

Luton Borough 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

Inspection date: 11 January 2016–4 February 2016

Report published: 29 March 2016

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

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

Executive summary

Children's services in Luton require improvement. Senior managers and leaders recognise that the help and support that children and families receive is not good enough. They have spent most of the last 12 months putting in place the systems, structures and processes needed to address the shortcomings and deliver sustainable improvements. More work is required before services for children can be considered good.

Governance arrangements have been strengthened. The volume and quality of performance management information have improved, as has the level of scrutiny and critical challenge. However, although the help and support that children receive from children's social care is improving, it is not yet good enough.

Early help services have been restructured to strengthen the interface with children's social care. The number of early help assessments has increased significantly. A good understanding of the thresholds for access to children's social care ensures a prompt response to contacts and referrals in the vast majority of cases. Professionals are able to get advice and guidance from social workers based in the duty team, but feedback to referrers on the progress of referrals is poor (Recommendation).

Consent is routinely sought and recorded. Child protection investigations are timely, although strategy meetings are not always used to best effect to shape these investigations. Although inspectors did not identify any children who were at immediate risk of significant harm, they found delays in the start and completion of assessments. Most assessments require improvement.

While most core groups and child protection conferences are well attended, the chairs of child protection conferences are not consistently providing the right level of critical challenge. Child protection plans are not sufficiently child-centred, focused on outcomes, specific or measurable. However, partner agencies work well together to safeguard and protect the children and young people. Information is shared effectively. The voice of children is not well reflected in case records and assessments.

Strategic and operational arrangements have been strengthened significantly in response to the thematic inspection of child sexual exploitation in late 2014. There is increased awareness at all levels of the risks associated with sexual exploitation.

Close cooperation between the local authority and the police, and good awareness and understanding among partners of the threat of radicalisation, have led to an increase in referrals to the Channel panel from early intervention services.

Further work is required to make sure that all children are offered return home interviews (RHIs). The information gathered from those RHIs that do take place is being used effectively to safeguard and protect children. The absence of a shared database on child sexual exploitation and children who are missing from home and care and education, makes it difficult to maintain an effective overview and

undermines the ability of agencies to respond proactively.

Private fostering is still not being given a sufficiently high profile.

When it is not safe for children to remain at home, appropriate protective action is taken, although pre-proceedings work requires improvement. Inspectors saw no evidence of children being looked after who did not need to be.

A product of poor-quality assessments, child care plans lack clear timescales, are not sufficiently focused on outcomes and do not reflect well the wishes and feelings of children and young people. Independent reviewing officers do not consistently provide the right level of critical challenge. As a result, reviews are not always effective in progressing plans for children.

The majority of children live in good placements, which meet their needs and help them to achieve. For some children, there is drift and delay in making decisions about placements because of a lack of urgency and understanding of the importance of permanency planning.

Most children looked after attend a good or outstanding school. Effective use of personal education plans (PEPs) means that in most cases there is a good link between academic and personal targets. School attendance is good. Exclusions are low. Attainment is improving.

While the completion of health assessments is in line with comparators, initial health assessments are not being completed in a timely fashion. Placement choice is not improving quickly enough. A shortfall in suitable foster placements is making it difficult to place sibling groups together.

Adoption is not routinely considered for all children who are unable to return home safely. While the number of adoptions has increased and timescales are improving, children are still waiting too long to be adopted. Prospective adopters are well prepared and assessed. Adoption breakdowns are extremely rare, owing to good post-adoption support.

Most care leavers say that they feel, and are, safe. The majority of pathway plans are good and care leavers are well supported to develop independent living skills. Care leavers have access to a good range of accommodation options. The number of young people who are not in education, employment or training is comparatively low. Although they receive good-quality information about their rights and entitlements, further work is required to ensure that all care leavers receive a health passport.

The average size of social workers' caseloads is falling, but remains high in the referral and assessment team. Social workers are not yet consistently receiving high-quality supervision and there are weaknesses in the level and quality of management oversight of practice. For some children and families, frequent changes of personnel have had a negative impact on children's ability to build and maintain meaningful relationships with their social workers and have contributed to drift.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The previous inspection of the local authority's safeguarding services for children and young people was in April 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was also in April 2012. The local authority was judged to be adequate.
- The local authority operates one children's home. This home was judged to be good in its most recent Ofsted inspection.

Local leadership

- The director of children's services has been in post since July 2014.
- The chair of the Local Safeguarding Children Board has been in post since September 2015.

Children living in this area

- Approximately 54,700 children and young people under the age of 18 years live in Luton. This is 26% of the total population in the area.
- A significantly higher proportion of the local authority's children are living in poverty, compared with regional and national averages.
- The proportion of children entitled to free school meals:
 - in primary schools is 18% (the national average is 16%)
 - in secondary schools is 20% (the national average is 14%).
- Children and young people from minority ethnic groups account for 61% 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 Asian British and Black and Black British.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 52% (the national average is 19%)
 - in secondary schools is 48% (the national average is 15%).

Additional contextual information

- Luton is in the top quartile of England authorities for child poverty and is the 47th most deprived local authority in the country. One in four (14,769) children in Luton live in poverty, using the national definitions. The levels of deprivation

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.

affecting children in Luton are high, with several wards having output areas in the top 10% most deprived areas in the country.

- More than 120 languages are spoken in Luton. Half of all school children do not speak English as their first language.

Child protection in this area

- At 30 November 2015, 1,916 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,480 at 31 March 2015.
- At 30 November 2015, 158 children and young people were the subject of a child protection plan. This is a reduction from 241 at 31 March 2015.
- At 30 November 2015, two children lived in a privately arranged fostering placement. This is a reduction from five at 31 March 2015.
- Since the last inspection, nine serious incident notifications have been submitted to Ofsted. Five serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 30 November 2015, 388 children were being looked after by the local authority (a rate of 71 per 10,000 children). This is a reduction from 399 (73 per 10,000 children) at 31 March 2015. Of this number:
 - 181 (47%) live outside the local authority area
 - 24 live in residential children's homes, of whom 79% live outside the authority area
 - seven live in residential special schools;³ all of these children live outside the authority area
 - 290 live with foster families. Of these, 41% live outside the authority area
 - 22 live with parents. Of these, 32% live outside the authority area
 - 13 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - 20 children have been adopted
 - 28 children became the subject of special guardianship orders
 - 180 children ceased to be looked after, of whom 9% subsequently returned to being looked after

³ These are residential special schools that look after children for 295 days or less per year.

- 16 children and young people ceased to be looked after and moved on to independent living
- one young person ceased to be looked after and is now living in a house of multiple occupation.

Recommendations

1. Significantly reduce the average size of social workers' caseloads in the rapid intervention and assessment team.
2. Ensure that professionals routinely receive feedback on the response to, and progress of, referrals that they have made to children's social care.
3. Ensure that all staff receive regular, high-quality supervision that is appropriately challenging and provides a robust audit trail of decisions taken and action agreed. Ensure that managers have appropriate training to support this.
4. Ensure that, as key agents of change, the chairs of child protection conferences and independent reviewing officers act as passionate advocates for children and young people by consistently providing rigorous oversight and robust challenge.
5. Ensure that all assessments: are of a consistently good standard; take full account of the needs, wishes and feelings of children; effectively consider the impact of equality and diversity; include a robust analysis of needs, risks and protective factors; and provide clear recommendations.
6. Ensure that all plans are easily accessible, focused on outcomes, specific and measurable.
7. Ensure that strategy discussions include an appropriate range of professionals and agencies, including health partners, and are used effectively to inform and shape child protection enquiries.
8. Ensure a more robust approach to the use of the Public Law Outline in pre-proceedings work so that progress is effectively monitored and maintained and families understand what is required and expected of them.
9. Ensure that there is a suitable range of placements available to meet the current and future needs of children looked after, not least so that siblings can be placed together when appropriate.
10. Ensure that senior managers and leaders make best use of existing information and data about children who are missing from home, school or care and those who are at risk of exploitation, including child sexual exploitation.
11. Ensure that adoption performance data and trends are rigorously analysed in order to understand why older children and children from some ethnic minority communities appear less likely to be considered or placed for adoption.

12. Ensure that life story work is completed with children who are in the process of being adopted, so that they are well prepared before they move in with their adoptive families.

Summary for children and young people

- Children and families in Luton are able to get the help and support that they need when they first need it.
- Schools are particularly good at trying to make sure that children and families get the help they need quickly.
- Grown-ups are working hard together to try to stop people hurting children or young people or getting them to do bad things.
- The local authority and the police are working well together to keep young people safe from potential radicalisation.
- Children are not yet getting a good enough service from children's social care.
- Social workers protect children when they are in danger, but some children and families have to wait too long before they get other kinds of help.
- Social workers talk to children and young people, but sometimes they do not listen properly.
- Some social workers have too much work to do, which stops them from doing a good job.
- Some children's social workers keep changing, which makes it hard for children and young people to get to know and trust their social workers properly.
- Things are getting better, but managers need to do more to make sure that all children and families get a good service.
- Most children and young people who are not able to live with their own families are living with foster carers.
- There are not enough foster families who can look after brothers and sisters together.
- It is not always easy for children and young people to understand who is going to do what to help them or when.
- In order to keep children safe, Luton Borough Council and the police need to do more to make sure that they use the information they have about children who are missing from home, school or care or who are at risk of being sexually exploited.
- When it is not safe for children and young people to go home ever, some of them have to wait a long time before they find a new family.
- When the time comes for young people to leave care they get lots of help and support to prepare them for independence.
- Some young people are able to stay with their foster families, even beyond the age of 18 years.
- Many young people who used to be in care are going to college or university, but they do not always get enough information about their health histories.

