is evident in the low numbers of children missing from home and numbers and repeat episodes have reduced further in the year 2013–14.

72. When privately fostered children are identified they receive timely and appropriate assessments to ensure their safety and well-being. The recent increase in privately fostered children known to the authority, whilst an improvement, and mostly now in line with an average for London, continues to be a small number, despite some active work in raising the profile of such arrangements.

73. There is a prompt and effective response to the allegations of harm involving those working with children or vulnerable adults. Referrals from a range of agencies are subject to timely and proportionate enquiries, particularly so in relation to educational settings. Awareness of the Local Authority Designated Officer role is promoted well amongst local organisations including faith groups, with well established relationships with local churches and mosques.

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

74. Arrangements to support children on the edge of care are well targeted and effective. The range of targeted services, often through the access to resources team (ART), have a positive impact. They keep most children in their families and support return home, including as part of parallel planning during court proceedings. These services lead to a high number of children being effectively diverted from care into stable, safe placements for children, either at home or to relatives.

75. In the past year the large majority of children worked with had either been prevented from becoming looked after or had left care through family group conferencing (FGC), crisis intervention and restorative justice team interventions. Over 90% of the children benefiting from these interventions in 2011–2012 remained out of the care system by January 2013. These figures indicate good targeting and effective interventions.

76. There are effective arrangements in place to support children coming into care under voluntary arrangements. Inspectors found no children inappropriately within the care system through these arrangements. The demand for looked after children provision continues to rise sharply, but is in line with the rapidly changing child population profile; between 2013 and the beginning of the inspection the rate of children being looked after had risen sharply (from 72 to 82 per 10,000 children, with an England average of 59.8 per 10,000). The child population has increased from 20% of the total population to 30% in the space of four years; those in poverty have increased markedly, as has the number of homeless families resident in the borough that have come from other parts of London.

77. Some children continue to be subject to statutory removal from the care of their parents through the police exercising their powers of protection prior to sufficient checks and enquiries being completed with, for example, other agencies and extended family members. Although the number of these episodes is reducing slightly and a higher proportion are leading to care proceedings, many of these children do return to live with their families, appropriately and after a brief period. This could indicate that they did not need to be in local authority care.

78. The high and rising number of children entering care through statutory interventions benefit from legal and social care services working constructively and closely together within the public law arrangements, which is used effectively at all stages including throughout proceedings. The local authority has the fourth highest number of care proceedings in London, heavily influenced by the large changes in the population profile, but maintains a strong performance for the timely completion of these, being in the top third overall.

79. Compliance and quality assurance of court work has a high priority for the local authority. This, together with the high quality training staff receive, enables matters to go through court quicker, with a reduction in the need for experts to be appointed or assessments ordered. Early active work to consider alternative permanence for children has resulted in a reduction in the number of additional assessments being undertaken in proceedings. Effective work with children's guardians and through the family justice board arrangements, have actively supported appropriate, timely action in planning permanence for children.

80. Some carers report that frequent changes of social worker undermine the willingness of some children to trust their social worker. This is further weakened by fewer than 80% of monthly visits and just 61% of 6 weekly visits taking place within the expected period, although here has been a recent improvement in this.

81. Almost all carers who inspectors spoke with develop positive, strong relationships with the children placed with them and, together with other professionals, play a key role in helping children understand what is happening to them. Work undertaken by a play therapist is valued by carers in supporting some children to move placement, and in providing training and consultation for carers.

82. Complaints and concerns are taken seriously by the local authority and children access advocates to help them in making and following through on complaints. The children's rights officer maintains active involvement until there is a resolution. Several examples were provided of children being well supported in achieving child-centred planning and having their voices more effectively heard. Regular reporting also takes place directly to senior officers. However, those children seen by inspectors were unclear about how to make a complaint.

83. Although the large majority of children who subsequently return home are well supported through individual support packages, there are some who return home where the quality of support is less assured, with poor arrangements in a minority of cases that provide less positive or robust support. This tends to be the case where young people drive decision-making.

84. Children and young people, including looked after children, are able to access good support and guidance to keep themselves safe from bullying. There has been a strong focus on cyber-bullying and e-safety within schools. This was not an issue for those children and young people seen by inspectors or in those cases seen.

