

Hertfordshire County Council

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 Board¹

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Children's services in Hertfordshire are good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance		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.

Executive summary

Hertfordshire County Council is led by competent leaders and managers and is now delivering a good service overall to children and their families. Leaders have successfully improved services to children, young people and their families since the inspections of children looked after services in 2010, and child protection in 2013, when services were found to be adequate. There are a minority of children who are receiving outstanding services. Services to children in need of help and protection require improvement to ensure that all children benefit from timely planning and intervention. Almost all areas for improvement identified in the previous inspections in 2010 and 2013 have been addressed in full and, as a result, services to children and their families have improved. The local authority continues to work diligently to address the very small number of areas for improvement still being progressed.

Very clear governance arrangements are in place that ensure there is a shared vision and that statutory functions are delivered. Senior leaders and managers work well with partnership boards and provide strong leadership. The Chief Executive engages purposefully with the children's agenda, as does the Lead Member who has built up a robust understanding of issues within children's services during his term in this post. A skilled and influential Director of Children's Services (DCS), together with her determined leadership team, has cross-party political support and effectively manages a very large children's services department. The Local Safeguarding Children Board (LSCB) is performing well and effectively influences services to children and families. The Health and Wellbeing Board (H&WB) successfully oversees and drives forward the children's agenda. Strong links have been established with the police at all levels of the organisation to enhance partnership working.

Children and families receive timely and coordinated early help services across the county to meet their emerging needs. If their needs escalate, the vast majority are promptly allocated to a social worker and receive good assessments that address need, risk and also consider the child and parents' views. For the large majority of children requiring protection, action is taken promptly and risk is reduced. However, planning for children in need, including those in need of protection, is an area requiring improvement to ensure targets are clear and that progress is made. Systems to monitor the effectiveness of step-up and step-down arrangements between early help and children's social care are not currently in place.

The local authority is appropriately identifying those children who are at risk of child sexual exploitation and, for the vast majority, puts plans in place that reduce risk. Effective oversight of the most vulnerable children is routinely undertaken by senior managers and they use local and national research to help inform their planning. The timeliness and quality of return home interviews for children who go missing from home and care requires improvement. A few risk management plans are not sufficiently detailed and information about vulnerable children is not always brought together in a single place, including data about children missing education.

Children looked after by the local authority receive a good service and, for the vast majority, their outcomes improve as a result of being looked after. They become

looked after at the right time, have good assessments of their needs and wishes, and the majority live in stable, high-quality placements with families. The local authority is having success in achieving more timely permanence planning for children than they had previously, and they continue to focus on this. Children in primary school progress well, however GCSE outcomes are currently poor for children looked after. While children have good access to advocacy services, there is further work required to ensure more children have access to an independent visitor.

For children with a plan for adoption, they have families secured with a sense of urgency and both they, and potential adopters, are prepared well to ensure these matches are successful. Developments are needed to improve the quality and content of some post adoption support plans.

Care leavers speak highly of the good service they receive and almost all are in touch with the local authority. Personal advisers provide consistent support and guidance, and enable care leavers to plan effectively for their futures. Although an increasing number of care leavers are attending further and higher education, including universities, this is still relatively low and too few have the opportunity to undertake apprenticeships.

Particularly noteworthy is the progress the local authority has made in ensuring planning is better influenced by the views of children, young people and carers – an area for improvement in their last inspection of child protection services. Users' views are now routinely sought to inform individual intervention and planning, and also at an organisational level to inform commissioning and strategic planning.

An area of particular strength, previously an area for improvement in the most recent inspection of services for children looked after, is the service provision for young people aged 12 plus through the Targeted Youth Support (TYS) service. This team offers effective specialist intervention and support to adolescents from a team of highly skilled staff.

Almost all performance management and quality assurance arrangements are strong within the local authority. The combined use of data, audit, complaints, consultation and external evaluation ensures senior leaders understand the authority well. Effective oversight by front line managers does, however, require further improvement.

Commissioning arrangements have been reviewed and improved during the past year to build on the existing good practice of joint commissioning. There are now three commissioning priority groups with detailed action plans in place, which are securing a more integrated approach to commissioning across the partnership. Very effective developments in workforce planning have led to a more secure and stable workforce, most of whom now have manageable caseloads. The use of the social work and management academies have been a key component of this success.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates six children's homes. Two were judged to be good or outstanding in their most recent Ofsted inspection. Three of the remaining homes were judged to be requires improvement and one was judged to be inadequate and is not currently operational.
- The previous inspection of the local authority's arrangements for the protection of children was in March 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for looked after children was in November 2010. The local authority was judged to be adequate.

Local leadership

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

Children living in this area

- Approximately 261,746 children and young people under the age of 18 live in Hertfordshire. This is 23% of the total population in the area.
- Approximately 13% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 9% (the national average is 16%)
 - in secondary schools is 7% (the national average is 14%).
- Children and young people from minority ethnic groups account for 17% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian and mixed ethnic groups.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 15% (the national average is 19%)
 - in secondary schools is 11% (the national average is 15%).

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.

Child protection in this area

- At 31 March 2015, 5,441 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 5,882 at 31 March 2014.
- At 31 August 2015, 721 children and young people were the subject of a child protection plan. This is a reduction from 1,140 at 31 March 2014.
- At 31 August 2015, 16 children lived in a privately arranged fostering placement. This is the same as at 31 March 2015.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 August 2015, 1033 children are being looked after by the local authority (a rate of 39.5 per 10,000 children). This is an increase from 1,005 (38 per 10,000 children) at 31 March 2015.
 - Of this number, 330 (or 31.9%) live outside the local authority area
 - 67 live in residential children's homes, of whom 70% live out of the authority area
 - 16 live in residential special schools, of whom 100% live out of the authority area
 - 829 live with foster families, of whom 29% live out of the authority area
 - seven live with parents, of whom one lives out of the authority area
 - 49 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - 68 children have been adopted
 - 53 children became subject of special guardianship orders
 - 485 children ceased to be looked after, of whom 6.6% subsequently returned to be looked after
 - 96 children and young people ceased to be looked after and moved on to independent living
 - 32 children and young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Strengthen the quality of planning and management oversight for children in need and those on a child protection plans to ensure children experience timely intervention and support. (pages 13, 30 paragraphs 27, 29, 103)
2. Monitor the effectiveness of step-up and step-down arrangements between early help and children's social care, and ensure that appropriate actions are taken to improve services as a result. (page 10, paragraph 14)
3. Ensure that risk management plans for children at risk of child sexual exploitation are sufficiently specific to meet the degree of risk and inform intervention. (page 13, paragraph 31)
4. Improve the timeliness and quality of return home interviews for children who have been missing from home and care. (page 18, paragraph 50)
5. Ensure that data relating to all children who go missing, including those missing from school, are collated and analysed to inform risk management and service planning, both for individual children and strategically to inform disruption activities and service planning. (page 13, 30 paragraphs 31, 106)
6. Increase opportunities for children looked after to be supported by an independent visitor. (page 17, paragraph 43)
7. Continue to maintain progress in achieving early permanency planning through timely legal processes. (page 16, paragraph 41)
8. Improve the quality of post adoption support plans to include timescales for actions and support to adopters. (page 23, paragraph 78)
9. Improve the number of care leavers who are engaged in employment, education and training by expanding the range of education and training options available to care leavers; particularly apprenticeships and traineeships. (page 25, paragraph 85)

Summary for children and young people

- Councillors and senior managers know their services well. They want to improve children's lives through providing good quality services to children and their families. Managers have made very good progress in improving services since the previous inspections and know what they need to do to make further improvements, particularly to services for children who need help and protection. Managers regularly listen to the views of children and young people when planning services.
- Children and their families receive help when they need it from professionals such as teachers, children's centres and health visitors. Parents say they value this support.
- Some children, young people and families receive very effective help and protection, but not all yet receive a good enough service. Social workers are really good at finding out what children need, but do not always take action quickly enough.
- Social workers are good at identifying when children may be at risk of being sexually exploited. When children come home after being missing, social workers do not always talk with them quickly enough to find out whether they are safe.
- Social workers make sure they get to know children well and consider their needs sensitively. They make regular visits to them and offer valuable help and support.
- Children who are looked after receive a good service. The majority of children come into care at the right time. They are also supported to move back home with their families if this is right for them.
- Social workers find the right homes for most children, including adoptive families where appropriate. Social workers make sure that adopters and foster carers are very well prepared to care for children. The vast majority of children and young people thrive in their placements and managers are working hard to increase the number of foster families within Hertfordshire.
- Most children who are looked after attend good schools. Children in primary schools make good progress, but the virtual school has got more to do to ensure that young people looked after do well in their GCSEs.
- There is a strong service for teenagers, which ensures they get the right level of support by skilled workers.
- Care leavers receive a good service. Nearly all stay in touch with their personal advisers and receive a high level of support and guidance. Not enough care leavers are currently in apprenticeships.
- The Children in Care Council is doing some good work to make sure services are more child and young person friendly. Members of the group also work well with managers and councillors to support them in their work of being effective and committed corporate parents. The council are currently undertaking a review of how they organise their corporate parenting panel and inspectors support this.