The experiences and progress of children who need help and protection

Requires improvement

Summary

Children benefit from effective early help services, which have been restructured to strengthen the interface with children’s social care. As a result, the number of early help assessments has increased significantly in the last year. Arrangements to escalate cases to social care when risks increase have also been strengthened.

Good understanding of the thresholds for access to children’s social care means that most referrals are appropriate and timely. Professionals are able to get advice and guidance from social workers based in the duty team, although feedback to referrers on the progress of referrals is poor. Contacts and referrals are responded to promptly in the vast majority of cases. Consent is routinely sought and recorded. While child protection investigations are timely, strategy meetings are not always used to best effect to shape them. Inspectors did not identify any children who were at immediate risk of significant harm, but did see evidence of delays in the start and completion of assessments.

Most assessments require improvement. A lack of robust analysis is a common problem. The voices of children and young people are not well articulated in case records or assessments. Direct work with children does not appear to be a consistent feature of social workers’ practice. The quality and effectiveness of management oversight needs to be strengthened.

Core groups and child protection conferences are well attended. Information is shared effectively and partner agencies work well together to safeguard and protect children and young people. However, the chairs of child protection conferences do not consistently provide the right level of critical challenge. Furthermore, child protection plans are not sufficiently child-centred, focused on outcomes, specific and measurable (Recommendation).

Close cooperation between the local authority and the police, and good awareness and understanding among partners of the threat of radicalisation, has led to an increase in referrals via early help to the Channel panel.

While information and intelligence from return home interviews (RHIs) are being used effectively to safeguard and protect children, further work is required to make sure that all children who go missing are offered RHIs. The absence of a shared database on child sexual exploitation and children who are missing from home and care and education, makes it difficult to maintain an effective overview and undermines the collective ability to respond proactively.

Private fostering is not being given a sufficiently high profile. Equality and diversity are not consistently well considered in all cases.

Inspection findings

13. Well-developed early help services ensure that children, young people and families are able to get the help and support that they need to tackle problems as soon as possible. An arrangement with the local airport provides £4 million worth of ring-fenced funding for voluntary sector services, including a young carers' service, weekend and summer support schemes for children with disabilities and youth groups for young people from the Bangladeshi and Pakistani communities. A range of sexual health and drug and alcohol services are commissioned through a well-established joint commissioning arrangement, as is the local child bereavement and trauma service.
14. The Flying Start programme, which is part of the early help strategy, is bringing together children's centres, health visitors and school nurses alongside other early help services, including the early help hub. The aim is to strengthen the focus on prevention and early intervention by developing a more integrated approach to services for children aged five years and under. With an extensive consultation programme already underway, plans are well advanced to restructure the seven children's centres and 16 satellite 'hubs' in order to deliver a more robust core offer of services. With good links to health visitors, the support workers for young fathers and young mothers are increasing the level of engagement with young parents. Working closely with school nurses, a dedicated health and schools coordinator has had a significant impact in taking the public health agenda into schools and improving the quality of personal, social and health education (PSHE) by making sure that it encompasses radicalisation, child sexual exploitation and mental health.
15. Schools recognise the importance and significance of early help. They provide effective early support to families when need is first identified and/or direct them to other early help services as appropriate. With family support workers funded by, and based in, schools, the number of early help assessments (EHAs) has more than doubled, from 525 in 2014–15 to 1,191 in the first nine months of 2015–16. Of the 1,191 EHAs, 45% were generated by schools. Schools and other partners are increasingly willing to take on the role of the lead professional, coordinating help provided for individual children and their families.
16. Early help services have been restructured to ensure a better fit with children's social care. The early help hub, established in September 2015, provides advice and guidance to partners, sorts and filters EHAs to ensure that children and families get the right support and facilitates a 'team around the child' when the needs of the child or family require a more coordinated response. Weekly allocation meetings ensure sufficient management oversight. When risks increase, cases are escalated appropriately to children's social care. As confidence in the effectiveness of early help increases, partners

are less inclined to make inappropriate referrals to children's social care. This enables social workers to concentrate on those children and families who need their help and support the most.

17. Timely and effective work delivered by early help services at tiers two and three is improving outcomes for children and families. Flexible working hours mean that the Stronger Families team is able to provide intensive support when it is most needed.
18. Families with no recourse to public funds are well supported while they try to confirm their immigration status. They are given accommodation and financial assistance to prevent them and their children from becoming destitute.
19. Thresholds for access to children's social care are well understood and applied. Professionals are able to access advice and guidance from social workers in the rapid intervention and assessment team. Children and young people who are at risk or in need of social work intervention are identified and referred appropriately to children's social care by partner agencies. In almost all cases seen, the quality and timeliness of referrals were appropriate. However, a small minority of referrals lacked sufficient detail. This meant that further information had to be obtained by the duty social worker before it was possible to make a decision about the most appropriate response, resulting in a short delay for the children and families concerned.
20. Suitably qualified social workers with effective management oversight make decisions. A timely and appropriate response to the majority of contacts and referrals ensures that there is a steady throughput of work. Consent is routinely sought and recorded. However, referrers do not consistently receive feedback on the progress of referrals. A letter template is being developed for this purpose, but it is not yet available for use. Headteachers were particularly critical about the feedback from children's social care, which they described as poor. This impacts on the ability of schools and other partners to know what is happening and track progress.
21. When safeguarding issues and concerns are first identified, the initial response is timely. Decisions about whether or not to carry out a section 47 enquiry, on a joint or single agency basis, are appropriate in almost all cases. Inspectors did not see any evidence of children and families being subjected to child protection procedures unnecessarily. However, most strategy discussions involve the police and children's social care only and are not well used to shape, inform and plan investigations. This was not seen to impact on children's well-being or safety (Recommendation).
22. With easy access to the local authority's electronic case management system and good links to daytime services, the emergency duty team, shared with the two neighbouring local authorities, provides a timely and effective response to referrals outside of normal office hours.

23. While most social workers are able to talk knowledgeably about children's wishes and feelings, case records do not always make it clear that children have been seen and seen alone by their social workers. Inspectors saw limited evidence of direct work with children and, despite having been given direct work tool bags by the local authority, social workers were not always able to describe what tools they would use to help them understand and make sense of children's experiences. For some children and families, repeated changes of personnel have made it difficult for them to build and maintain meaningful relationships with their social workers. This has contributed to drift and delay in implementing plans, hindering efforts to promote change within families.
24. Senior managers have had some success in reducing the average size of social workers' caseloads, particularly in the neighbourhood teams and the children with disabilities team. However, caseloads remain stubbornly high in the rapid intervention and assessment team, where approximately a third of the staff are employed on agency contracts. As well as having an impact on the quality of work, high caseloads are also contributing to drift and delay in the start and completion of assessments. As a result, some children and young people have to wait longer before they receive the help and support that they need (Recommendation).
25. Assessments require improvement. While social workers recognise significant harm and identify and respond to immediate risks, their assessments are not consistently well developed and lack robust analysis. In some cases, risks and strengths are not described clearly enough. In other cases, less acute risks are not fully explored. The voice of the child is frequently absent and it is not always evident that children's wishes and feelings are being taken fully into account or being used effectively to inform their plans. This is particularly true when there is more than one child in the family and assessments fail to differentiate clearly between the needs of individual children (Recommendation).
26. Most child protection plans require improvement. The template used is not child-friendly or easily accessible. Outcomes are not clearly articulated and plans lack specific and measurable targets and/or timescales with which to assess progress and hold partners to account. However, this was not seen to impact on children's well-being or safety (Recommendation).
27. Most core groups and child protection conferences are well attended. Information is shared effectively and, despite the limitations of child protection plans, agencies work together well to manage risks and deliver better outcomes for children. However, progress between reviews is limited in some cases, sometimes because there has been a change of social worker. This means that some children remain on child protection plans for longer than they need to.