85. A range of high quality services is available to help protect children and enable them to reach their potential. These include Subwise, an effective local drugs service open to all young people with links to the borough. It supports looked after children living in nearby authorities. The youth offending service is proactive in prevention of offending and diversion from court. This has led to a decrease in the already comparatively low figures for looked after children

offending. Before making placements, workers ensure appropriate services are in place to meet the specific needs of the child.

86. Carers feel well supported in helping children achieve academically. The virtual school is valued, notably in maintaining children in educational provision through comprehensive packages of support. A large majority of children attend good or better schools. No looked after child is missing from education and almost all are receiving full time education. Absence from school is reducing, including persistent absence, although this remains above national averages.

87. There have been no permanent exclusions of looked after children from primary schools. Unfortunately, one young person has been excluded from a secondary school outside of the borough. Most children have an up-to-date personal education plan (PEP) in place, although almost one in five do not. Those PEPs seen are sufficient to inform plans and provision for pupils, with many children having continuity of schooling as part of the arrangements. The local authority is also working to ensure that PEPs and reviews are held outside school time.

88. Education attainment results show improvement at Key Stage 2 in 2013, where the impact of the pupil premium can be seen. Key Stage 4 results for that year were poor. Only two of the 25 pupils (8%) achieved five good GCSEs including English and mathematics, which is well below national and statistical neighbour averages. Systems to track and monitor children's progress do not ensure that the virtual school has comprehensive, up to date information. However, for those children where data is known, most are making good progress.

89. Significant improvements have taken place to raise the performance of annual health assessments for children looked after. At 94.7% it is now well above the London average (88%). A similarly high performance is shown for both dental checks and eye tests. Healthy lifestyles are strongly promoted in reviews, with data showing higher take-up of health checks through initiatives such as the Splash health reward cards.

90. Health needs are identified and responded to in a timely manner. Foster carers and social workers value the weekly consultation from the child and adolescent mental health services (CAMHS) as well as the signposting to other services that can meet children's emotional needs. There are clear pathways in place for accessing CAMHS for Looked After Children with waiting times for this service of less than one month for an initial appointment.

91. Children are actively encouraged to develop their personal skills and interests through participation in relevant activities. For example, a child attended a wide variety of creative arts facilities, clearly aiming to enhance and improve her self-confidence as well as to form attachments with her carers and with peers outside her school.

92. The number of looked after children who go missing is small (nine in the current quarter). A robust reporting procedure notifying connected workers is in

place. While identifying actions if young people are missing for more than two days, there are no specific actions for those missing for multiple shorter periods. Effective feedback systems are in place after children return, including personal interview. For children missing and known to be at serious risk, these are addressed at chief officer level, with a range of responses including, where appropriate, secure accommodation with a clear exit plan.

93. Assessments of looked after children are not routinely updated, with some plans consequently needing improvement as they are mostly descriptive and lacking a sufficiently clear time frame. Those assessments prepared for Court are good, including a clear analysis with a sharp focus on addressing risk. Issues of diversity, including ethnicity, culture and religion, are consistently well considered in care plans as is contact with family members. Children are encouraged, where appropriate, to keep in contact with their parents, siblings and extended families. Sibling attachment is a cornerstone of plans and is strongly promoted in placement reviews.

94. Most reviews cover all key areas, seeking the views of all involved, particularly parents and children. Written reports from agencies are not routinely provided, reducing the full picture of service coordination in place around the child. There is very good attendance of children in their reviews (98% in 2012–13). Independent reviewing officers (IRO) work constructively with advocates and the children's rights officer to ensure that children are kept informed of and involved in planning for their future. Action has been taken to improve the timeliness of reviews (Overall 82% in time in 2013-14) and although improvements are noted it is too early to see the full impact of this improvement on outcomes for children. Independent visitors are also provided for all children who need them, wherever they are.

95. The performance of and challenge by IROs is variable. In some cases and meetings seen there was strong, constructive challenge to include children's wishes and feelings. In other cases, however, there is a lack of challenge in terms of care and permanence planning. For some children, this has contributed to some delays in permanence planning.

96. Robust management decision-making and oversight is not always apparent in agency records nor consistently through formal supervision. Social workers are, however, well supported by their managers through continuous availability and open access to consultation.