The experiences and progress of children who need help and protection	Requires improvement
<p>Summary</p> <p>Children, young people and families who receive help and protection are not all receiving a consistently good service. A small number of cases seen were examples of outstanding practice. In these, children were quickly supported and protected and their needs were understood through good assessment that used research and considered the impact of their previous histories on their current needs.</p> <p>Early help services are offered through a range of flexible and effective services, and feedback from parents about the early help they receive was positive. Currently, the local authority is not robustly monitoring cases that move between early help and children’s social care. However, in cases seen, children who need help and protection have an assessment of their needs undertaken without delay.</p> <p>Thresholds are generally well understood, but a small number of children were identified during the inspection who were not receiving the right level of service to meet their needs. The local authority acted swiftly to ensure these children were not at risk and that their needs were being met.</p> <p>The majority of assessments for children are strong and contain clear evidence of the views and wishes of children and their families. Children’s plans, including child in need and child protection plans, are not yet consistently clear, but most do coordinate good multi-agency support.</p> <p>Child protection conferences, reviews and core groups are not always clear about what needs to change to reduce risk in all cases. Frontline management oversight is not sufficiently challenging to ensure actions and progress are timely for all children.</p> <p>Risk is initially identified well for children who are at risk of child sexual exploitation, and, while there is some evidence of reducing risk for young people, this is inconsistent. Some risk management plans lacked sufficient detail to gauge risk. Return interviews for young people missing from home require improvement as they were not always timely and did not consistently lead to an understanding of why individual young people had gone missing.</p> <p>Arrangements for the management of allegations against adults working or volunteering with children through the Designated Officers are strong, although the IT system to record this work is weak.</p> <p>Good practice was also seen in the emergency duty team and joint child protection teams. Creative efforts are made to identify and support children who are privately fostered, however, numbers of children known to be living in these arrangements remain low.</p>	

Inspection findings

10. Children and young people in Hertfordshire who require help and protection are listened to and supported by skilled professionals committed to meeting their needs. The local authority has made a concerted and successful effort to ensure that children's views are heard and that their wishes and feelings are central to the service offered to them. Direct work and engagement with children is also consistently strong across children's social care. Children are visited regularly, and seen alone.
11. Families are supported well through a wide range of early help provision. Early help services are strong and are provided primarily through a large number of children's centres, early years' services, the Targeted Youth Support (TYS) service and a successful thriving families service³. School professionals also provide a great deal of early support to families. Parents spoke very positively about the early help services they receive.
12. When contact is made with the local authority and the threshold for social work assessment is not met, referrals are passed through the new multi-agency safeguarding hub (MASH). Children and families are then signposted to receive an early help service, and children who would benefit from an early help assessment are being identified appropriately. In the six months prior to the inspection, 1368 children received an early help assessment or targeted intervention. Although these assessments were often very brief, they did contain the key information to ensure children and their families received appropriate services to meet their needs. The introduction of an easy to use web-based electronic database to record all early help assessments is supporting multi-agency colleagues to formally record their assessments and support work with children and their families. This is leading to a more coordinated early help response to a larger group of children.
13. The local authority early help strategy includes an increased focus on evidencing progress and measuring outcomes. Children's centres, school partnerships, thriving families and Youth Connexions are currently using a new outcomes tool, with some early evidence of the services having a positive impact on improving outcomes for children and their families.
14. The local authority currently does not have a robust system for monitoring the effectiveness of step-up or step-down arrangements between early help and social care, which means they cannot be sure that these arrangements are sufficiently timely and effective for all children.
15. When children or young people require a social care service, contact is made with an established customer service team. Referrals are appropriate and

³ Local name for the 'Troubled Families Programme' team

demonstrate that other professionals understand thresholds for children to access the appropriate level of service. Children who require immediate safeguarding are passed to the joint child protection investigation team for child protection enquiries to commence. Children who require a social service other than immediate safeguarding are referred through the MASH; adolescents, are fast-tracked to the Targeted Youth Support (TYS) teams.

16. The joint child protection investigation team is made up of social workers and police officers who respond promptly to allegations of all forms of child abuse. Good work was seen where strong working relationships with the police were evident and children's needs were safeguarded swiftly. Managers in the joint child protection investigation team are alert to the indicators of risk of female genital mutilation and investigate directly. Clear information on female genital mutilation is available on the local authority website to assist identification.
17. Issues regarding consent are well understood in the customer service team and they have received recent training relevant to their role. During the inspection, a social worker was added to the customer service team to ensure professional advice was available to inform decisions regarding which team to pass the referral to for threshold decisions. The customer services guidance document is complex and lengthy; the local authority is appropriately reviewing this document to ensure it is aligned with the agreed LSCB threshold document.
18. The new MASH team is well resourced and includes social care, police, probation, education and health professionals. These professionals are working effectively together to reach good decisions for children that are informed by all relevant information available across the agencies. The high degree of commitment and good multi-agency input was seen to impact positively on the assessment of risk for children. A very small number of cases seen had not been assigned to the most appropriate part of the MASH service and the local authority audited these and responded quickly to ensure that needs were appropriately met. Delay was seen in some cases rated as less urgent in the MASH service.
19. The emergency duty team is a dedicated service for children and effectively manages referrals regarding children outside office hours. Practice is timely and prompt emergency placements are made when required.
20. The TYS service offers a comprehensive range of services for adolescents and young adults. It offers an integrated, multi-disciplinary service from early help through to children looked after, care leavers and youth offending services. All TYS services seen for children were of a consistently high quality and early help work showed appropriate interventions for young people to prevent their circumstances escalating.
21. Homeless young people aged sixteen and seventeen are initially assessed by the Herts Young Homeless Team. If it is considered that their needs cannot be

met by the homeless team, young people are referred to TYS where an assessment is undertaken by a qualified social worker; young people become looked after when this is appropriate. The local authority also offers a time limited crash pad service for up to 21 days until supported accommodation is available. Tenancies are secured promptly and the local authority showed a clear and timely response to young people in these circumstances.

22. Transfers between teams were clear and timely and work is allocated promptly, with children not experiencing any delay in having their needs assessed. Managers provide clear case direction on cases transferring between the MASH and Assessment teams.
23. Child and family assessments are of a high quality, but some do not sufficiently demonstrate clear management direction regarding next steps. Some assessments seen were outstanding, due to comprehensive consideration of history, strong analysis of risk factors, including domestic abuse, effective use of research and strongly featuring the voice of the child, with good consideration of impact of current circumstances on the child. Chronologies are of a consistently high standard and positively inform workers of children's histories and experiences. This was an area for improvement in the previous child protection inspection.
24. Currently more than half of children supported by a child protection plan have domestic abuse in their families and half have parents affected by substance and/or alcohol misuse. In response to these needs, the local authority is developing new Family Safeguarding Teams, which have been designed specifically to enable adult and children's services to improve support to families in order to help them understand the impact of domestic abuse, parental substance misuse and adult mental ill health on their children's outcomes. The first of these teams to be operational is demonstrating positive work, with assessments and plans for child protection and child in need being of a good quality.
25. The quality of child in need and child protection services are variable, resulting in some children receiving an outstanding service and some children receiving a service that requires improvement. The local authority is showing an improving performance in timeliness for initial child protection conferences (ICPCs). In 2013–14 only 30% of ICPCs were held within 15 days and this improved significantly to 78.3% in 2014–15; there has been slight fluctuation in this during the current reporting year, with a drop to 69.8% of children having an ICPC within 15 days in August 2015. The local authority demonstrated strong senior management oversight to improving performance during 2014–15 and it continues to scrutinise performance closely. A very small number of cases were being supported as child in need where child protection enquiries and ICPCs should have taken place. The local authority responded promptly to address this and no serious detrimental impact was seen for the children.

26. Currently, 71.3% of children are subject to a child protection plan due to neglect, with 22.7% for emotional abuse, 3.1% sexual abuse, 2.8% physical abuse and 0.1% multiple categories. Through the effective work of the local authority and LSCB in analysing the use of the neglect category, there has been an appropriate increase in the use of this category, from 58.9% at 31 March 2014. In one case seen that was of outstanding quality, the identification of neglect in an environment of domestic abuse appropriately reflected the wide range of risks to children. Fewer children are on child protection plans, currently 714 compared to 1,140 at 31 March 2014. This has been the result of concerted and effective efforts by service managers to scrutinise requests for ICPCs and to ensure decisions are relevant to the risks and needs of children.
27. While most child protection conferences and core groups are effective, a small minority of conferences do not result in plans that consider the full risk and protective factors for children or provide clear detail on what needs to change. For a very small number of children, there is no purposeful plan and core group meetings do not adequately consider risk. Other cases show good practice in this area, with timely plans that identify clearly what needs to change, and the plans are appropriately progressed through the core group.
28. There are 220 children in Hertfordshire who have been on a child protection plan for more than 12 months and 40 children who have been on a child protection plan for more than two years. The local authority recently undertook an audit to understand this trend. A sample of these children was evaluated during the inspection and for the majority the local authority has been proactive, including initiating court proceedings where appropriate.
29. The quality of planning requires improvement for most children in need and those in need of protection. Although a minority of plans are of good or outstanding quality, with detailed and clear targets, together with timescales and the person responsible for delivering them, the majority lack specificity. This means that the potential for cases to drift without progress being made is increased. This was an area for improvement at the last inspection.
30. The local authority has put in place a policy to ensure that those children who cease to be subject to a child protection plan due to reduced risk continue to receive support via a child in need plan for a minimum of twelve weeks. This was in response to an area for improvement at the last inspection and has now become established practice. The policy is driving effective practice. An inspector observed a review child protection conference, where this process was used effectively to establish clear expectations with the family and other professionals about what support and oversight would be in place via child in need services following step-down from child protection.
31. The local authority operates a multi-agency risk management panel, which considers young people who go missing and/or are at risk of child sexual exploitation. It produces and reviews risk management plans. In 2014–15, 56

cases were referred to the panel and 20 cases were discharged at the first review, showing some evidence of reduced risk. The local authority is planning to review the panel to ensure it develops a greater focus on risk reduction and on increasing disruption of alleged perpetrators. Although intelligence is shared, data regarding children missing from education and those at risk of child sexual exploitation are not currently effectively joined with data regarding children missing from home and care and those at risk of child sexual exploitation. This means that there may be missed opportunities to identify trends and hotspots and to disrupt potential perpetrators. Young people who are at risk of child sexual exploitation are supported well through the TYS service. Young people who have experienced child sexual exploitation are able to access independent sexual violence advisers and youth work support.