28. Some good examples of child in need plans were seen, particularly in the children with disabilities team. These plans were clearly focused and regularly reviewed, leading to good outcomes for children and young people.
29. Step up and step down arrangements are effective, although the relevant procedure, updated in October 2015, has not yet been fully implemented. A representative from the early help team now attends the weekly case transfer meetings in children's social care. Furthermore, a 10-day case transfer rule has been introduced to ensure that cases continue to be held by the transferring team until children and families have been introduced to their new social workers. However, inspectors saw a small number of cases where the transfer had gone ahead without the benefit of a formal handover meeting. This risks compromising continuity and is not helpful for children and families.
30. The local authority has adopted a whole-systems approach to electronic case management. This is in recognition of the need to ensure that managers are able to exercise robust oversight of the experience and progress of individual children as they move between early help and children's social care services. Social workers will have online access to early help assessments within the next few weeks, increasing their understanding and awareness of children and families' case histories.
31. The level and quality of management oversight in the rapid intervention and assessment team and the neighbourhood teams is not sufficiently robust. Further work is required to ensure that all social workers receive regular, high-quality supervision which offers opportunities for reflection and critical challenge in equal measure. Currently, the focus is primarily on compliance rather than quality. Nevertheless, inspectors saw evidence of drift and delay (Recommendation).
32. Multi-agency risk assessment conferences are effective in sharing information, identifying risks and developing appropriate responses to protect children affected by domestic abuse. There is good attendance at these conferences by a range of partner agencies, including children's social care. Attendance by children's social care at multi-agency public protection meetings is less than good. Lack of consistent attendance at these meetings inhibits the flow of information and intelligence and limits children's social care's contribution to public protection planning.
33. The risks associated with radicalisation are clearly seen as a safeguarding issue. Strong partnership working at both a strategic and operational level between the local authority and the police is having a positive impact. The number of referrals to the Channel panel has increased from 21 in 2014/15 to 30 in the first nine months of 2015/16.
34. Male and female Channel 'interventionists' are being deployed sensitively and intelligently to assess potential vulnerabilities and help reduce risks. Channel

partners recognise that they need to improve the recording and reporting of their impact and effectiveness.

35. The local authority maintains a list of children identified as missing from education. Once children missing from education are known to the local authority they are monitored and action is taken to escalate any concerns. Schools play their part by notifying the local authority when pupils are taken off roll or fail to arrive at the time of admission. Education welfare staff are active in trying to resolve non-attendance directly with parents. At the time of the inspection, 13 children were known to be missing from education. Senior managers responded swiftly and took decisive and well-considered action upon the discovery of two private education providers who were breaching the law in respect of registration or not operating safely. Senior managers have put in place a range of measures to address the issue of children who, though not technically missing, are not in education. This includes the development of a single central register of providers of education and childcare, which will enable colleagues to check providers' status and provide information about the most recent regulatory visits.
36. Parents who choose to, or are thinking about, electively home educating their children are given up-to-date information. This covers, for example curriculum guidance as well as information about parents' obligations and the action the local authority may take if it is not satisfied that children are being appropriately educated. The local authority also maintains, as best as it is able, a current list of children who are being home educated. The local authority recognises that parents are not under any legal obligation to notify it if their children are home educated and that some parents prefer to avoid all contact with the local authority.
37. While children who go missing from home are offered return home interviews, the way in which these interviews are recorded makes it difficult for the local authority to assure itself that the existing arrangements are sufficiently robust. Currently, there is no direct correlation between the number of children who go missing, the number of missing episodes and the number of interviews offered and completed (Recommendation).
38. Over 1,000 staff from across the council responded to a recent survey on child sexual exploitation by saying that they knew what to look for and who to tell if they suspected a case. A dedicated team provides a single point of contact for issues and concerns about child sexual exploitation, missing children and domestic violence that do not meet the threshold for children's social care. Members of the single point of contact team undoubtedly know what is happening on a day-to-day basis and are effective in mobilising appropriate help and support. However, in the absence of an integrated approach to data on children who are missing from home, school and education and those who are at risk of child sexual exploitation, the local authority cannot be assured that it has a coherent overview or that it is able to identify trends, patterns and possible connections. While risk assessments are being completed and

most cases result in appropriate protective action, assessments are not being updated with sufficient regularity (Recommendation).

39. In one case seen by inspectors, a good awareness of the issues relating to female genital mutilation and effective sharing of information led to a swift protective response, resulting in a successful application for a female genital mutilation prevention order.
40. Arrangements for responding to allegations about adults in positions of trust are satisfactory. Appropriate action is taken to protect children. However, the lack of a bespoke system to record and monitor the progress of cases means that the level of critical scrutiny is limited. More work also needs to be done to increase awareness of, and engagement with, faith communities and with voluntary and other community groups. Currently, most of the referrals to the designated officer are from schools.
41. With access to good-quality information about their rights and entitlements, homeless 16- and 17-year-olds are supported to make informed decisions about whether to accept help and support under section 17 or section 20 of the Children Act 1989. Although not always completed by a qualified social worker, assessments are routinely signed off by a team manager. In one case, the assessment identified an issue regarding forced marriage, which led to an appropriately protective response. Six of the seven cases sampled resulted in young people being offered suitable accommodation; the seventh young person was supported to remain in their family home.
42. Private fostering is not, and has not been, given a sufficiently high profile. At the time of this inspection, there was only one child who was known to be living in a private fostering arrangement; two fewer than in September 2015. More needs to be done to ensure that children who are living informally with people to whom they are not related are properly safeguarded.
43. Issues associated with equality and diversity are not consistently well considered in all cases, although inspectors did see some good use of interpreters with children and families. In addition, some services are provided in community languages, including the Freedom programme.
44. Currently, very few children or young people are making use of the advocacy service to enhance their participation in, and contribution to, child protection conferences. The most recent quarterly return shows that only four young people exercised their right to complain.

The experiences and progress of children looked after and achieving permanence

Requires improvement

Summary

Decisions to look after children are made appropriately and the immediate risks to children are well considered. Most children live in stable placements and increasing numbers are achieving permanence through special guardianship orders. However, for many children, progress towards the development of a long-term plan leading to permanence is too slow. Assessments do not analyse children’s needs sufficiently well and the resulting plans lack focus and clear timescales for change. Visits to children are not planned and purposeful, making it harder to move plans forward.

Most children who go missing from care have a return home interview, although some interviews are not undertaken quickly enough. The response to children looked after who are at risk of sexual exploitation requires improvement; assessments and plans are not updated regularly enough in all cases.

The virtual school works well with partners to promote children’s achievement. Personal education plans are of variable quality, with some good examples seen. There is still more work to do to ensure that the attainment of children looked after more closely matches that of their peers, particularly at GCSE.

Children’s reviews do not consistently drive plans forward. While independent reviewing officers have begun to escalate concerns more frequently, this has not yet had a significant impact on the quality of practice. Placement choice is not improving quickly enough. The local authority understands what placements it needs but progress has been too slow, particularly for groups of brothers and sisters. However, a high proportion of children are living in family placements.

When children are unable to return home or to their families, adoption is not routinely considered as a permanent alternative option and some children are waiting too long to be adopted. The adoption panel provides effective scrutiny and has challenged the inconsistent quality of child permanence reports. Life story work is of good quality but is not being completed before children move to live with adopters. Effective post-adoption support services are provided in a timely manner.

Support given to care leavers is good. Most care leavers have effective pathway plans to prepare them for independence. Young people speak positively about the services and support they receive, including good-quality housing. Education, training and employment opportunities are actively promoted. Young people are encouraged to achieve. Health support is developing; however, care leavers are not yet taking up all the support that is available to help them stay healthy.

Inspection findings

45. At 31 March 2015, 400 children were looked after by Luton Borough Council. This represents a rate of 73 children per 10,000 of the population, slightly lower than the rate for similar local authorities. At the time of the inspection, there were 388 children looked after, a reduction of 3% since March 2015. The proportion of children looked after under voluntary agreements is in line with national figures. Last summer, the local authority audited these cases in order to assure itself that their legal status was appropriate. This resulted in a number of cases entering proceedings.
46. In most cases, children and young people are looked after appropriately; risks both from others and from their own behaviour are well managed. Inspectors did not see any cases where children were looked after who should not have been.
47. The pre-proceedings process under the Public Law Outline is not sufficiently robust in progressing plans for children and making clear to parents what changes they need to make. Inconsistent monitoring and review contributes to drift and delay in many cases. Letters before proceedings are too long. They lack focus on outcomes for children, do not always set out clear, realistic timescales and do not list actions in priority order. This makes it difficult for parents to understand what they need to do to stop the local authority going to court (Recommendation).
48. While care applications are accepted by the courts, the quality of statements and care plans is not consistently good. Assessments of family members are completed in good time and those seen covered the required information well. The average length of care proceedings has reduced from 50 weeks in 2013–14 to 30 weeks in 2014–15. This remains above the national target of 26 weeks, but is in line with the latest national figure of 29 weeks. Cafcass reports that the standard of the local authority's work is improving.
49. When children return home, risks are assessed appropriately beforehand in the majority of cases. However, once children return home, they do not always benefit from effective, focused child in need plans to support and direct ongoing work, drive progress and ensure that the right resources are in place to meet their needs. Despite this, the number of children returning to care for a second or subsequent time is low; only eight of the children looked after at the time of the inspection (2%) had been previously looked after. Inspectors saw no evidence to suggest that this was a product of risks to children being overlooked.
50. When children go missing from care, return home interviews are routinely undertaken, although in some cases delays in making the referral for an interview mean that children are not seen until sometime later. This limits the effectiveness of return home interviews as tools to help understand why young people go missing and to help reduce the risks of this happening again.

Once completed, return home interviews describe the reasons for young people going missing well enough to allow identification of risk factors.