97. Fostering recruitment campaigns have been continuous and effective, helping to ensure that looked after children are placed with local foster carers. Recruitment strategies are appropriately based on recently assessed need, with strong recruitment in adjoining boroughs. This has supported a reduction in the number of placements more than 20 miles from their home in recent years (13.1% of those placed since October 2013). Of particular value is the fact that the support packages, training and support groups for in-house carers are available to external providers as well. Management of almost all out of

borough placements is good at all stages, including for children placed in residential homes a considerable distance away. Children are consistently placed in provision judged as good or better by inspection. These homes were positive about all aspects of their working relationship with the area.

98. Fostering and other family care assessments are of a consistently high quality enabling children to be placed safely with skilled carers. All local authority carers have an annual review with high retention rates of appropriate carers. Carers are highly positive about the support and quality of training they receive, considering it well targeted on key issues such as challenging behaviours and child-parent separation. Children are reported by carers to find the welcome book in each foster home helpful. Records show a well-coordinated approach to family finding between social work teams and the fostering team. The proportion of children placed within family settings is good (81.5% in foster placements, and 89.5% in family settings generally) compared to similar authorities and England in general.

99. Getting the right number and type of permanent placements is a significant challenge, with just 17 adopters recruited in 2012–13. Placement matching is a particular strength. Placement staff have very good knowledge of providers and the local consortium has helped to improve quality overall. Good consideration is given to diversity including ethnicity, culture and religion when placing children. As a consequence high levels of placement stability are evident. Long term stability is 74.8%, higher than national averages and those of similar authorities. The proportion of children experiencing three or more placements in a year is also consequently very low (9%).

100. The borough has established an innovative project helping to support children to live in families, reducing the need for residential care. Pitstop is a foster care scheme using a range of proven methods. This short term scheme is proving highly effective in supporting stability, with almost all children remaining in their family settings several months after intervention. Intensive support packages put in place to address difficulties also help in reducing the number of children and young people having attended three or more schools while looked after (10 children in the last year).

101. The majority of children and young people who spoke to inspectors felt safe and happy in their placements. All those in foster care placements felt safe and happy with their carers. Those who were less content understood why they were in that particular placement. The high number of special guardianship orders to carers of children placed is a purposeful strategy by the local authority as a stable, continuing alternative to adoption, where it accords with children's wishes and feelings.

102. The active children in care council, Skittlz, (CiC) regularly present their views to the corporate parenting board. Some service changes have been achieved as a direct consequence of the group, such as the health 'passport' for over-16s; a more sensitive process around arranging emergency care; and the recently

revised, user friendly format for carer's welcome books. However, there are too few children and young people involved, with many children's views not represented, including those out of borough. None of the children spoken with by inspectors, other than those in the CiC, know of the pledge, the care website or how to make a complaint.

The graded judgment for adoption performance requires improvement

103. Some children experience delay in going to live with an adoptive family, with many plans for those who have been waiting a long time to be adopted now changing to other arrangements. A low proportion of those with adoption plans move in with their new family within the target of 20 months (at 43% this is much lower than the national average of 55%). While timeliness is improving, there has been a lack of urgency for some children, hampered by a lack of parallel planning (planning for adoption at the same time as other outcomes, including return home). Family finding is not being started quickly enough in the planning process overall.

104. During 2013–14, there was a slight decrease in the number of children made subject to an Adoption Order (18 compared to 21 in 2012–13). At 6.6% the proportion of children leaving care through adoption is below national and statistical neighbour averages. IROs do not consistently provide sufficient challenge when plans are delayed or changed. There are no arrangements to prioritise and track those children most at risk of drift.

105. Of the 56 children subject to a Placement Order and yet to be matched with an adoptive family, a significant proportion (36%) now have a plan for long-term fostering or Special Guardianship. However, for many, the change of decision away from adoption to long-term fostering is in accordance with their wishes and feelings and reflective of the strong attachments they have formed with foster carers, prioritising stability over permanence.

106. The recruitment of a sufficient pool of adopters locally is challenging due to the rapidly changing population profile. Although the number of adopters approved increased from 17 in 2012–13 to 35 in 2013–14, this still falls short of the local authority's target. Both the recent two-stage assessment process, implemented from September 2013, and the preparation training are well regarded by prospective adopters. The Adoption Support Grant is targeted on increasing capacity of the adoption service, but these developments to strengthen and provide more tailored marketing and recruitment strategies have not yet had an impact. The local authority is also yet to formally introduce a 'fostering to adopt' scheme.