32. Managers have a good awareness of children missing education and effectively use a database to check that children are not enrolled in a school out of county. The numbers have reduced from 59 in 2014–15 to eight at present, showing good performance in this area. Links with the police are strong and managers appropriately share information regarding individual children who are moving abroad or at risk of radicalisation or child sexual exploitation. Good support and information is also provided to parents of the 521 electively home educated children. Two specialist home education advisers support parents by offering detailed written guidance, including how parents can help their children with their studies. Managers ensure they are fully aware of the children missing from education.
33. There is strong engagement and partnership working from the local authority with the Multi-Agency Public Protection Arrangements (MAPPA) and the Multi-Agency Risk Assessment Conferences (MARAC). Clear understanding of risk and good quality information is shared between participating agencies. MARAC have an effective programme of ongoing improvement following a review and there is now a young MAPPA and young MARAC to effectively consider the needs of those under 18 years.
34. The arrangements for the management of allegations against adults working or volunteering with children is provided through two full-time designated officers. Practice is strong and a new management information system is due to be implemented to assist with analysis and overview of the service data.
35. Considerable creative effort has gone into awareness-raising in relation to private fostering. Currently, there are 16 active private fostering cases. Children who are privately fostered are seen alone, and have their needs assessed appropriately, however, this would be strengthened by fuller recording and greater management oversight.
36. Advocacy and participation has had a renewed focus in the local authority, but there are still too few children and young people accessing the advocacy service to gain support to attend their child protection conferences. In a

recent audit, the local authority identified that although 84.4% of young people did not attend their child protection conference, they all had their wishes and feelings conveyed by their social worker. In a small number of cases, there is good use of advocacy services. For example, one young person successfully argued, with the help of her advocate, to remain on a child protection plan as she felt this would improve her safety.

37. Some good work was seen when considering the diversity and cultural needs of children and young people, including use of interpreters and placement matching through the emergency duty team. However, identity is insufficiently considered for all children and young people who require help and protection.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Good</p>
<p>Summary</p> <p>Decisions about whether children need to become looked after are timely and appropriate. Strong and bespoke multi-agency edge of care support is in place, which enables children to remain at home where at all possible. Practice before and after care proceedings is effective, with rapid recent improvement in the timeliness of proceedings and early permanency planning. The local authority appropriately continues to prioritise timeliness of permanency planning.</p> <p>Social workers know children well, regularly visit them and give sensitive and thoughtful consideration to their needs. As a result, children and young people looked after achieve positive outcomes. Arrangements to identify and respond to risk for children who go missing from care are robust. However, arrangements for return interviews for children are not always sufficiently effective.</p> <p>Children looked after are well supported in their education by the virtual school. Educational progress is variable, with strong performance across key stage one, and low attainment at key stage four.</p> <p>The local authority has driven a range of initiatives to increase placement choice and placement stability, and to secure more local placements for children. This is having a positive impact and the fostering service is providing a good range of placements to meet individual children’s needs.</p> <p>The independent reviewing service regularly reviews care plans, and there is a culture of informal and formal challenges to care plans. Children looked after make good use of advocacy services, however the independent visitor service is only available to a small number of children.</p> <p>The Children in Care Council is a strong and effective group and children looked after are involved in a number of relevant activities, including service development.</p>	

Adoption is considered and achieved for a wide range of children, with the large majority being prepared well and placed without unnecessary delay. The preparation and assessment of adopters is thorough and children are well matched with their potential adopters. The content of support plans for adopters requires improvement and there are currently too few fostering to adopt placements.

Care leavers are well supported by skilled personal advisers who keep in touch with them. Pathway planning is effective. Young people receive information about all their entitlements. Care leavers would benefit from further expansion of education, training, apprenticeships and traineeships opportunities, and clearer support pathways into adult services for vulnerable young people.

Inspection findings

38. At the time of the inspection, Hertfordshire looked after 1029 children. The local authority is achieving its strategic priority to provide effective and flexible edge of care services for children and young people, and at the same time decrease the number of children looked after across the local authority. Children and young people are very well supported through effective multi-agency edge of care services, provided by the innovative Targeted Youth Support (TYS) service. Creative and bespoke individual support packages are in place for young people over 13 years and these enabled the majority of young people to remain successfully at home. The rate of children becoming looked after, at 38 per 10,000 in 2014–15, is lower than statistical neighbours and England (52 and 60 per 10,000 respectively).
39. The large majority of children have improved outcomes as a result of being looked after: emotional vulnerabilities and well-being are addressed, educational progress is achieved for children who attend school regularly, and children experience an expansion of leisure activities and improved relationships with others. Decisions about whether children need to become looked after are timely and appropriate in almost all cases. Inspectors did see a small number of cases where children came into care too late and, while risk was responded to, intervention could have been timelier.
40. Where the plan was for the child to return home, the majority of children and young people were subject to multi-agency assessments and supported by children in need plans. Inspectors found a small minority of cases where children were returned home without a clear assessment or a support plan, but most continued to receive effective social work intervention when at home.
41. Where legal proceedings are required for children, a structured approach to the Public Law Outline (PLO) process is in place, with clear guidance for staff to avoid drift and delay. Management and legal oversight of the PLO is appropriate and this has led to improved practice, with children being placed in permanent homes more quickly. Letters to family members, prior to the

authority applying for a court order, are clear and explain expectations and what needs to change. In most cases, legal permanence for children looked after was pursued promptly through a range of suitable options. There has been a rapid improvement in timeliness in care proceedings from 49 weeks in 2013–14, to 30 weeks in the first quarter of 2014–15, but this is still outside the government target of 26 weeks. Early permanency planning for children includes the extensive use of family group conferences to identify extended family members, and effective parallel planning. An excellent example of early permanency planning was where the Agency Decision Maker had made adoption decisions for 19 children who were in care proceedings in order to plan for swift adoption placements.

42. There is variability in the timeliness of viability assessments undertaken for extended family members and permanency planning has not been timely enough in the majority of cases. This was most often the result of some historic drift and delay, where permanency plans were slow to evolve. Good permanency planning was seen in nearly half of cases, with permanency achieved without delay. Some excellent casework was also seen, with a baby placed very quickly for adoption. The local authority has recently improved the tracking of permanency planning to address historical issues of delay and continue to improve timeliness and coordination within the whole permanency system.
43. Children and young people are listened to and their views inform decisions regarding planning for their care. Social workers know them well and visit regularly, often beyond statutory requirements, and give sensitive and thoughtful consideration to their views, needs and circumstances. Children looked after use the commissioned advocacy service well, with 393 children and young people accessing the services in 2014–15. A well-embedded complaints system has led to improvements in services. For example, in one case, a placement move was postponed until after a young person’s complaint was resolved. The advocacy service made 17 complaints on behalf of young people in 2014–15. The independent visitor scheme is underperforming, with only 15 young people currently accessing this service. A more ambitious target was set in July 2015 to achieve 20 independent visitor matches over the next year.
44. Children and young people are aware of their rights and entitlements. The pledge for children looked after, which highlights age-appropriate rights and responsibilities, is actively promoted by social workers and independent reviewing officers (IROs) to ensure that the principles of it are woven into current practice.
45. Assessments of children’s needs are strong in the large majority of cases and take account of children and parents’ views. A dedicated group of social workers sensitively seek to meet individual children’s needs. In an outstanding example, a social worker had developed specific skills to be able to communicate effectively with a disabled child and understand their wishes and

feelings. Children live in placements that have been carefully matched to meet their needs. A young person, for example, was placed specifically to avoid further risk of gang involvement. In a very small number of cases, placements did not fully match a child's ethnic or cultural needs. For example, a black young person was placed in a residential children's home in a predominantly white area.