51. The response to children looked after who are at risk of child sexual exploitation requires improvement. No cases were seen where the risk to the child or young person had not been recognised. On the contrary, those working with children are well aware of the risks associated with child sexual exploitation and know how to respond when risks are identified. However, risk assessments are not consistently updated. As a result, the local authority's list of children looked after who are at risk of sexual exploitation is not totally reliable. Some young people remain on the list even when the risks have receded or no longer apply. This means that the local authority does not have an up-to-date picture on which to base its strategic and operational responses (Recommendation).
52. Only a very small minority of cases demonstrate effective and timely decision making. In some cases, there are significant gaps in supervision records and limited evidence of management oversight, sometimes over a period of several months. Supervision records do not demonstrate that supervision is effective or challenging; supervision notes are brief and descriptive, lack evidence of reflection and do not give clear timescales for actions. For some children this has contributed to drift and delay in achieving permanence (Recommendation).
53. Most assessments of children's needs require improvement; they were judged to be good in less than a third of cases tracked by inspectors. In some cases seen, there was no recent, relevant assessment to demonstrate that the local authority had fully understood the child's needs. Additionally, the quality of analysis is often poor. Better assessments seen made good use of history to understand children's circumstances and set out risks well (Recommendation).
54. The poor quality of assessments is reflected in the poor quality of care plans, which are good in only a very small minority of cases. Care plans lack clear, focused outcomes and timescales, are not updated to reflect current circumstances and are not sufficiently comprehensive. In some cases, key outcomes are not addressed. Children and young people are not always supported to understand their care plans and are not always engaged in producing or implementing them (Recommendation).
55. Permanence is achieved without delay for only a small minority of children. Not all children have detailed permanence plans, and inspectors saw little evidence of the use of parallel planning. When permanent placements, or plans for permanent placements, break down the response is inconsistent. Children are not always helped to understand what has happened or why and in some cases alternative permanent arrangements are not put in place quickly enough within the child's timescales.

56. While social workers know the children they are working with well and are able to articulate children's wishes and feelings, the voices of children, young people and families are not well reflected in case records. They were absent altogether in over half of the cases tracked by inspectors. Similarly, while statutory visits are taking place, the way in which they are recorded reflects a lack of purpose, with little evidence of meaningful work being carried out with children. It is difficult to see how assessments and plans are influenced by what children say and feel. Conversely, when talking about the children they are working with, it is readily apparent that social workers know the children well and are adept at articulating children's wishes and feelings (Recommendation).
57. Children have access to advocates who help them contribute to their looked after reviews and support them well when, for example there are issues about family contact or difficulties in their placements. Young people and carers speak positively about the advocacy service. Eight young people have independent visitors and some of these relationships are long-standing. However, a further eight young people are waiting for an independent visitor to be identified. In some cases, this is because social workers had not provided enough information for a match to be made.
58. An established virtual school team maintains good contact with schools both within and beyond the local authority's boundaries. The virtual school team links well with partner agencies and increasingly with children's social care to support and strengthen the education of children looked after. Educational outcomes for this small cohort were slightly improved in 2015, with seven of the 17 children eligible (41%) achieving level 4+ in reading, writing and mathematics. This compares favourably with previous years but falls well below the 73% for all Luton children. At GCSE, five of the 33 pupils (15%) achieved at least five GCSEs at grades A* to C compared with 12.9% the previous year. While these are incremental improvements, the local authority recognises that the poor educational attainment of children looked after is still a concern.
59. The majority of children looked after attend a good or outstanding school. Decisions made by virtual school staff about school placements are informed by children's social and emotional needs balanced with children's need for stability. School attendance is good and exclusions are low, comparing favourably with statistical neighbours.
60. The virtual school team is effective in promoting children's wider social and emotional development through enrichment activities, trips and personal support. Its interventions to support children are timely and carried out in close cooperation with designated teachers. The virtual school team also provides effective training and networking opportunities for designated teachers. These events are well attended.

61. Personal education plans (PEPs) are useful in informing the planning of children's education albeit with some marked variability in their quality. The better plans provide a sufficient depth of analysis, read coherently, achieve a balance of detail and brevity and make good connections between academic and personal targets. Some plans include helpful comments from virtual school staff, giving additional weight to the actions agreed in the document. Attendance at personal education planning meetings by carers and partner agencies is good, invariably leading to a better, shared understanding of the child's needs. Improvement and forward planning by the virtual school are not yet sufficiently well developed as evidenced, for example by the weak application of data in relation to children's progress (Recommendation).
62. There is a clear and coherent approach to using alternative education to meet children's needs. The range and diversity of provision, whether therapeutic or activity-based, is good. The local authority maintains an up-to-date list of alternative education placements, with the right level of detail, including reasons for referrals and hours of access to education. It keeps a tight grasp on the quality of alternative provision and supports and challenges its providers well.
63. Knowledgeable local authority staff support schools well in relation to anti-bullying and e-safety work. Local research and good networks ensure that schools are well informed about the nature of young people's risk-taking behaviours. The local authority provides responsive support to schools through staff development, bespoke guidance and the offer of curriculum opportunities, as well as through theatrical productions designed to raise children's awareness about personal safety.
64. Looked after reviews pay good attention to children's health and well-being. The completion of annual health assessments has improved significantly and is now in line with national figures. Recognising that too few initial health assessments were being completed on time, the local authority is taking decisive action with its health partners to rectify the situation. Children whose mental health and emotional well-being is a concern receive an effective response from the Child and Adolescent Mental Health Service (CAMHS).
65. Children benefit from a range of leisure activities, which helps them to enjoy and achieve. Sports and leisure activities are considered as part of looked after reviews, although where it is reported that children do not have any extra-curricular interests, discussions could and should be more robust. Foster carers have a clear understanding of delegated authority, although the terms of this are not consistently updated to reflect changing circumstances.
66. The majority of children live in good placements with carers who meet their needs, help them to achieve and show commitment to them. Of those children looked after at the time of the inspection, 40 (10.3%) had had three or more placements in the previous 12 months. This is in line with Luton's past

performance and with the most recently available figures for similar local authorities.

67. Just under half (48%) of children looked after are placed beyond the local authority's boundaries. Almost a quarter are living more than 20 miles from home. However, children are encouraged and supported to maintain contact with the people who are important to them, even, for example, when children are living some distance from family and friends. When contact needs to be supervised, the local authority's contact centre provides a safe environment in which it can take place.
68. Most children (84%) are living in family placements. There are 20 children (4%) placed with their own parents, in line with the most recent national figures but slightly below those for similar local authorities. Of those 20 children, six (30%) live beyond the local authority's boundaries.
69. Although sufficiency needs are well understood, progress in meeting them has been slow. The local authority recognises that it needs to recruit foster carers from just beyond its borders, where the housing stock makes it more likely that potential carers will have a spare room available. However, the fostering service has not yet managed to recruit the right mix and range of foster carers required to meet the current and future children looked after population in Luton. The lack of in-house placements is mitigated to some extent by well-established arrangements for commissioning external placements. However, it is not always possible for brothers and sisters to be placed together (Recommendation).
70. In a third of the cases seen, looked after reviews were not sufficiently effective in progressing plans for children, either because actions were not being completed between reviews or because a lack of specificity made it difficult to progress actions. In some cases, independent reviewing officers clearly know children well and have a good understanding of their needs. While independent reviewing officers are now escalating concerns to managers more frequently, the impact of this on the overall quality of the work has yet to be felt. Independent reviewing officers' caseloads are in line with statutory recommendations. With some joint training having taken place, working relationships between children's Cafcass, children's guardians and independent reviewing officers are contributing to the general reduction in the average length of care proceedings (Recommendation).
71. Overall, the quality of case recording is poor, with key discussions and decisions missing from many children's records.
72. Young people are rightly proud of the achievements of the young people's panel (YPP), which is Luton's equivalent of a children in care council. Working closely with the Corporate Parenting Partnership Board, young people have comprehensively rewritten and re-issued the pledge. Individual members of the YPP have gained a lot from their participation, and elected members are

showing good commitment to, and engagement with, the panel's work. However, while the work of the panel has the potential to impact positively on the wider population of children looked after and care leavers, it is not yet fully developed.

73. In half of all cases, examples were seen where needs arising from diversity had been considered well. These included issues associated with the maintenance of contact with the birth family, placement with a family member and situations where sexuality or choices about religious observance were bringing young people into conflict with parents. In the weaker cases, diversity was not explored or addressed thoroughly.

The graded judgement for adoption performance is that it requires improvement

74. The local authority has taken decisive action to improve the work of the adoption team, to increase understanding and awareness at all levels of the importance and significance of permanence planning and to reduce the length of time that children have to wait between entering care and being placed for adoption. There is evidence of improvement, but there is still some way to go.
75. Adoption is not routinely considered as a permanent alternative option for children who are unable to return home or to their families. Four of the 13 children (31%) who have been adopted in 2015–16, and 11 of the 61 children (18%) who are currently in the process of being adopted, were aged five years or over at the time of the inspection. This compares favourably with the national average of 5%.
76. White British children continue to make up the single largest ethnic group in Luton. In 2015–16, 46% of the children who were adopted were White British. By contrast, children of Pakistani origin, who feature prominently in the looked after population, only accounted for 3% of those who were adopted in the same year. The local authority has not yet rigorously analysed its adoption figures to understand why some groups of children are less likely to be adopted than others (Recommendation).
77. Fewer children are being adopted in Luton than elsewhere. In 2014–15, 25 children who left care (13%) did so by way of an adoption order. Although higher than for the previous year, when 9.1% were adopted, this is still lower than comparators (17%). So far in 2015–16, the number of children looked after who have been adopted has fallen and it is predicted that only 16 children will have been adopted by the end of the year. However, the number of children who achieved permanence by way of a special guardianship order has increased year on year. The local authority is aware that it needs to do further work with its own staff and the judiciary to make sure that adoption is

actively considered and rigorously pursued for all children for whom it is the right option.