107. The local authority uses consortium arrangements and the Adoption Register to identify appropriate potential adopters. The authority has successfully placed some older children and sibling groups within adoptive families. Matching arrangements are effective and are well supported by foster carers, who

demonstrate good knowledge of the child's needs. As a consequence, disruption rates have remained low for several years.

108. Preparation for children going towards adoption starts when the child becomes looked after in foster care, through the use of life story work and memory boxes. Particular attention is paid to sibling attachment and children's emotional well-being through the direct work of a play therapist. This has contributed to some plans involving sibling separation being changed, with consequently good outcomes for the children. Later life letters are completed in a timely way but are variable in quality, as are the child profiles and photographic records. The agency has also taken part in activity days, through BAAF, but these have yet to result in suitable matches being identified.

109. The Adoption Panel is well managed and chaired, and supported by an experienced, stable adoption team. 'Prospective adopters reports' are mostly good, although the 'child permanence reports' are more variable, with some not being current or outlining the child's story sufficiently well. The panel receives appropriate legal and medical advice, although there have been some delays in obtaining timely medicals. Oversight of practice between the independent panel chair, panel advisor and agency decision maker is under-developed, not enabling a full view of performance improvement.

110. Adoption support is a clear strength in the borough. Specialist training for foster carers, social workers, special guardians and adopters is highly regarded and the authority is well-advanced in its implementation of the 'adoption passport'. Adopters are positive that the help they receive matches the post-adoption support plan. Comprehensive arrangements for face-to-face and letterbox contact with birth families are in place. Counselling for birth families is provided by a commissioned service, with plans to introduce a birth fathers group in June 2014 to supplement the current birth mothers group.

111. A recently commissioned independent 'diagnostic assessment' of the adoption service demonstrates senior management commitment to improvement. The revised adoption service plan details a full range of priorities for the local authority with timescales for action, but does not include performance impact measures of timeliness and quality improvements of adoption practice from the initial identification of children and adopters.

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

112. The service is based in a central location which is both accessible and welcoming for young people, some of whom commented positively on the easy availability of advice and support. The service has sufficient staff resources, allowing manageable caseloads for social workers in the transition part of the service (16 to 18 years) and young person's advisers working with those over 18. The quality and range of information provided to care leavers about entitlements is good. Care leavers report that staff are well informed and

knowledgeable. The care leavers 'pledge', however, is not widely known and its influence and impact are limited.

113. All care leavers have an up to date 'pathway plan', but these are not helpful, meaningful tools in purposefully guiding and supporting care leavers' progress. Some plans and interventions seen by inspectors were of good quality, reducing risk behaviours, and have clearly resulted in better outcomes for those young people. The electronic format of these plans makes them unnecessarily lengthy with a consequent lack of clarity, resulting in delays in service delivery.

114. There is a good range of commissioned accommodation providers, particularly for young people aged 16 to 18 years in supported, semi-independent homes. These settings offer a range of independence programmes which augment the rolling group preparation programmes provided by the service. The availability of independence preparation training is good, with young people commenting that they are offered helpful inputs on cooking, budgeting, managing to sustain tenancies and maintaining healthy lifestyles. There are no care leavers living in bed and breakfast accommodation, although a small number of care leavers told inspectors that they feel unsafe in the area their accommodation is located.

115. A low proportion (11%) of young people are identified as living with foster carers after they are 18 under supported lodging, 'staying put', arrangements, although this is improving. A high proportion live in semi-independent and independent settings (66% compared to 37% in similar authorities). There is insufficient management information to reliably establish the quality and safety of these residencies. The number of care leavers known as living in suitable accommodation has reduced in the past year, although it is important to note that there are few tenancies that break down. The service has an Accommodation Officer who undertakes quality assurance work with accommodation providers, but this post was vacant during the inspection.

116. The accommodation and support provided to unaccompanied asylum seekers looked after by the local authority, particularly for those aged 16 to 18 years, is good. Comprehensive, tailored packages of support are provided in supported housing settings where their language, learning and independence needs are purposefully addressed.