46. The quality of written care plans for children varies. A range of plans were seen, including post support plans, care plans and pathway plans that did not all fully capture details or have smart targets for monitoring purposes. This means that children and young people, their carers and other professionals cannot fully check that actions are completed and progress is being made. Up to date and comprehensive case recording accurately reflects the work undertaken with children and young people, and effective direct work is undertaken to assist children and young people to understand their life histories.
47. IROs have manageable caseloads and escalate important issues if the need arises. IROs review the very large majority of children's plans (91%) within statutory timeframes. There is a culture in the organisation of both informal and formal challenges to care plans with an acknowledgement that there should be an increase in the use of formal challenge to enable clearer monitoring of issues in the future. IROs regularly meet children before reviews, and in between them where possible, to ensure their participation remains strong.
48. Within the current cohort of children looked after, the large majority (89%) of children and young people live in stable and secure placements and only experience one or two placement moves. The local authority has successfully driven improvements to placement stability via therapeutic training and support to foster carers, residential respite beds, and support from the Adolescent Resource Centre (ARC) and improved matching of children to carers.
49. When children go missing from care, their carers report this promptly to the police, and action is taken to establish their whereabouts. Social workers make concerted and repeated efforts to get in touch with young people. The local authority maintains clear tracking processes, using 'need to know notifications' and recording of risks and relevant information to ensure that the young people at highest risk are monitored effectively. There is a small cohort of looked after young people who go missing regularly and are at risk of child sexual exploitation; practice and intervention has effectively reduced risk for the majority of these particular young people. There has been a slight decrease in the total number of missing episodes for young people who are looked after, with the length of time that they are missing also decreasing steadily, with most young people missing for less than 24 hours.

50. Return interview arrangements for children who have been missing from home or care are not always timely enough, and the local authority is aware that practice needs to improve further. A minority of children are not asked in sufficient detail where they have been, or who they have been with, while they have been missing to inform a full picture of potential risks. Appropriate use is made of secure accommodation to protect those young people at the highest levels of risk.
51. There are appropriate and effective services for children looked after via the TYS to meet the needs of young people who offend. An effective countywide commissioned service works with those young people who are at risk of misusing drugs and alcohol.
52. Children looked after, including those placed out of county, benefit from appropriate contact arrangements while living away from their families. Contact is considered in all matches for permanence seen by inspectors.
53. The very large majority of children looked after have their health needs identified and their health improves through the support of a dedicated looked after children health service. Initial health assessment and health review performance has improved because of increased capacity and effective performance monitoring, with 82% of children having an up to date health assessment. Access to a range of therapeutic and psychiatric support is available for children and young people and their carers via the ARC. A dedicated children looked after child and adolescent mental health service (CAMHS) also provides a fast track service to respond to the emotional wellbeing and mental health needs of children looked after.
54. The head of the virtual school provides extensive training and support to designated teachers and head teachers to support them in their work with children looked after. She monitors and tracks the educational achievement and progress of children looked after at all stages thoroughly.
55. The 2014 educational outcomes for children looked after showed that a very large majority (89%) of children looked after at Key Stage 1 made good progress from often low starting points. Almost half, 48%, of children looked after who took the Key Stage 2 tests in 2014 made more than expected progress. The achievement and progress of children looked after at Key Stage 4 in 2013–14 was low, with only 11% of these pupils achieved 5 A*–C, including English and mathematics, against the national average for children looked after at 12%.
56. Just over a third of young people who have become looked after in the past 12 to 24 months have not fully settled into school. In recognition of this, the virtual school has appropriately focused on engaging them in their learning, however the impact of these actions is not yet evident in the achievement for children looked after.

57. Headteachers make effective use of pupil premium to support children through their education, offering learning support resources and enrichment activities. Teachers make good use of personal education plans (PEPs) to monitor the support and progress of children looked after, although managers recognise that the target setting in PEPs needs to be refined further to demonstrate impact on the children in their personal behaviour, confidence, social and emotional skills and resilience.
58. Children looked after have the full opportunities to attend school. The number of pupils with fixed-term exclusions has fluctuated from 47 in 2012–13 to 55 in 2013–14 and 45 in 2014–15. The number of permanent exclusions have a downward trend, from three in 2012–13 to one in 2013–14 and none in 2014–15.
59. The virtual school has accurate data, and effective tracking mechanisms for the numbers of children looked after in alternative and part-time education and those who are missing school. Staff work diligently to place children looked after in appropriate and good settings, and take swift and appropriate action to ensure that this happens.
60. Where children are placed out of county, strong links are made by the virtual school with other local authorities, which means that appropriate educational provision is identified. The clinical commissioning groups and health providers have recently implemented changes to improve the timeliness of health assessments for those children placed out of the local authority area, however, no cases were seen where children were not receiving appropriate health services in their new locality. This included one young person whose health needs were being well met by specialist health provision.
61. The use of delegated authority by foster carers to take some day-to-day decisions on behalf of children and young people is widely in place. Children and young people are routinely encouraged by foster carers and other professionals to build friendships and attend a wide range of activities in order to enhance their life experiences and build self-esteem.
62. Careful and sensitive matching for children and young people with carers takes place via the Brokerage service. A very large majority of children live with their brothers and sisters. There is appropriate placement choice for emergencies. Children are appropriately referred to independent fostering agencies or other specialist provision where needed. Evidence was seen of appropriate and careful long-term matching of children to permanent carers. There is a need to improve choice and availability of local placements, particularly for adolescents with challenging behaviour. The local authority is aware of this and there is a strong strategic drive to recruit more foster carers in the local area and to improve placement choice. This is producing some success, with an expected net gain of ten foster carer households at the year-end, based on previous years' losses through retirement and termination.

Commissioning work is also being undertaken to improve the capacity of local independent fostering agencies to meet the needs of Hertfordshire children.

63. Assessments of foster carers are good and they receive in-depth foster carer reviews. However, there were some minor lapses in compliance to fostering regulations in cases seen; for example, foster carer agreements on file were not found, and not all annual reviews occurred within timescales. Foster carers are integrated into the fostering service and influence its development. They reported very good working relationships with all professional staff and are provided with a high level of support by a range of appropriate support services. A comprehensive learning and development programme, including e-learning and specialist training, is available, although attendance is not always recorded well.
64. Children are thoroughly prepared for permanence and carefully matched. Foster carers described some social workers as 'brilliant' in how well they work with children. Children are prepared well for transitions, ensuring that they understand their plans and their views are heard. The quality of the life story book work seen by inspectors for children who are placed for adoption was factually thorough, but could be more imaginative and child-focused.
65. The Children in Care Council is an effective group and has strong engagement from senior leaders. Young people effectively participate in formal meetings and they have appropriate engagement in service developments. Young people from the Children in Care Council have worked hard to ensure that a young person's perspective is in place for development of services. For example, they have been influential in improving contact centre venues to be more child-friendly; they have assisted in consulting with other young people to redraft the Pledge; and they have developed the new template for pathway plans for care leavers, making it more user-friendly for young people. In addition, they provide highly valued training to foster carers and social workers to further their understanding regarding issues affecting children looked after. The Children in Care Council also organises a broad range of events and celebrations for children and young people looked after and care leavers to enjoy.

The graded judgment for adoption performance is that it is good

66. Adoption is considered and achieved for a wide range of children; this includes older children, groups of brothers and sisters and disabled children. Adoption decisions are thoroughly considered and children are well prepared for adoption. The number of adopted children has been steadily rising year on year, with 87 children being adopted in 2013–14. There has been a slight reduction in 2014–15 to 68 children. There are approximately 58 children waiting for adoption. A tracker group is in place to monitor all children waiting

for adoption, and who have a placement order granted by the court, to ensure that any potential delays are identified.

67. Adoption workers routinely attend permanency planning meetings to ensure that adoption is considered at the earliest opportunity. Permanence options are also considered at most children's second looked after review. Of the 67 children adopted over the last 12 months, the large majority (79%, 53 children) were adopted in less than a year, with the quickest time being less than three months. Active family finding is taking place for the 45 children currently waiting; all are aged over three years, and 19 have been matched with their adoptive families or have a potential link. The local authority reports an improving trajectory for 2012–15, with the average time between a child entering care and moving in with their adoptive family being 619 days. In 2011–14, this took 681 days, which was 134 days longer than the target of 547, and 102 days longer than comparative authorities.
68. The adoption service secures adoption placements for children, with family finding activity commencing at the time a placement order is granted. There is a wide range of family finding activity, from timely referrals, to the National Adoption Register, to use of the East of England consortium. Transitions work is very effective in preparing children for a move to their adoptive family. Inspectors saw a creative approach to family finding activity days with the introduction of craft days, where adopters and children interact while undertaking an activity. Not only is this imaginative but it is producing some early success with 23 children involved to date, leading to 13 matches. For some children with complex needs, timescales to find adoptive families are appropriately put in place alongside other permanence options to maximise the opportunity of identifying permanent families.
69. There has been delay for 23 children as a result of birth family appeals to the court, none of which have been successful. This demonstrates that the local authority decision-making processes for adoption are thorough. At the time of this inspection, of the 130 children recently matched, the large majority (92 children) fell outside the government set target of 121 days between receiving a placement order and being matched with a family by an average of 76 days. Further analysis of the data suggests that the majority of children who exceed the target are those that entered care before mid-2013, meaning that for a small minority of children, it has taken over a year to match them.
70. The local authority is tenacious in pursuing adoption when it believes that this is the right permanence option for individual children and does not give up on finding an adoptive family when this meets the child's assessed permanence needs. A small number of children who have waited a long time for adoption are now living with their adoptive family. This has impacted upon the local authority performance against the government target for matching children with their adoptive families. The adoption scorecard figure for the three year average 2011–14, shows that the average time between the local authority receiving court authority to place a child and deciding on a match with a

family was 197 days. This was 15 days longer than comparative local authorities and 45 days longer than the performance threshold of 152 days.