78. The local authority has had some success in finding suitable adoptive placements for brothers and sisters. In 2014–15, 10 of the 25 children adopted were members of a sibling group. In 2015–16, six of the 13 children placed for adoption to date have been placed with a brother or sister. Together or apart assessments are comprehensive, analytical and include clear recommendations about future placements. However, at the time of this inspection, seven of the 17 children waiting for an adoptive match were waiting to be placed with brothers or sisters.
79. The local authority is not afraid to pursue adoption for children with complex needs. In 2014–15, 20 of the 25 children who were adopted had been identified as being 'hard to place' and two of those currently waiting for adoption are children with disabilities. Inspectors also saw examples of children with a range of emotional and physical health needs for whom the plan was adoption.
80. Children in Luton are waiting too long to be adopted. The 2011–14 three-year average for the length of time between a child entering care in Luton and moving in with their adoptive family was worse than comparators and exceeded the performance threshold of 547 days by 187 days. In 2011–14, 71% of children waited more than 18 months between entering care and moving in with their adoptive families, well above statistical neighbours and England averages (52% and 49%, respectively).
81. However, adoption timescales are improving. According to the local authority's own unvalidated performance data, at the end of September 2015, the proportion of children who had waited more than 18 months between entering care and moving in with their adoptive families had fallen to 54%.
82. Until recently, permanence planning has not been given sufficient focus, with the result that too many children have experienced delays in being matched and in moving in with their adoptive families. The average length of time taken between the local authority receiving court authority to place and a match being found has increased from 42 days above the threshold for the period 2011–14 to 108 days above the threshold in 2012–15. According to the local authority's own unvalidated performance data, this had dropped slightly to 101 days above the threshold in 2015. In only four (29%) of the 14 cases tracked by inspectors was permanence achieved without delay. In a large majority of children's cases seen by inspectors, permanence planning meetings had not taken place at the required intervals and there was an absence of effective oversight by managers and independent reviewing officers. The local authority has introduced a number of measures to strengthen its adoption performance, including the use of a permanence tracker and the early allocation of family finders in an attempt to improve

performance. However, it is too soon to see the impact and effectiveness of these measures.

83. Family finders know children well. The quality of children's profiles, including photographs, is good. As well as looking for families in Luton, family finders use a number of different sources, including a local consortium, the adoption register, publications and exchange, to try to find suitable matches. When potential matches do not proceed, for whatever reason, family finders actively review those cases in order to identify whether, for example the style and content of information provided in profiles and reports contributed to the lack of progress.
84. In the past year, only one child with a plan for adoption had their plan changed from adoption and then only in response to the child's health needs and the length of time they had been waiting. This compares favourably with the period 2011–14, when 15 children (14%) had their plans for permanence changed from adoption, and indicates a more robust approach to adoption. This is an improving picture and reflects positively on the impact of the director of children's services in her role as agency decision maker (ADM).
85. The recruitment of adopters has been given renewed focus. Marketing materials have been refreshed and advertising strategies revised. However, the local authority is still failing to attract adopters for older children and, in sufficient numbers, for groups of brothers and sisters. At the time of this inspection, nine couples and three single adopters from a variety of ethnic backgrounds were waiting to adopt. Only two of these households were willing to consider brothers and sisters and all, apart from one couple, were looking for children under the age of five.
86. The local authority is developing a more targeted approach to the recruitment of adopters, recognising that as a relatively small authority it needs to work closely with neighbouring authorities to extend its reach. Work to develop a regional approach through Adopt East has started, but this is still at an early stage and there is no immediate evidence of its impact.
87. The preparation and assessment of, and support for, adopters are very thorough. Adopters spoken to talked positively about the initial response from adoption social workers. Prospective adopters are provided with useful information and given plenty of opportunity to talk through their concerns. Assessments include detailed information about adopters' strengths and vulnerabilities and take full account of the possible impact on birth children and/or children adopters have already adopted. Adopters described an assessment process which really made them think about key issues and enabled adoption social workers to gain a thorough understanding of adopters' circumstances and potential.

88. Fostering to adopt and concurrent placements are not yet sufficiently well developed. Only two foster to adopt and one concurrent placement have been made during the last 12 months.
89. While the adoption panel is led by an experienced chair, includes members with first-hand experience of adoption and has good access to legal advice and medical expertise, it does not fully reflect the diversity of the local community. Currently, the panel does not include anyone from an Asian background and its members are all women. Efforts are being made to broaden the panel's membership. In the interim, the minutes of adoption panel meetings reflect rigorous scrutiny of adoption cases, leading to clear reasons and recommendations. The panel is able to show that it has analysed and challenged adoption practice appropriately, including for example the variable quality of child permanence reports (CPRs).
90. The rationale for decisions made by the ADM is clear and well recorded. The ADM meets regularly with the chair of the adoption panel to discuss and review practice and performance. She is also working closely with the newly appointed panel adviser who, among other things, has been charged with ensuring that in the future CPRs contain up-to-date information and provide the right level of detail to enable adopters to have a full understanding of children's histories, including children's birth families.
91. Life story work is not completed soon enough for children who are being adopted. In all of the three cases seen by inspectors, no life story work had been done directly with the children to help them make sense of their own history and prepare them for a move. Life story books are not completed until several weeks after a child has been placed, so that photographs and information, which could assist and support a child's transition, are not readily available to their prospective adopters. However, once completed, the quality of life story books and later-life letters is good; they are informative and written sensitively and well, in a way that makes it easy for children to understand (Recommendation).
92. The quality and effectiveness of post-adoption support is good. As part of the preparation process, prospective adopters are routinely given information about post-adoption support, which is also promoted via a quarterly newsletter. Adoption support plans, completed when children are matched, are appropriately detailed and clearly set out entitlements to support over time. In the last 12 months, five successful applications have been made to the Adoption Support Fund for therapeutic support. Most post-adoption support is provided through a commissioned service that works with adopters, adoptees and special guardianship order carers and provides adoption information, counselling and support to birth families. As well as offering a range of services, including life story work, the commissioned service also runs regular training events. In 2014–15, the service worked with 63 families and individuals; it has continued to work with 33 of those this year. Support for a further 10 families has been agreed. The local authority has also helped

a number of adopters to access time-limited one-to-one support from a 'buddy' or specialist parent consultant via Adoption UK.

93. Birth families routinely receive information and advice about post-adoption support, including the contact details for the national helpline Birth Ties, which supports birth families. In tracking and sampling cases, inspectors saw evidence of leaflets being discussed with, and where appropriate translated into other languages for, birth families. With assistance from the post-adoption support officer, 130 families are using the letterbox system to stay in touch with their children and/or their children's adoptive families by exchanging written information. Inspectors saw examples of effective support being given to birth parents to assist them in writing their first letter to children who have been adopted.

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

94. The local authority is in touch with 217 (99%) of its care leavers. It works well with partners to help care leavers successfully manage the transition into adulthood and achieve independence. Social workers and personal advisers are thoughtful and passionate about their work and take time to build trusting relationships with care leavers. Care leavers are encouraged to have high aspirations, make wise choices and develop realistic and achievable plans for the future. Care leavers describe the support that they receive as 'brilliant' and 'really helpful' and talk about the difference it has made to them, not least in terms of their post-16 education.
95. Almost all of the 219 care leavers have an up-to-date pathway plan. Most plans are reasonably comprehensive; they address care leavers' needs and identify appropriate actions to help them to be safe, do well in their education, training or employment and achieve independence. Young people are fully involved in the development of their plans and most are actively involved in their six-monthly reviews. However, while the majority of pathway plans are focused on outcomes, they are not always sufficiently specific and measurable. In some cases, clearer timescales are required to ensure that progress can be measured and monitored effectively. Additionally, oversight of pathway plans is limited and often consists of little more than a quick paper review during supervision. In a small minority of cases, management oversight failed to identify a lack of progress, which in two cases seen by inspectors resulted in delays in finding and securing suitable accommodation for the young people concerned (Recommendation).
96. The local authority uses the 'preparing for adulthood planning' documentation effectively to assess the ongoing support needs of young people with disabilities. They represent 5% of the care leaver population. Two personal advisers, specialising in transitions, work closely with adult health and social

care services to ensure that transition assessments and plans are completed before these young people reach 18 years of age. This helps to achieve a seamless transition to adult services. While there was little evidence of the use of pathway planning materials, support or oversight for these young people from a care-leaving perspective, the continuing care and support arrangements that are put in place are sufficient to ensure that their transition to adult services is well managed.