117. The social care service structure for those looked after and leaving care young people has three transition points involving a transfer of worker. This can reduce consistency and continuity of professional relationships for looked after young people at a time of many other changes in their lives. Some care leavers commented to inspectors that the frequent changes of worker were unhelpful. The current arrangements do, however, support a strong focus on independence preparation for looked after young people as they approach adulthood.

118. Health information and signposting of universal and specialist health services available for care leavers is good. A health programme as part of the

independence training, delivered by a specialist nurse for looked after children, substance misuse and mental health services, helps with providing clear information for young adults. This nurse provides valued health consultation and advice to young person's advisers. The implementation of a 'health passport' for care leavers, providing the health histories of young people to them, is about to be implemented.

119. A continuing high proportion of care leavers, particularly those aged 19-21 years, are not in education, employment or training, adversely affecting their current and future prospects. Contextually, the area also has very high general rates of both youth and adult unemployment. Despite this challenging profile of the borough, not enough is being done to assist many care leavers into apprenticeships, training or stable employment. There is a limited resource dedicated to promoting employment, but this has insufficient impact.

120. Much better performance is evident in relation to satisfactory participation by 16 to 18 year olds in further education. The number of care leavers attending higher education and university is good compared to both national and similar authority rates. Care Leavers say they value the recognition of their achievements and progress, however modest, through an annual awards ceremony.

121. While social workers and young people's advisers' records are up to date they are often descriptive, with the work undertaken not being fully linked to the priorities identified within pathway plans. Supervision and case management of practitioners was regular and with good access to consultation. Supervision is strongly task focused, but limited in overall evaluation or reflection.

122. Qualitative management information of service impact is limited. Performance monitoring and management of the service does not fully evaluate the effectiveness of the support provided, particularly for those young people who are more vulnerable and/or harder to reach (for example, those experiencing substance misuse, emotional or mental health difficulties or who are disengaged from services). Inspectors saw evidence of some individual practitioners tenaciously tracing care leavers who had disengaged from the service, but there are no management tools for routinely assessing risks, complexities and vulnerabilities at a service level.

Leadership, management and governance requires improvement

123. There is an insufficiently robust strategy by the local authority for ensuring services will be able to meet demand beyond the immediate and into the medium to long term future. The area continues to have a significantly changing profile and rapidly increasing child population, with large numbers of families arriving, mostly from other parts of London. The challenges posed by high and rising rates of domestic abuse (currently the highest in London), the significant increases in the number children with complex needs and the consequent rapid, persistent rise in referrals to children's social care, as well as

looked after children and those with child protection plans, are not supported by clear forward planning. Many agencies, including children's social care are working to, or beyond, their capacity.

124. The local authority has responded to the immediate demands by creating a number of additional temporary social work posts, but caseloads remain high. Key agencies such as police and health have been successful in procuring agreement to additional resources although these have yet to be put in place. While understanding this context the local authority has yet to make clear, albeit difficult, resource decisions to meet these needs.

125. Elected members have been consistently supportive of senior managers' efforts but have not exercised sufficiently strong and effective strategic leadership. Children's services have achieved substantial additional temporary funding for practitioners, with some recently put into the base budget. While sufficient to meet needs identified some time ago it does not keep pace with the rapidly changing demand. Scrutiny has been challenging in specific areas of activity but there is no systematic, detailed examination of core children's services responsibilities in relation to help, protection and looked after children.

126. Performance reporting and monitoring within the local authority is well supported by other key statutory agencies, particularly housing, police and health. The key strategic leaders within the local authority meet regularly, engaging in honest, open and robust dialogue and consideration of data and implications of specific pressures on services, with direct discussions and mutual challenge evident between agencies. As a result the local authority has a good understanding of performance and pressures on the system.

127. The Director of Children's Services (DCS) works closely with the LSCB chair. The LSCB Chair, Lead Member, Leader of the Council, Chair of Corporate Parenting Group, DCS and Chief Executive hold a monthly 'trigger' meeting to jointly consider high-level data and other information, such as child protection and workforce data. However, arrangements for the Chief Executive to hold the LSCB chair fully to account are acknowledged to be insufficiently well developed.

128. The local authority is an active, responsive participant in the work of the Local Family Justice Board, and its relationship with Cafcass is positive, helping to reduce and minimise the risk of delay for children in care proceedings. However, there remain some significant unresolved long-standing challenges across the agency partnerships, for example in addressing the very high numbers of children subject to exercise of police powers of protection, and the capacity of the child and adolescent mental health services (CAMHS), other than for looked after children.