71. The preparation and assessment of adopters is thorough. Most adopters spoken with on this inspection feel that the assessment process assists them in learning about the children waiting and understanding their capacity to meet their needs. Adopters felt their assessing social workers 'knew them inside out' and this assists with the early identification of potential matches. A significant strength within Hertfordshire is the involvement of experienced adopters in supporting social workers to prepare and support new adopters. The local authority has also set up a youth panel of adopted young people who will meet with prospective adopters to encourage adopters to consider older children for adoption. This is a creative service development that demonstrates the local authority's inclusive approach to the voice and participation of children and young people.
72. Prospective adopter reports (PARs) are of a good quality and are well informed by effective tools such as attachment style questionnaires. The reports are detailed and well analysed, with positive work undertaken to prepare the children of second time adopters. For example, in one case, careful attention had been given to seeking the views of the first adopted child to help him explore how he would feel about, and prepare for, having a new brother or sister. In 2014–15, there was only one adoption disruption, demonstrating the robustness of the local authority matching practices.
73. The Agency Decision Maker (ADM) decisions are of an outstanding quality, due to the detailed analysis of documentation and thorough consideration of permanence options. The number of decisions that changed away from adoption was 65 at the end of 2013–14; this reduced to 38 at the end of 2014–15 and currently stands at eight for the year to date. Where plans have changed away from adoption, ADM decisions show that reasons for a change in decision are thoroughly explored. This means that the local authority is confident that the plan is the right one for the child.
74. Hertfordshire's adoption panel is chaired by a suitably experienced independent professional and is appropriately constituted, with regular and relevant training for panel members. Medical advice is readily available to prevent delay, with panel minutes demonstrating well considered and relevant scrutiny of suitability, matching and post adoption support plans.
75. A comprehensive recruitment strategy is being successfully implemented, with swift attention to enquiries and initial visits. Sixty-four adoption households were approved during 2014–15 and the service is on track to recruit 60 new adoption households this year. Recruitment materials such as posters and leaflets are of good quality and various routes are effectively used to attract new adopters, including an updated web page and creative use of social media.

76. Timescales for assessing prospective adopters through the two stage assessment process are on an improving trajectory. The service has recognised the need to improve performance further and has engaged with an Adopt the Future programme, which aims to reduce the number of children waiting and the length of time they wait. Not all adopters are being assessed quickly enough through the two stage recruitment and assessment process. Of the 68 approved adopters in 2014–15, half completed stage two of the assessment processes in four months, with the remainder finishing within six months. While some adopters need longer in the stage two process to consider and reflect on the assessment, there are too many where their assessment is not meeting timescales.
77. Post adoption support is readily available from a specific team who receive requests for support. Since April 2015 there have been 125 requests for advice and guidance and 35 requests for an assessment of post adoption support, all of which have appropriately resulted in a service. Effective direct support to adopters and children awaiting therapy, supporting life story work and contact arrangements are undertaken by workers within this team. The local authority adoption service has appropriate plans in place to further develop a wider range of therapeutic services for adopted children and is working with commissioners to explore this issue. Birth parents whose children are going through the adoption process have good access to support via a commissioned service. Adoption workers meet with birth parents and there is a helpful information pack available to them at permanency planning meetings. There are currently 557 letterbox contact arrangements supported, with a further 39 in the process of being set up. There are also 53 open records relating to adopted adults who require birth records counselling.
78. The needs of children are identified well in post adoption support plans, although sometimes these lack specific timescales for completion of actions. For a small number of adopters, their needs are not always identified in full. For example, a case was seen that lacked detail of how the adopters could be helped, and when was the right time for them to explain the life story of their child who has complex needs.
79. The quality of child permanence reports (CPRs) is variable, from requiring improvement to good; this has not impacted upon decision making for children. All examples seen by inspectors set out the child's history, contact arrangements and the full range of permanence options. A minority of CPRs provide insufficient attention to heritage issues and lack comprehensive information in relation to the child's birth family, but this did not impact negatively on matching for the children.
80. Fostering to adopt has been slow to be implemented in this local authority, with only one arrangement currently in place. An example was seen by inspectors of a very young baby being placed from birth through fostering for adoption; this is good practice. The limited use of fostering to adopt

placements hinders some babies living with their adoptive families as soon as possible.

The graded judgment about the experience and progress of care leavers is that it is good

81. Care leavers have access to a holistic package of support from the multi-skilled Targeted Youth Support (TYS) service and this results in most young people being prepared well for independence. The service has high aspirations for their care leavers, they do not give up on them and there are systems in place for care leavers to return for support when they need it. Young people are successfully encouraged to remain looked after until they are 18 years old and they are supported to 'stay put' beyond 18 years when it is appropriate. In 2014–15, this meant that 53 of the 58 children who turned 18 remained with their foster carers.
82. Highly skilled personal advisers keep in touch with 98% of care leavers. Persistent efforts are made to keep in touch with the 2% of care leavers that are not in regular contact. Workers respond effectively to young people's changing needs and, for example, direct and refer them to other agencies or creatively review support packages as relevant. Good risk assessments are used well to inform decisions and actions where limited or no contact is a concern. Care leavers value the role of their personal advisers and believe that their input provides a platform for building trusting professional relationships.
83. Overall, pathway planning is effective and all care leavers have an individual plan. Pathway planning appropriately starts with young people when they are 15 years 5 months, and 95% of plans are in place by the time they are 16 years 4 months. The format of the plans has recently been revised by the Children in Care Council and this has resulted in a far more interactive tool, which supports clearer goals and better outcomes. Objectives are clearly set out, with detailed, accountable actions and contingency plans. Reviews of plans are thorough and are updated at least twice a year as young people's circumstances change. Young people are engaged in their pathway plan reviews and value the opportunity to look back on their progress. A small number of plans are less effective as they do not fully detail young people's needs or include clear actions.
84. The number of care leavers who are in education, employment or training (EET) is improving. Currently, 79% of care leavers are EET, compared to 49% in 2013–14, and higher than the England average (62% in 2013–14). The virtual school and Connexions Service work tenaciously to reduce the not in education, employment or training (NEET) numbers. The whereabouts and destinations of older care leavers and those living out of county are closely monitored. For example, the local authority is in touch with, and trying to

support, 14 unaccompanied asylum-seeking care leavers who have moved out of the county and are refusing help. Attendance at university is improving: 4% of care leavers are attending university; this is still lower than the England average of 6%. Retention rates for young people successfully staying on their chosen courses, however, at 98%, are excellent.

85. The number of apprenticeships for care leavers within the council has slowly increased from three care leavers in 2013 to 10 in 2015. Additionally, 16 care leavers have been recruited to apprenticeships within organisations external to the council since April 2015. Five care leavers are currently completing traineeships; this is a very successful programme, as the young people have not previously engaged in conventional training courses. Care leavers are supported to complete the national citizenship award and the Duke of Edinburgh award. The 61 young people who have completed these awards have improved their confidence, resilience and readiness for work. A good service underpinned by a joint working protocol with the Department for Work and Pensions (DWP) supports young people on benefits.
86. Transition planning to adult services for most disabled children is effective. Joint work with adult services enables all disabled care leavers to have their needs assessed well before they are 18 years old. Most young people experience no interruptions or delays to receiving the support services they need. A small number of young people who have a high level of vulnerability and require long-term support do not have a clear pathway into adulthood. An example of this being a young person whose emotional health needs do not meet the criteria for adult services. The local authority is aware of this and is working with other services to establish pathways for these young people.
87. Care leavers have their independent living skills and needs well assessed through the use of an effective and enabling work book. Housing providers have received training on how to appropriately use the work book and this has improved their understanding of the needs of care leavers. Most young people aged between 16 and 18 years are provided with preparation for independence training. This is provided by social workers, housing support workers and personal advisers. This work is supported by a range of supported and semi-independent housing providers who offer independence preparation as a core component of their contract specifications. The TYS teams provide a range of good services such as emotional health and wellbeing support, substance misuse, sexual health, therapeutic services and counselling support. All care leavers are provided with a detailed summary of their health histories, which provides everything they need to take charge of their own health needs. This holistic support offer is equipping care leavers well for adulthood.
88. Ninety-seven per cent of care leavers live in suitable accommodation. A very small number of care leavers are living in unsuitable accommodation. These are short-term arrangements, and personal advisers are working with the care leavers to help them find suitable permanent accommodation. The local

authority has great success in encouraging young people to remain with their foster carers under 'staying put' arrangements. There is a strategic drive to increase this number to enable more young people to benefit from these arrangements. No young people are placed in bed and breakfast accommodation and only a small number of care leavers over 18 years old live in houses of multiple occupancy. Where this happens, assessments of their needs and suitability are completed prior to placement. Almost all care leavers report that they feel safe in their homes. Swift action is taken to ensure the safety of the small minority of care leavers who say they don't feel safe.