97. Completion rates for health assessments are steadily improving and are now in-line with national targets. However, health professionals acknowledge that there is still more to do. Workers actively encourage young people to maintain healthy lifestyles and offer appropriate challenge when, for example, young people's sexual activity involves an unnecessary degree of risk. However, it is clear that some care leavers are choosing not to make full use of the support provided or to take advantage of the annual health assessments routinely offered to all children in care and care leavers. Conversely, evidence was seen of care leavers, involved with the youth offending service, who were making good use of support provided by the drugs worker to address their misuse of drugs. Evidence was also seen that care leavers, including unaccompanied asylum-seeking young people, are accessing counselling and intensive mental health support provided by CAMHS, despite the fact that there is not a dedicated service specifically for care leavers.
98. Despite the recent development of health passports, care leavers are not consistently being given comprehensive, detailed information about their personal health histories on, or immediately after, their 18th birthdays. With the support of the care leavers' information panel, work is underway to rectify this situation. However, at the time of the inspection, not all young people had access to essential health information at the point at which they were leaving care.
99. The 16+ team is using the independent living assessment and pathway plan checklist effectively to help care leavers prepare for independence. Developed in conjunction with young people, carers and other professionals, the checklist enables young people to identify, with support, the areas that they need to work on. Plans are then drawn up to ensure that the practical and emotional help and support that the young people require is provided at each stage. Young people say that they value and appreciate this staged approach to independence; the support provided by social workers, personal advisers and key workers has taught them how to pay bills, learn to cook and look after themselves. In some cases, preparation for independence involves a series of planned moves from one type of accommodation to another. Rather than this being a negative experience, young people told inspectors that they welcomed this approach: it recognises young people's progress and achievements and provides incentives for them to continue to develop their skills, knowledge and experience as they work gradually towards independence.

100. Personal advisers generally support care leavers over the age of 18 years. Social workers work predominantly with 16- and 17-year-olds but, where appropriate, they continue to support the most vulnerable young people regardless of age, including those who are at risk of sexual exploitation, face mental health challenges or are at risk of offending. Close working relationships with accommodation and education partners ensure that care leavers receive good 'wraparound' support. Partners reported that 16+ workers are good at keeping them informed of what is happening and are active in implementing care and support plans, organising appointments and responding to legal or financial matters. Partners also reported that 16+ workers are very supportive at times of crisis. Young people hold their support workers in high regard. One young woman, who was considered to be at risk of sexual exploitation, was hugely appreciative of the fact that the social worker from the 16+ team maintained contact with her even after she had moved to another area.
101. Inspectors saw evidence of workers going to great lengths to re-establish contact with care leavers who chose not to stay in touch. For example, workers visit the care leavers' families even when the young people concerned refuse to see or speak to workers directly. As a result of this persistent approach by workers, only two former relevant care leavers, both of whom are aged 20 years and currently living with parents or relatives, have refused to have any contact with the local authority.
102. The local authority is active in supporting young people in staying put with their foster carers. The young people's guide on staying put makes it clear that care leavers are able to stay with their carer(s) until they are ready to leave, any time up to the age of 21 years. Foster carers are able to access training on working with young people. Particular attention is paid to communication and preparation for independence courses in order to ensure that carers have the right knowledge and skills and continue to provide ongoing care and support for young people who choose to stay with them. This increased focus on staying put means that currently 10 of the 48 care leavers aged 18 years (21%) are still living with their foster families as part of a staying put arrangement. Plans are in place to increase the numbers of care leavers who stay put; 21 of the current cohort of 50 17-year-olds who are looked after (42%) are planning to remain with their foster carers after their 18th birthdays.
103. The local authority commissions a range of suitable accommodation exclusively for Luton care leavers and young people aged 16 or 17 years who have been assessed as being homeless. Use of bed and breakfast accommodation is extremely rare because the 16+ team has access to emergency accommodation. Personalised support packages are provided in response to the individual needs of young people, including those who are from diverse backgrounds and/or those who are more vulnerable, including young people with histories of offending. Young people told inspectors that they are living in good-quality, suitable accommodation in areas where they

feel safe. Young people are supported to move to more suitable accommodation or locations if they feel unsafe or are unhappy about the area in which they are living.

104. When difficulties arise, workers provide practical and emotional help and support to assist young people in working through the challenges. As a result, no care leavers have been evicted within the last 12 months because of problems with their accommodation. In some cases, young people are supported to move to accommodation where there is a higher level of support. For example, instead of being evicted, one young man, who had been assessed as representing a risk to other young people in the same property, was moved to another property managed by the same housing provider.
105. A specialist social worker supports unaccompanied asylum-seeking young people while their immigration status is under review. Support includes health and counselling support in response to the physical and emotional trauma that some of these young people have experienced. Each case is different and the response is person-centred. For example, every Sunday, one housing provider took a young person to attend an Eritrean Orthodox church in Suffolk.
106. Care leavers aged 18 years or over are given priority access to accommodation provided by the housing department in Luton. Once they are accepted onto the housing register and start bidding for housing, these care leavers are usually able to get a council tenancy within two or three months. The success of this scheme is partly due to the fact that social workers, personal advisers and housing providers put a young person's name forward only when they are confident that the young person is ready for independence and have the evidence to support their assessment. As a result, care leavers become council tenants when they are ready to take on that responsibility and not before. In the case of some young people with criminal records, there was reluctance on the part of the housing department to allocate council tenancies to them while they were still the subject of community orders. Despite petitioning by the 16+ team, these young people had remained in accommodation commissioned by the 16+ team until their orders had expired.
107. When young people are ready to live independently, they are offered a degree of choice about where they live and who they live with. While most opt to move into their own council accommodation, that is not always the case. One young person who was certain that she did not want to live on her own was helped to move into a flat with a group of friends.
108. Care leavers are encouraged and effectively supported to go into further or higher education, employment or training, including apprenticeships. Arrangements are in place to ensure that all Year 11 care leavers have a secure destination by the start of Year 12. A large majority of the personal education plans sampled by inspectors were good and ensured that young people were aware of the educational and other options available to them.

Two appropriately skilled personal advisers, with networks across the sector, are available to support young people up to the age of 25 years.

109. In December 2015, more children looked after and care leavers aged 16 to 19 years were not in education, employment or training (NEET) than their peers: 10.6% compared with 4%. The NEET figure for older care leavers is subject to considerable fluctuation because cohort sizes are small. It rose to 20% during the course of 2015. Many of these young people find the move to independent living challenging. However, they are known to, and well supported by, personal advisers.
110. The proportion of care leavers in higher education has risen steadily and the local authority provides an appropriate level of financial support. Currently, 28 care leavers are doing a degree course. The number of apprenticeships available to care leavers has increased.
111. The local authority celebrates carer leavers' successes. Even the smallest achievements are recognised and acknowledged, as evidenced by the annual celebration event for care leavers; last year it paid tribute to the achievements of 60 young people.

Leadership, management and governance	Requires improvement
<p>Summary</p> <p>The quality of help and support that children and families receive is not yet good enough. While senior managers and leaders now have a clear sense of purpose and direction, and are taking decisive and appropriate action to improve performance and drive up practice standards, it is too early to be able to evaluate the impact of many of the changes that have been made.</p> <p>Action has been taken to increase accountability by strengthening critical challenge and scrutiny. Governance arrangements provide clear lines of reporting and accountability. A more robust approach to performance management and quality assurance means that managers are better able to understand what is happening at the front line. However, the quality of service and audit action plans is variable.</p> <p>Mature joint commissioning arrangements have increased, and are increasing, the focus on outcomes. However, sufficiency remains a problem; a shortage of foster carers makes it difficult to place sibling groups together. The corporate parenting role is not yet fully developed.</p> <p>Close cooperation between the local authority and the police, and good awareness and understanding among partners of the threat of radicalisation, have led to an increase in referrals to the Channel panel via early prevention and intervention services. Strategic arrangements have been strengthened considerably in response to the November 2014 thematic inspection of child sexual exploitation, which the local authority took part in. However, the absence of a shared database on child sexual exploitation and children who are missing from home, care and education makes it difficult to maintain an effective overview and undermines the ability to respond proactively.</p> <p>While information and intelligence from return home interviews (RHIs) are being used effectively to safeguard and protect children, further work is required to make sure that all children are offered RHIs.</p> <p>There are weaknesses in the level and quality of management oversight. Some social workers are not receiving regular supervision, and the quality of supervision provided is variable. Independent reviewing officers and child protection chairs do not consistently provide robust and effective scrutiny and critical challenge.</p> <p>While the workforce development strategy has generated a lot of activity, the absence of a coherent action plan means that the activity is not well joined up. Although the average size of social workers' caseloads is falling, it remains stubbornly high in the referral and assessment team. In some cases, frequent changes of personnel have had an impact on the ability of children and families to build meaningful relationships with their social workers and contributed to drift.</p>	