129. Social workers are well-supported by their managers, with the recently appointed Principal Social Worker beginning to work closely with social workers toward a better understanding of front line work issues. Regular access to

consultation is valued and staff present as buoyant and optimistic about the future. Practitioners have high caseloads that also have significant complexity, with practitioners seen working with 20-30 children at any one time.

130. Formal management guidance and direction in case work does not consistently ensure that assessments and plans are of a high quality or that they focus on the right things, with improvements for children being achieved at the earliest point. Managers authorise and sign off work that is of variable quality. Formal reflective supervision is often poorly recorded, with drift or delay not always addressed and minimised. When these issues arise they have also not been picked up by conference and reviewing officers. Children's services have taken action to remedy these shortcomings, but the necessary changes are not yet having a sufficiently consistent impact.

131. The need to increase the stability of the workforce is being addressed through an ambitious workforce development strategy. However, at the point of the inspection almost half (46%) of current social work posts are vacant, with all but a few filled by medium-term agency workers. The local authority has initiated a range of initiatives to recruit and support permanent staff, including newly qualified social workers, of whom there are 13 across the area. It is too early for the strategy to have had much impact. While there is not a large turnover of staff the number on short-term contracts remains too high.

132. Senior managers have recently established an extensive and constructive plan to redesign the social care service, incorporating further significant increases in capacity, particularly with regard to managerial oversight. The significant additional resources necessary to implement this have only recently been approved by the local authority. While this transformation plan is ambitious, it remains a long way from partial delivery, let alone full implementation.

133. Structures for the delivery of corporate parenting are in place and established with evidence of positive impact. However, the recently appointed Chair of the Corporate Parenting Group does not yet express a full understating of the range of key issues for children and young people. There is dialogue with the children in care group Skittlz which, while small in numbers, have engaged in addressing some issues of concern. The local authority receives feedback from a broad range of young people's groups, which, in some instances, has resulted in positive changes in practice. These have included contributing to staff appraisals, out of borough feedback events and the development of the younger children in care group.

134. Appropriate arrangements are in place to respond to complaints on an individual basis, with the DCS taking a direct interest in ensuring any learning feeds into practice. While there is limited capacity in this part of the service, feedback to improve practice is given to individual practitioners as well as through the regular meetings with the DCS and senior managers.

135. The local authority commissions a broad range of services providing additional, specialist support for children and families. These include a range of domestic violence services, independent visitors and advocacy for looked after children. On a wider basis, Barking and Dagenham is also a member of other pan-London consortia for procurement of looked after children provision, engaging well with adjacent local authorities over some shared services; for example, alongside three other boroughs over the newly established out of hours children's service. There is a clear 'sufficiency' analysis and evaluation of likely need linked to a 'year one' action plan. While this has timescales for the appropriate objectives across looked after children, adoption and care leavers services, the plan does not identify who is responsible for carrying these actions through.

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 requires improvement

Areas for improvement

136. Ensure the LSCB Chair strengthens the coordination, focus and impact of the boards work in the Health and Wellbeing Board.

137. Undertake an evaluation of the full impact of training on the performance of practitioners to ensure it targets improvements in outcomes for children.

138. Sustain and extend the positive and constructive role of the practitioners forums in promoting multi-agency working through improving the attendance of social workers.

139. Strengthen oversight of private fostering by the board, supporting efforts to ensure all such children are identified.

140. Ensure the annual report and business plan are focused on understanding and addressing local needs and on evaluating progress made in achieving improved outcomes for children.

Key strengths and weaknesses of the LSCB

141. The LSCB operates in line with its statutory responsibilities. The Chair is suitably independent and uses this independence well to hold partners to account, for example through direct communication with the metropolitan police and crime commissioner, and with NHS England over a range of issues which have a potentially adverse impact on local safeguarding work.

142. The Board has an appropriate range and status of membership and partner agency representatives attend regularly, actively contributing to the work of the Board and its sub-committees. However, effective arrangements for the Chief Executive to exercise full accountability of the chair of the LSCB and hold them to account are not clear. The Young People's Safety Group, the lay member and voluntary sector representative each have protected time on the Board's agenda to ensure the contribution of those partners likely to find it more difficult than others to have a voice at the LSCB are fully heard.