89. The majority of care leavers aged 18 years and over live in independent accommodation provided by the private rented sector or through social housing nominations. There is an effective commissioning programme in place to expand the range of supported housing providers, both for young people aged 16 to 18 years and older care leavers. Providers are commissioned through a framework arrangement; care leavers are involved in every stage of the commissioning cycle. Good arrangements result in providers who are trained to effectively respond to children at risk of sexual exploitation and those who go missing. Clear service provider agreements are influenced by care leavers, resulting in positive joint work to support young people into independence. A positive impact of this is that young people are successful in securing their own tenancies. An effective multi-agency risk management and safeguarding panel is in place to ensure the needs of high risk care leavers are responded to, including planning for care leavers who are in custody. Good arrangements are in place, effectively coordinated between children's services and housing, for assessing the needs of and planning for young people aged 16 or 17 years old who present as homeless. Young people become looked after if reunification is not possible and they are unable to live independently.
90. Care leavers say that they feel listened to and are well supported. The local authority provide a clear message to care leavers that if things go wrong, they will be supported and helped to 'start again'. Foster carers have set up a mentoring scheme for care leavers, which is well used and valued. Exit interviews for care leavers have recently been introduced, and their feedback will be used to develop service provision. However, it is too early to measure the impact of this new work.
91. The Children in Care Council and the care leavers' group influence service development through their involvement with corporate parent elected members and key decision makers. Good examples include the new pathway plan and the review of the personal adviser caseloads. Effective work by the Children in Care Council supported by the participation team ensures that young people are aware of their entitlements. Information is available through the charter to care leavers and the local authority website. The local authority is currently developing a care leavers' website and smart phone application to ensure it reaches out to a wider audience. Care leavers value the annual awards events to celebrate their achievements.

Leadership, management and governance	Good
<p>Summary</p> <p>Leaders and senior managers in Hertfordshire know their services well and are persistent and successful in delivering improved services to children and their families. They achieve this through both internal and external review of existing services, together with actively seeking the views of children, families and other stakeholders to deliver against ambitious action plans for service development.</p> <p>The local authority has made substantial progress since their last inspections, with only a very small number of areas for improvement continuing to require further work. They recognise they have further work to do to improve management oversight at the front line to ensure that actions are taken within children’s timescales.</p> <p>Governance arrangements between senior leaders, both political and local authority officers, and key partnerships and boards are very clear. This ensures preventative services through early help, and also statutory functions, are coordinated and delivered effectively.</p> <p>Commissioning arrangements have recently been effectively aligned under the Health and Wellbeing Board into three priority areas. This is to ensure partners build on existing strong joint commissioning arrangements to address the key priorities for children’s services.</p> <p>The use of children’s views is particularly strong. For example, the recruitment of a youth ambassador and training for young commissioners ensures commissioning arrangements are responsive to local children’s views and needs. The Joint Strategic Needs Assessment (JSNA), is not being effectively used to inform commissioning across children’s services.</p> <p>The local authority aims to be a committed corporate parent and has achieved success in engaging children from the Children in Care Council in their work. The local authority is appropriately undertaking a review of corporate parenting arrangements to ensure they are fully embracing this crucial role.</p> <p>Strong performance management and quality assurance arrangements ensure that both the quality and performance across children’s services is fully understood at all levels of the organisation and across partnerships. This enables leaders and partners to respond promptly to issues or changing trends as they arise.</p> <p>The local authority has achieved great success in securing a more stable workforce and this has enabled them to reduce caseloads to a very manageable level for social workers. They have achieved this through careful workforce planning, alongside the creative development of their social work and management academies.</p>	

Inspection findings

92. Governance arrangements are robust and clearly understood by both political and local authority senior leaders. These arrangements ensure that lines of accountability between senior officers, political leaders and also the Local Children Safeguarding Board (LSCB) and Health and Wellbeing Board (H&WB) are clear and that statutory functions are discharged effectively. An appropriate range of meetings are established in order to promote communication and follow-through of key issues; these include regular meetings between the DCS, Lead Member, Chief Executive and chair of the LSCB to ensure all are effectively held to account.
93. Political and local authority leaders ensure they know their services for children and families well and that they understand what is happening at the front line through routine consideration of a comprehensive set of performance information. This includes data, trend analysis, audit findings and routine reporting, such as complaints and performance of the independent reviewing service. Furthermore, the DCS and Lead Member ensure that they have regular contact with children and their families through, for example, attendance at the Children in Care Council meetings and events, and visits to children's centres. The DCS has also invested significant energy to gain a direct line of sight to what is happening at the front line through focus groups with staff, visits to teams and direct observations of practice.
94. The local authority has been successful at developing and maintaining a H&WB that considers children's issues and is the body that the LSCB and commissioning groups report to. This year, partners have worked together to ensure children's issues are reviewed as part of its strategy, through careful use of a life stages model against all of their priorities. For example, the local authority and its partners have successfully improved timely access to Child and Adolescent Mental Health Services (CAMHS) and this feeds into the H&WB mental health priority. They plan to make children's issues even more explicit in the priorities of their future strategies.
95. The recently developed integrated commissioning framework for children's services establishes three main priority areas: early years and early help; children with special educational needs and disabilities (SEND); and safeguarding and children looked after. The three priority commissioning work streams for the H&WB are early childhood, 0–25 integration, and child and adolescent mental health. These new commissioning priorities are enabling the local authority and its partners to build on its existing effective practice of joint commissioning of services for children and their families. Although there has been some delay in achieving all actions from the children's services 2014–15 commissioning plan, relevant and ambitious commissioning strategies are now in place for 2015–18 to provide an effective framework for strategic commissioning.

96. Particularly noteworthy developments in relation to commissioning are the appointment of a Youth Ambassador, a jointly funded post between the local authority, Public Health and the two clinical commissioning groups (CCGs) to promote engagement of young people in commissioning activities. Training programmes are also being delivered to care leavers and young people with special needs, to enable them to undertake paid work to support commissioning of services in the local area.
97. The local authority effectively pursues consultation with key stakeholders, including parents and children in their commissioning activities. For example, there was considerable attention to using a range of consultation methods prior to the recommissioning of children's centres. Contract management arrangements are robust within the joint commissioning team and the local authority is effectively delivering against an action plan to ensure all commissioning activities across children's services have these robust processes applied.
98. The local authority actively pursues opportunities to develop their services further through securing additional funds and was very successful in its innovations bid to central government to develop family safeguarding teams. All professionals spoken to during this inspection are excited and clear about the potential benefits of having multi-professional teams, however, it is too early to demonstrate a positive impact for individual children and their families of this new working style.
99. Partners express great confidence in the senior leadership team of children's services. There is much evidence of the two CCGs, public health, the police and schools working closely together with the local authority, particularly in developing early help and preventative services. An example is how issues of domestic abuse and child sexual exploitation are being addressed through the development and use of a resilience toolkit that helps young people to explore domestic abuse, healthy relationships, bullying and sexual health and also the sharing of Chelsea's Choice across secondary schools.
100. The Joint Strategic Needs Assessment (JSNA) is routinely used by partners within their commissioning activities, for example in children's centres. However, there is further work to do to ensure the JSNA is sufficient to effectively inform commissioning for children looked after and also to ensure children's services consider relevant data from the JSNA in all their commissioning activities. Currently, children's services undertake bespoke needs assessments to inform particular commissioning activities.
101. The local authority is committed to being an effective corporate parent and has achieved success in engaging with young people from the Children in Care Council to ensure services are responsive to the needs of children looked after. The Lead Member for children's services chairs the Children's Services Panel, which also provides the corporate parenting overview function. The panel ensures performance data regarding children looked after and care

leavers is understood and scrutinised by members, and invites young people to present when relevant, however, this does not occur at every meeting. This arrangement is appropriately under review by the local authority to ensure that the multi-function panel is sufficiently addressing the scrutiny function for children looked after.

102. There are established links between the virtual school governing body, the Children in Care Council and the Children's Services Panel, and progress has been made in key areas, such as improving care packages for young people living in supported lodgings and ensuring that housing offers are available for care leavers across the county. There is more to do, for example, to increase the range of therapeutic support for children looked after, to close the gap for 16 and 18–24 year olds and to increase use of apprenticeships. Elected members, as corporate parents, are not always engaged with celebrations and events organised for children looked after, and training is only now being delivered to them.
103. Management oversight of the quality and performance of children's services is a strength, with systematic performance data being effectively used to monitor practice. There is also good use of audit to consider both compliance and the quality of work with children and their families. Performance information receives regular scrutiny, by front line managers through to senior leaders, and this helps to accurately identify where immediate intervention is needed, or further information is required to understand emerging trends. For example, as a result of senior scrutiny, a task and finish group was convened to consider the issue of placement stability. Actions from this group, such as increasing the availability of therapeutic support for children looked after, have had a positive impact on placement stability. Senior managers recognise that there is further work required to strengthen management oversight at the front line to ensure timely actions are taken for children after robust assessments have been undertaken.
104. There is a clear quality assurance loop, using information from audits, complaints and serious case reviews, together with direct feedback from children and their families. The policy and practice team carry out a full analysis of the findings from audits, identifying any trends, areas of good practice and areas for improvement. These findings are appropriately reported to the Children's Social Care Board on a quarterly basis, along with service-led commentary and a collated single improvement tracker. Complaints are managed well and outcomes are analysed effectively. Learning from complaints is routinely shared with front line staff via regular bulletins to improve practice. The local authority is also persistent in its work to improve understanding of its services and so seeks external review to gain further insight. Most recently this has included critical reviews of child and adolescent mental health services and domestic abuse services, which are already leading to improvements in services to children and their families.