Inspection findings

112. The local authority has had three different directors of children's services since the last inspection. It recognises that the service it currently provides to children and families is not good enough. Following a period of critical reflection, senior managers and leaders have spent most of the last 12 months strengthening the systems, structures and processes needed to address the shortcomings and deliver sustainable improvements. With increased openness and transparency, a robust self-assessment and a clear sense of purpose and direction, decisive action has been, and continues to be, taken to improve performance and drive up practice standards. This has included robust action to tackle poor performance. A number of staff have had their contracts terminated and some have decided to leave.
113. An improvement board, chaired by the chief executive, is overseeing the implementation of the local authority's strategic improvement plan for children's services. There is good cross-party support and elected members have allocated significant additional resources to support the change programme. A new computer system and an increase in social work posts mean that staff now have the tools and the capacity to deliver a better service, although the average size of social workers' caseloads remains stubbornly high in some areas.
114. Governance arrangements are well established, with clear lines of reporting and accountability. The chief executive is active and involved. There is good engagement from elected members, leading to increased scrutiny, as evidenced by the setting up of a children's services review group (CSRG), which reports directly to the overview scrutiny board. However, while members of the CSRG now have a good understanding of the work of the children and learning department, it is too early to evaluate the group's impact.
115. Close working relationships with the clinical commissioning group and the police, at both a strategic and operational level, are starting to make a real difference. There is good buy-in from partners, particularly schools. Although there is still more work to do, the response to child sexual exploitation has been strengthened considerably. There is increased awareness and understanding of the risks; policies, procedures and frameworks are more robust and the sharing of information has improved. With a strong focus on community cohesion, and an extensive programme of WRAP (workshops to raise awareness of prevent) training, there is increasing evidence of the impact and effectiveness of the Channel panel in dealing with the threat of radicalisation.
116. The Health and Well-being Board is becoming more focused, with good engagement by key partners. While some progress has been made in response to the increasing problem of obesity, particularly among children,

the local authority and its partners are in the process of developing a neglect strategy. However, this seems quite tardy, given the local authority's own estimate which suggests that 21,000 children in Luton are affected by at least one of the elements of the 'toxic trio' of parental substance abuse and mental ill-health and domestic abuse.

117. As well as providing a reasonably comprehensive picture of local needs, the latest joint strategic needs assessment offers a clear and concise set of strategic recommendations. With two cross-cutting and three age-specific themes, children and young people are given due prominence. The focus on making sure that 0- to 19-year-olds have a healthy start in life chimes well with the vision of the Children's Trust and the ambitious programme of activity that is being delivered under the auspices of the Flying Start strategy to develop an integrated service for 0 to 5-year-olds.
118. Mature joint commissioning arrangements, as part of a long-standing section 75 agreement with health, make use of a good mix of block and spot contracts to deliver a range of services, including sexual health and drugs and alcohol services, in response to identified need. However, progress in implementing the 2014–17 sufficiency strategy is slow. There is a clear mismatch between the supply of, and demand for, foster carers which, for example makes it difficult to place sibling groups together in suitable family placements. This results in some children living further away from home than might otherwise be the case (Recommendation).
119. Outside of the formal commissioning arrangements, but no less significant, is the relatively unique arrangement with the local airport, which funds around £4 million worth of youth work services and services for children with disabilities. Relationship managers, rather than commissioners, working with the two main consortia of voluntary sector providers are developing an increased, and increasing, focus on outcomes.
120. The corporate parenting role is not yet fully developed. While the Corporate Parenting Partnership Board has been renamed and restructured, and its membership extended to include young people, foster carers and a range of partners, it does not yet have the performance management tools to monitor and drive forward the implementation of the pledge, which was developed in collaboration with young people.
121. Recognising the need to increase the impact and effectiveness of the Local Safeguarding Children Board (LSCB), the director of children's services (DCS) was instrumental in recruiting and appointing a new chair and business manager. As well as meeting regularly face-to-face with the LSCB chair, the DCS also attends the quarterly review meetings that the chair has with the chief executive and the lead member. Robust reporting arrangements ensure an appropriate degree of accountability.

122. The volume and quality of performance management information have improved considerably since the introduction 12 months ago of a new performance management and quality assurance framework. Middle and senior managers now have access to a range of reports which give them a direct line of sight to what is happening at the front line. The chief executive, lead member and leader of the council routinely review the directorate's performance scorecard. However, further work is required to ensure the accuracy and reliability of the data. Currently, the data are not weighted or ranked in order of importance. The local authority needs to concentrate on those performance indicators that will make the most difference to children and young people, eradicate drift and delay and have the biggest impact in terms of achieving lasting change in organisational culture and working practices.
123. A more systematic approach to the use of audits is helping to drive improvements although, for children, young people and families who are using children's social care services, the pace of change is slow. The quality assurance and performance panel ensures that there is robust follow-up on individual case audits that are judged inadequate. It also plays a key role in making sure that audit findings are translated into improvements in practice and processes. For example, lessons learned from audits led to the introduction of guidance for practitioners on written agreements with families and to the rewriting and relaunch of the supervision policy. However, there is still a long way to go to secure lasting improvements at the front line. When supervision practice was last audited in September 2015, it was found that only 67% of social workers were receiving regular supervision and that the quality of supervision provided was less than good in 60% of the cases audited.
124. Senior managers recognise that the standard of practice and performance is not where the local authority wants it to be and where children, young people and families have a right to expect it to be. They are continually looking for ways to improve and the approach they take is outward looking. Luton is an early adopter of the Graded Care Profile, has been accepted for early take-up of a reunification programme and is, along with a number of other local authorities, due to pilot the new social work accreditation scheme. The principal social worker is visible and active in trying to raise practice standards and provides a valuable source of two-way communication between middle and senior managers and front-line staff. However, while there is no shortage of service and audit action plans, the quality of these plans is variable. They are not consistently focused on outcomes, specific and measurable. This has the potential to limit the effectiveness of the plans (Recommendation).
125. Cafcass reports that the standard of the local authority's court-directed work is improving. The average length of care proceedings has fallen but, at 30 weeks, is still above the national target of 26 weeks. Relationships between Cafcass, children's guardians and independent reviewing officers are described as positive, with evidence of some joint training.

126. Management understanding and control, at both a strategic and operational level, is not yet sufficiently robust. Senior managers do not have a direct line of sight to vulnerable children, including those who are considered to be at risk of child sexual exploitation. There is a need to strengthen the arrangements for monitoring the offer and take-up of return home interviews. Independent reviewing officers and chairs of child protection conferences are not consistently providing the right level of critical challenge. Social workers do not have access to regular, high-quality supervision and performance appraisal is not well embedded. Oversight of casework decisions is not sufficiently child-centred or challenging (Recommendation).
127. Partly as a result of the investment in, and restructuring of, early help services, the average size of social workers' caseloads is falling, though not quickly enough in the rapid intervention and assessment team. At 12.6%, the staff turnover rate is comparatively low, but the local authority continues to be heavily dependent on agency staff. With a vacancy rate of 22.9%, there are currently 39.4 full-time equivalent social workers on interim contracts covering 28.7 vacancies, albeit with some of them being retained to provide additional support for newly qualified social workers (NQSWs) by co-working more complex cases with them. The local authority has invested significantly in NQSWs, 22 of whom are doing their assessed year of employment. It is also making good use of the Step Up to Social Work Programme; the local authority has 10 participants. However, a reluctance to pay the going market rate is making it difficult to permanently recruit independent reviewing officers and chairs of child protection conferences with the right levels of skills, knowledge and experience. While the workforce development strategy has generated a lot of activity, the absence of a coherent action plan means that that activity is not well joined up. Furthermore, a lack of effective engagement and activity by human resources has limited the impact of the strategy.
128. Training is responsive to identified needs and increasingly being delivered flexibly rather than being wholly reliant on traditional classroom teaching. Social workers have good access to a range of training opportunities, including, for some, post-qualification training at the local university. How best to evaluate the impact of learning on individual performance is currently under review. In the absence of a well-embedded performance appraisal system or a robust competency framework in children's social care, what is not clear is how middle and senior managers make sure that the right staff are doing the right training. Currently, those responsible for workforce development are unable to specify what management and supervision training front-line team managers and deputy managers have had. Given the concerns about supervision and management understanding and control, this is a significant omission (Recommendation).

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The LSCB has maintained a clear focus on serious incidents and on ensuring effective challenge between board partners. This is in spite of a very busy year, which has included four serious case reviews and a 50% turnover of board members. However, the board has not quality assured multi-agency practice sufficiently through joint audits. For example, to date it has not reviewed early help services, and it has yet to fully deliver against the new board structure that was implemented in April 2015.

In the short time that they have been in office, the newly appointed independent chair and business manager have already had a significant impact on the LSCB's work. The board has successfully developed a performance scorecard with which to routinely monitor front-line practice. However, further work is required to ensure that the scorecard includes appropriate measures relating to children who go missing and are at risk of sexual exploitation.

The board effectively undertakes serious case reviews and reviews of child deaths in order to ensure that lessons are identified to improve safeguarding practice for children and their families. Some significant changes to policies and procedures have been made as a result of learning from case reviews and audit, but follow through on action plans and evidence of impact have been variable, with some actions outstanding.

Although the main board partners are appropriately undertaking section 11 assessments of their safeguarding practices, further work is needed to engage with faith and voluntary sector organisations in reviewing their safeguarding practices.

The board does not assess front-line practice for children at risk of sexual exploitation effectively enough. However, it has worked well with the local authority at a strategic level to raise awareness and safeguard children.

The board has delivered a range of training to professionals across the partnership and has a comprehensive suite of policies and procedures to guide practice. It has appropriately identified the need to strengthen the training offer and regularly review policies and procedures. The board has also identified the need to ensure that policies and procedures remain relevant and up to date.

The LSCB does not yet have sufficient influence across strategic partnerships to inform and influence priority setting and planning for children and their families.