143. The Board's recent use of a structured development session between member agencies is a positive approach to tackling shared concerns. This is aimed at enabling agencies to work together to identify issues under a range of previously agreed themes (for example, 'pressures in the system') encouraging a more robust approach to problem-solving and forward planning. These discussions lead to an agreed action plan, and while it is too early to see impact

from this, or how it will link with other existing priorities of the Board and other strategic planning arrangements, this is a positive approach that is being taken.

144. The LSCB Chair promotes links between partnerships through membership of the Children's Trust, attending regularly, and feeding back on the work of the Board. However, the LSCB Chair is not a member of the Health and Wellbeing Board. This weakens the LSCB's link with and influence on the work of this body.

145. The LSCB risk register provides a helpful and coordinated approach through collating and monitoring progress of the priority risk issues for each partner agency as well as shared ones. Detailed consideration of the issues facilitates a sustained focus on those issues most important to partners as well as in the identification of areas where partners should take action to support one another to improve outcomes. Key issues at the time of the inspection include the impact of health service changes, workforce difficulties and limits to commissioning capacity across several agencies. While the difficulties around the extent of exercise of police powers of protection and dwindling attendance at conferences have been escalated there remains no satisfactory outcome to these issues.

146. The LSCB Business Plan, however, does not sufficiently or effectively identify local needs and the desired outcomes for children. This limits its effectiveness as a tool to understand what needs to change for children, and for ensuring that progress in achieving this is evaluated.

147. The LSCB oversees the publication of the clear and appropriately detailed local thresholds document. The Board has also undertaken some monitoring of the understanding and effectiveness of thresholds by agencies. During the inspection, some practitioners presented as unclear about the threshold for children in need, although they were clear about those in need of protection. There is also regular reporting of performance information by most agencies. This gives the Board a fuller view of the work being undertaken by practitioners across the area.

148. Partners fully participate in the programme of section 11 audits, which identify areas for development along with progress achieved in addressing previously identified issues. The action plan for improvements identified as needed is appropriately monitored through the LSCB business manager.

149. The LSCB's child sexual exploitation sub-committee is chaired at an appropriately senior level by the Metropolitan Police Detective Chief Inspector. This sub-committee ensures that the LSCB is well informed of the complexity and emerging picture of the extent of child sexual exploitation within the borough. It further enables the LSCB to have a clear overview of work in this area, contributing to coordinated focus and support.

150. The Board appropriately monitors the identification and work undertaken with missing children, including those missing from care and missing from education. The LSCB website also contains clear information and publicity materials about private fostering, although it does not examine or monitor this area of work effectively. This is important as it is acknowledged that a relatively low number of private fostering arrangements within the borough are known to the local authority.

151. The LSCB offers a wide range of relevant training for practitioners across the partnership. It also monitors training applications and attendance, identifying any trends in non-attendance. Immediate feedback from attendees is collated and reported to the board. This provides a picture of attendees' views on the value of training, facilitating the further development and tailoring of courses. There is, however, no evaluation of the longer-term impact of training on the practice of front line professionals and managers or on outcomes for children.

152. Ofsted has received three serious incident notifications in the past twelve months. SCRs are initiated appropriately. A previous SCR (from 2010) has been a source of considerable learning in the local authority, also resulting in the setting up of a practitioner's forum. The LSCB learning and improvement framework positively and actively involves front-line workers from the beginning of the SCR process of understanding events. This ensures that the experiences of front-line workers directly inform the findings.

153. The LSCB has established two multi-agency practitioners forums, that are well-planned and offer front line practitioners a constructive opportunity for discussion and debate of current professional challenges. The results of these are feedback to the Board giving it a direct view of current practice and practitioners' views on improvement. However, the attendance of social workers at the forums has declined, reducing the effectiveness of this positive initiative.

154. The annual report of the child death overview panel provides a clear outline of local themes, but does not evaluate the impact of the work undertaken. Similarly, the LSCB annual report has a comprehensive range of feedback from the Board, sub-groups and partners but does not pull this together into an overall assessment of the effectiveness of local services. This limits the report's effectiveness as a tool to understand what works well and what needs to change.

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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