105. The local authority listens to, and acts upon, children's and young people's views throughout all levels of the organisation: from influencing front line practice, through to feeding into commissioning and strategy decisions. This was identified as an area for improvement in the last inspection and is now a notable strength.
106. Learning from national and local research regarding child sexual exploitation, multi-agency and themed audits, and problem profiling is understood at the most senior levels of the organisation. This has led to clear priorities being established to improve responses to children at risk, both in terms of identification and in reducing their risk of sexual exploitation. Leaders and managers have a good understanding of the priority areas for improvement and have clear and robust plans in place to address these. However, data regarding children missing education are not collated with other data regarding the most vulnerable children and therefore are not currently informing the local authority's and partners' understanding of potential risk and prevalence.
107. There are good working relationships between children's services, the Local Family Justice Board, CAFCASS and local designated family judge, both strategically and operationally. The public law improvement group, which includes CAFCASS, the local authority and members of the judiciary, shares data and promotes positive communication and liaison. This has led to improvement in the quality of public law outline (PLO) pre-proceedings work and assessments. There is less reliance on expert and independent assessments, which had been a contributory factor in delays in proceedings work. The length of care proceedings has significantly reduced over the last 12 months, demonstrating the impact of these positive working relationships.
108. The vast majority of social workers have manageable caseloads across the service; this enables managers to allocate work more often on the basis of skill and experience to meet children's needs. Senior leaders are aware of risks and threats to stability and retention of staff and these are clearly addressed and planned for within the workforce strategy. Key priorities are identified within the strategy, with outcomes and deliverables that are both realistic and ambitious. Short-term priorities are identified in addition to longer term strategies. For example, a short-term priority is to deliver a comprehensive training programme for the family safeguarding model to ensure frontline workers are sufficiently trained with the relevant skills and knowledge to work successfully alongside their multi-agency colleagues. This has already been successfully delivered to the existing family safeguarding teams.
109. Significant improvement in both recruitment and retention has been driven over the last 18 months by senior leaders. There are now very low vacancy and agency worker rates, with only 32 (8% of the total workforce) vacant posts being covered by agency workers. Of these, offers of employment have been made to 24 posts.

110. Supervision of staff is regular and clearly recorded, and is in line with the supervision policy. There is clear evidence that supervision includes case planning and reflection on most cases to drive improvement in practice and monitor compliance with statutory guidance. Training and development needs are addressed to encourage high standards of practice, and performance issues are sensitively and robustly managed. Front line staff have the opportunity to feed back issues to senior managers, both within supervision and via focus groups and roadshows. Front line staff spoken with on this inspection feel listened to and supported by their managers, with the roadshows appreciated as an opportunity to speak directly to the DCS about issues and ideas for improving practice.
111. The impressive, and well-established, manager and social work academies have contributed to making Hertfordshire an attractive place to work. The local authority recognises that spotting leadership potential and creating a strong 'grow your own' culture for the future is an important factor in retaining talented staff and succession planning. The social work academy provides induction and training for up to 30 newly qualified social workers at any one time and has some flexibility to meet demand through running additional academies where needed. There is clear impact from the academy on improving practice, for example, in the numerous good or outstanding assessments seen during this inspection.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

This is an effective LCSB which is meeting its statutory responsibilities. Under the leadership of a strong independent chair, it has engaged leaders at the highest level across the partnership in promoting children's safety, and has a strong influence on commissioning across public services. It has a good understanding of need and uses multi-agency data, audit, case review and child death review findings to monitor the quality of safeguarding practice and to identify areas for improvement. Further work is required to strengthen audit action plans.

The independent chair has effectively fostered a culture of openness, scrutiny and challenge, which permeates the board's work, both internally and across the partnership. This outstanding partnership working has enabled the board to respond to emerging safeguarding issues and develop strategic responses that positively impact on practice with children and their families.

The LSCB disseminates learning from case reviews well, without waiting for reports to be signed off and published. A self-assessment, a multi-agency case audit and a strategic problem profile have strengthened understanding of local issues relating to child sexual exploitation. Child level data is effectively brought together to inform risk assessment, although there is a need to strengthen the board's oversight of return home interviews for children who go missing and activity to disrupt and pursue perpetrators of child sexual exploitation. The board is appropriately planning an evaluation of early help.

The LSCB's learning and development framework sets out clearly the way it is delivering an appropriate range of safeguarding training. A comprehensive approach to evaluation helps ensure good quality, although further work is required to put in place a more systematic approach to training needs analysis, diversify the training offer and address under-capacity on some key courses.

Recommendations

112. Ensure that action plans are implemented in response to all case audits, showing how relevant partners are being held to account for the improvements required. (page 33, paragraph 118)
113. Ensure regular oversight of return home interviews and risk assessments for children who are going missing, in addition to the annual report to the board about missing children. (page 37, paragraph 131)
114. Implement the findings of its recent training review, including the systematic approach to training needs analysis, continue to diversify the training offer and minimise any delays for professionals who need safeguarding training. (page 39, paragraphs 140, 141, 142)

Inspection findings – the Local Safeguarding Children Board

115. The LSCB is appropriately constituted. It has successfully engaged senior leaders from partner agencies and ensured their regular attendance at board and executive meetings. Membership and attendance is sustained at subgroup level and at local multi-agency forum meetings, ensuring good support for the board's activities and engagement of front line professionals. This helps the LSCB to identify priorities for improvement and gives it greater influence over the help, protection and care children receive.
116. Acting on the findings of a recent LSCB peer review, the board has strengthened risk management and oversight of LSCB activity. The LSCB's risk register is now appropriately overseen at board level; previously this was delegated to a subgroup. The board has not yet made the best use of lay members, with no lay member attending three successive meetings in 2014–15. It has addressed this gap by recruiting two new lay members, who started their role during the summer of 2015.
117. The LSCB uses multi-agency audits well to monitor the quality of safeguarding practice and to identify areas for improvement. Audits undertaken in the last year focus on aspects of safeguarding where case reviews, multi-agency data and other intelligence indicate the need for investigation and challenge. They include audits of cases stepped down from child protection, neglect-related child protection work, safeguarding for disabled children and help and protection for young people experiencing child sexual exploitation.
118. Lessons for practice are identified by most audits. For example, the child protection neglect case audit revealed that, while the majority of cases involve issues of poor parental mental health, domestic violence and/or substance misuse, in too many cases families were either not accessing the relevant specialist services or this was not clear from the child protection records.

Identifying specific areas for improvement like this is an important part of the LSCB's role. The board continues to oversee improvements, by going back to conduct further audits in order to assess progress. It is not always clear what action plans are being implemented in response to some other case audits and how the relevant partners are being held to account for the improvements required.

119. The LSCB effectively monitors the numbers of children receiving early help assessments through its multi-agency dataset and it has provided an overview of this activity in its annual report. An audit is appropriately planned for later in 2015–16, which will consider the effectiveness of early help. An audit of practice in response to female genital mutilation is also due to take place later in 2015–16.
120. The LSCB monitors partner agencies' section 11 assessments well. These audits are undertaken on a three-year rolling programme, with assessments completed by Hertfordshire Constabulary, Hertfordshire Probation, NHS England and East of England Ambulance Service in 2014–15. Assessments by District Councils were also in progress at the time of the inspection. Assessments are closely scrutinised by the LSCB's Audit Subgroup and summarised in the LSCB's annual report. The LSCB Business Unit tracks progress on actions required.
121. The LSCB's multi-agency dataset and commentary reports help partners hold each other to account and to identify areas for improvement. For example, the board noted the very high 66% of child protection plans (December 2014) being made under the category of neglect compared to the 43% England average (March 2014). This led to an analysis by the local authority of all neglect cases where children had been subject to child protection plans for over 12 months, to establish whether cases needed to be stepped down to child in need plans or stepped up to care proceedings.
122. The direct involvement of, and leadership by, the independent chair has led to greater scrutiny of partner agencies' performance. A letter from the Chair to the Director of Children's Services in June 2015 demonstrates challenge to the local authority on performance in relation to children in need, including children with a disability. This robust challenge was well founded in case review findings and it set out in specific terms where improvement was needed. The letter prompted a review by the local authority of a sample of children's cases. The board has accepted a set of recommendations to improve scrutiny of and support for practice in this area.
123. The LSCB leads and supports a wide range of case review activity. It uses serious case reviews, unpublished partnership case reviews, single agency reviews and audits well to identify areas for learning and improvement. Decisions on whether or not to initiate a serious case review are supported by a clear rationale. Decision making in this area is strengthened by discussion and challenge within the LSCB and scrutiny from outside.

124. The board drives action plans to disseminate learning from case reviews well. Partner agencies provide good support to ensure that key messages are conveyed to front line workers and their managers through training, bulletins and practitioner events. Social workers who were interviewed by inspectors were clearly aware of recent serious case reviews and their implications for their practice. The LSCB is proactive in taking forward learning as lessons emerge from case reviews, rather than waiting for reports to be signed off and published. For example, it has put training in place to address a concern emerging from review findings about a risk of uncritical acceptance of parental self-report by professionals, which can leave children's needs and circumstances unassessed.
125. The board works collaboratively with the Hertfordshire Safeguarding Adults Board and with other safeguarding boards across local authority boundaries. For example, the LSCB is currently leading a joint serious case review regarding a care leaver who was 19 at the time of his death in a neighbouring authority area. The board is already acting on the emerging findings from this case review, with changes being made to patient databases to ensure that mental health service users who are care leavers are identified as such on patient databases. This will improve information sharing and strengthen the help that young people with mental health needs receive.
126. Children and young people have had limited direct involvement with the workings of the LSCB itself. The approach taken by the board has been to use its influence to ensure that partners listen well to young people, rather than the board carrying out its own separate consultations. For example, during the past year, the board has identified the need to strengthen its ability to listen to the views and experiences of children with disabilities. The board has supported learning and improvement events, such as an East and North Hertfordshire NHS Trust conference on Working with Disabled Children and the two Hertfordshire Disabled Children Conferences. This aspect also featured within the board's own 2014 annual conference and is a significant learning objective on its multi-agency 'Working with Children with Disabilities' training course.
127. The LSCB's threshold document, 'Meeting the Needs of Children and Families in Hertfordshire', provides an effective overview of how services will be provided, from early help through to specialist services. It provides practical guidance for practitioners on thresholds for targeted and specialist services and sets out options for supporting children and families clearly, including a focus on early help assessments and use of the graded care profile for children experiencing neglect. It also provides contact numbers for professionals who need additional advice.
128. A dedicated sub-group, which is supported well by a range of partners, works across LSCB work streams to ensure that policies and procedures are regularly reviewed and that revisions and additions are made to take account of issues and lessons emerging from case reviews, audits and other intelligence. These

revisions support improvement well. Recent examples of new and improved procedures focus on concealed pregnancy, female genital mutilation, transfer-in child protection cases and children missing from care.

129. Actions to tackle child sexual exploitation have accelerated significantly, with a multi-agency audit, a self-assessment and a strategic problem profile all produced in the last 12 months. The problem profile identifies the profile of victims and offenders involved in reported child sexual exploitation incidents in 2014–15 and provides an area-by-area analysis of risk factors and indicators for child sexual exploitation. No specific hotspot localities were identified, although two areas are noted as having a higher incidence of risk factors. This local analysis confirms that children who go missing and looked after children are more likely than their peers of being potentially at risk of sexual exploitation. The problem profile uses the analysis to make evidence-based recommendations, concerned with awareness raising, outreach and intervention in target areas and for children who are looked after or go missing. The LSCB has also led a 'Say something if you see something' public information campaign, to raise public awareness of child sexual exploitation and seek help from local people in tackling the problem.
130. These initiatives have been supported well by the LSCB through its Strategic Safeguarding Adolescents Group. This subgroup's membership and attendance are dominated by police and local authority children's services, with involvement of health services and the voluntary sector less consistent.
131. Child level data on child sexual exploitation and missing children is brought together in order to inform risk assessment. There is a need for further development, as the data analysis underpinning the child sexual exploitation strategic problem profile found some gaps in information sharing. Specifically, for a quarter of victims subject to the Police's specialist Halo team investigation in 2014–15, the team had no indication as to whether they were a looked after child, and just under a quarter did not have their status as missing or not missing listed; there is also currently a lack of detailed analysis of return home interviews for children who have been missing from home or care. Such gaps could make it harder to identify and address risk for vulnerable young people.
132. A survey conducted in late 2014 as part of the child sexual exploitation audit found that a significant number of schools were not offering any education programmes at that time to help young people understand potential indicators of exploitation and harmful relationships. LSCB minutes in March 2015 record concern that few child sexual exploitation referrals were being made by schools. Following this meeting the board has secured additional funding, which has enabled it to extend the delivery of Chelsea's Choice performances through schools. At the time of the inspection, young people in 47 secondary schools (53%) have seen a performance, with the funding now in place to roll this out to the remaining 42 secondary schools (47%) in the coming months.

Performances have also been provided for some older pupils in primary schools.

133. An audit of cases involving bruising to babies has identified a potential risk of under-identification of physical abuse. In response, partners have agreed a bruising protocol to support practice and a 'lite bite' course has been delivered and evaluated. Professionals, who have attended the training, report that it has increased their knowledge and confidence and there are signs of greater numbers of referrals coming through.
134. The Child Death Overview Panel (CDOP) process is efficient, well organised and sustains the involvement of key partners. Its analysis of cases where very young children have suffered sudden and unexpected death has enabled partner agencies to better understand contributing factors that can be influenced through targeted prevention. This intelligence has informed a 'Love Your Bump' poster campaign on the dangers of smoking in pregnancy, and new guidance to help midwives and health visitors tackle risks to babies from co-sleeping and unsafe sleeping environments. CDOP also considers the wider public safety implications of child death reviews, for example, recommending road safety improvements following reviews of traffic-related deaths.
135. The LSCB uses its scrutiny role well to influence priorities and plans that affect children and their families. It has produced a very comprehensive safeguarding strategic needs assessment, as the children's 'chapter' of the Hertfordshire Joint Strategic Needs Assessment. Drawing on this effective overview of need, and on intelligence from case reviews and audits about how well the system is working for children, the board effectively influences partner agencies' commissioning priorities and provides challenge and support to ensure these are taken forward.
136. The LSCB has highlighted the need for agencies to have a greater focus on tackling self-harm in the light of concerns raised by the CDOP and a serious case review into the suicide of a young person. It has initiated an analysis by public health of local prevalence data and helped to shape a major review of child and adolescent mental health services (CAMHS). It has used its influence to help ensure a strong focus on children's mental health as one of the Health and Wellbeing Board's three overarching priorities.
137. The LSCB continues to develop its influence on front line practice in addressing issues of children's self-harm. It has, for example, put in place and evaluated additional 'lite-bite' courses to improve the take-up of training on self-harm. These have been well received by front line staff. The board monitors self-harm through its multi-agency dataset; this shows that the level of hospital admissions resulting from self-harm has gradually reduced over the last five quarters.
138. The independent chair of the LSCB meets regularly with the Chief Constable, the Police and Crime Commissioner, the Director of the Mental Health Trust

and the Council Leader, Chief Executive and Lead Member for Children's Services. He also has frequent meetings with the local authority's Director of Children's Services. Working closely with these high-level leaders enables him to raise the profile of safeguarding and to influence organisational priorities. For example, the local authority's Overview and Scrutiny Panel has recently held full-day scrutiny meetings on the LSCB and on child sexual exploitation.

139. The LSCB's learning and development framework sets out clearly the way the board is delivering an appropriate range of good quality safeguarding training. Courses take account of the different levels of training that partner agencies require and these are provided in a number of different locations across the county. A differential charging policy has helped to ensure good take-up of training places. The LSCB has a comprehensive approach to monitoring the quality and effectiveness of its multi-agency training courses. This includes direct observation by evaluators and participant feedback. Follow up emails and telephone calls are also used to assess how participants have put their learning into practice.
140. The board executive has recently received the report of a review of safeguarding training, which the board commissioned. This review found that the budget allocated for multi-agency training is modest in comparison to other LSCBs in the region, when the size of the county is taken into account. It also found that the board has made limited use of e-learning options and relied more heavily than other LSCBs on face-to-face training delivered by serving practitioners. This has meant that the demand for some courses has been difficult to meet.
141. As a result, some services have experienced delays in getting staff through multi-agency training. Training on the use of the graded care profile tool, to assist in assessment for children at risk of neglect, and level two multi-agency safeguarding courses, have been consistently over-subscribed. A review by inspectors of one quarter's attendance data shows that the bulk of attendees at multi-agency training are from children's social care, community health and early help services, with more limited take-up by early years providers, schools and colleges.
142. In response to the issues identified by the training review, the LSCB has identified a board member to provide a stronger strategic lead on training and development.
143. The 2014–15 annual report is comprehensive and meets statutory requirements. It covers the main areas of the LSCB's work, such as audit, training, CDOP, SCRs, child sexual exploitation and early help. It provides a good overview of the effectiveness of safeguarding across Hertfordshire and highlights areas for improvement identified through case reviews, audits and analysis. The report draws on multi-agency and partner datasets to provide more in-depth analysis in key areas, such as child sexual exploitation. The

LSCB is at the early stages of considering their role regarding the potential for young people to become radicalised.

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 9 of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Jansy Kelly

Deputy lead inspector: Tina Shepherd

Team inspectors: Louise Hocking, Louise Warren, Jenny Turnross, Harmesh Manghra, John Mitchell, Karen Wareing and Ian Young

Senior analytical officer: Stewart Hartshorne

Quality assurance manager: Jeremy Gleaden (Senior HMI)

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Manchester
M1 2WD
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Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk
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