Recommendations

129. Significantly extend the programme of joint- and single-agency audits to ensure that the LSCB is able to identify and prioritise areas for further development and improve the way in which children, young people and their families are safeguarded and protected.
130. Carry out a multi-agency audit of early help.
131. Ensure that the board regularly reviews the effectiveness of partner agencies' responses to children and young people who are at risk of sexual exploitation and, where applicable, identify areas for further improvement.
132. Agree and adopt an appropriate range of performance measures in respect of child sexual exploitation and children who go missing, so that the board is able to effectively monitor and evaluate the services available to these vulnerable young people.
133. Ensure that all action plans produced by the board, including those developed in response to serious case reviews and multi-agency audits, are effective and that their implementation is subject to rigorous scrutiny, resulting in improvements in safeguarding practice.
134. Increase the level of engagement with faith groups and voluntary sector organisations in order to ensure that they, and the LSCB, are confident that they are responding effectively to safeguarding issues.
135. Take steps to ensure that the board is able to exercise significant influence across all of the key strategic partnerships in the design, development and delivery of services for children, young people and their families.

Inspection findings – the Local Safeguarding Children Board

136. The last year has undoubtedly been a particularly busy one for the LSCB, with four serious case reviews, two individual management reviews, the restructuring of the board and a 50% turnover in board membership. The board has continued through this time of change to provide some effective challenge to key partners and to act on learning from serious incidents. However, some aspects of its work have been less impressive. In particular, it has failed to audit, monitor and evaluate work carried out by partners to safeguard children, including through early help. There has also been a significant delay in fully delivering against the board's new structure, which was due to be implemented in April 2015 (Recommendation).
137. Of particular note were the appointments of a new independent chair in September 2015 and a new business manager in December 2015. With a brief to increase the impact and effectiveness of the board, they have made a very positive start. As well as meeting with key partners to explore their roles and

respective contributions, the new independent chair and the new business manager quickly recognised the need for a renewed focus on the collective response to neglect. They have begun to bring greater clarity to the various board sub-groups to ensure that sub-groups' activity accurately reflects the board's priorities.

138. Governance arrangements between the LSCB, the director of children's services (DCS), the lead member and the chief executive are clear and well established. All three of them met with the new chair of the LSCB in January 2016 to get her initial impressions of the board and review the action she has taken. The DCS is also in regular communication with the LSCB chair.
139. The board's new structure provides a strong foundation on which to develop the role, function and impact of the various sub-groups and task and finish groups. Some of these are Luton-specific; others have a pan-Bedfordshire remit. Although the scrutiny and assurance group is up and running and delivering effectively on a number of work streams, there has been a delay in establishing some of the other sub-groups, despite these being integral to the board's restructure nine months ago. For example, neither the learning and improvement sub-group nor the bullying, sexting and online issues sub-group is yet fully operational.
140. Board members describe the primary focus over the past 12 months as having been to 'make sure we are doing the right things'. For example, a great deal of work has gone into developing the board's performance scorecard. This ensures that the board has access to relevant performance management information with which to assess the quality and effectiveness of partner agencies' front-line practice and identify areas for improvement. Used to good effect at the December 2015 meeting of the LSCB executive, the scorecard is still being fine-tuned. Currently, it does not include robust and reliable data on missing children and/or those who are at risk of sexual exploitation (Recommendation).
141. There is evidence of, and board members confirm that there has been, increasingly effective challenge between agencies on their respective contributions to safeguarding children and young people. Partners are now better able to hold each other to account. For example, in response to a particular challenge about police attendance at initial child protection conferences (ICPCs), police officers' schedules are now organised in such a way as to ensure that they are available to attend ICPCs on set days each week. Similarly, the housing department has recently been invited to provide assurance to the board that the current housing crisis, which is leading to the increased use of bed and breakfast accommodation, is not exposing vulnerable children and their families to greater risk, by virtue of their being temporarily housed alongside potentially risky adults.
142. The main partner agencies involved with the LSCB complete annual section 11 self-assessments of the effectiveness of their arrangements for safeguarding

children. In 2014–15, analysis of the returns confirmed that partner agencies understood the importance of safeguarding and had suitable arrangements in place. However, the returns provided little evidence of impact or improved outcomes for children and young people. This year's self-assessments are currently being analysed by a pan-Bedfordshire group; it is too early to evaluate how well this gap has been addressed.

143. One significant area of weakness, which the incoming chair and business manager have already identified, is the Board's lack of engagement with faith communities and the voluntary sector. To date, the Board has done little to support these groups to be able to assure itself about the quality of the groups' safeguarding arrangements. The new Board manager has now started a detailed piece of work to explore possible issues and sensitivities, in order to know how best to engage effectively with what is a complex, multi-faith landscape and with a voluntary sector that does not have a representative body (Recommendation).
144. With four serious case reviews (SCRs) underway and a fifth currently in the process of being commissioned, the SCR sub-group has been extremely busy. Additionally, the LSCB has completed two individual management reviews (IMRs) in response to serious incidents during the year. Learning from child deaths, SCRs and IMRs has been used effectively to inform changes in procedures and developments in practice across Luton. The board is proactive in acting on the learning from such events without waiting for reports to be agreed or published. This is good practice. For example, a bruising protocol has been developed and implemented, with training provided, to ensure that there is a robust professional response when bruising to babies or children is seen. Similarly, the threshold document has been reviewed and relaunched within the last 12 months in response to learning from case reviews.
145. However, there is room for improvement in the sign off, and subsequent follow-up, of SCR action plans. Practice is variable and ranges from rigorous monitoring to ensure that actions agreed have been completed in the case of one SCR to less frequent review of the SCR action plan by the executive board in another. Recognising that the LSCB also needs to improve its ability to evidence the impact of SCR action plans, the LSCB multi-agency audit group is planning in future to audit all SCR action plans to determine their quality and effectiveness in terms of progress, review and impact (Recommendation).
146. The need to improve the professional response to neglect is a key learning outcome from a number of SCRs. Having identified the lack of progress in this area, the new chair of the LSCB has taken swift action to address the deficit by appointing a part-time development officer to focus on this issue. The new chair has also secured the services of a leading national expert on neglect to facilitate the board's development and business planning day in March 2016.
147. The child death overview panel (CDOP) routinely reviews all unexpected deaths of children in Luton, although in a small number of cases, there has

been a delay in sharing information with the SCR group. On one occasion, this led to a lengthy delay between the critical incident and the start of an SCR. Subsequently, the CDOP, which is a pan-Bedfordshire group, has changed its processes to ensure that the same thing could not happen again. The CDOP produces Luton-specific data, as well as information on county patterns and trends, so that the LSCB has the data and information it needs to provide effective scrutiny. Learning from reviews of child deaths is used well to try to reduce risks and mitigate modifiable factors, such as those associated with co-sleeping and consanguinity.

148. Although the board has delivered a good range of learning events to share findings from national and local SCRs with professionals and partner agencies, attendance by social workers at these events has been problematic. During this inspection, the vast majority of staff who spoke to inspectors were unable to say very much about the priorities or work of the board and almost all said that they had not received any briefings or information about SCRs, local or national. The learning and improvement sub-group is currently exploring how to improve communication across the partnership to increase awareness and understanding of the board's work, particularly the outcome of SCRs and the lessons learned from them.
149. The board delivers a range of relevant training to partners and professionals across Luton, although to date this has not included safeguarding training on for example parental mental ill-health and substance misuse, despite these issues figuring highly in the local profile. Having received feedback that the quality of training provided was not of a consistently high standard, the board undertook a speedy review and took decisive action to secure a new training provider. From 1 April 2016, the board's training will be delivered through a pan-Bedfordshire training group.
150. Multi-agency audits have not been used effectively to identify improvements in professional practice. During the last year, the Board has carried out only two multi-agency audits and in neither case is it evident that the outcomes of those audits have been fully implemented. For example, while an audit in early 2015 to consider the experience of individuals and agencies that had made referrals to children's social care prompted the development of the new threshold document, referrers told inspectors that feedback from children's social care is still poor. A second multi-agency audit, in November 2015, reviewed the cases of eight young people who, following referral to the child sexual exploitation panel, were judged not to meet the panel's criteria. Although the audit did lead to an appropriate review of the panel's function, action has not been taken to determine whether or not vulnerable young people consistently receive an effective and proactive service response to reduce the risk of sexual exploitation. Additionally, the board has not yet carried out an audit of early help services and/or the experience and progress of children and families who receive early help and support. This is a significant omission and means that the board cannot be assured that these services are robust (Recommendation).

151. The LSCB has developed an effective range of policies and procedures to promote the welfare of children and young people in Luton and is constantly on the alert to the possibility that new ones may be needed. For example, the Board is about to launch a new policy on female genital mutilation and has developed a clear pathway to protect children from female genital mutilation. However, at present the board does not have a robust approach to ensuring that policies and procedures are regularly reviewed and refreshed in order for them to remain relevant and up to date. The pan-Bedfordshire policy and procedures group has recognised, and is in the process of rectifying, this situation.
152. The LSCB chair recognises that the board's performance scorecard does not yet include robust data on child sexual exploitation and children who go missing and that, to date, its review of practice has been limited to a single audit of referrals to the child sexual exploitation panel. The LSCB chair has plans in place to address both issues (Recommendation).
153. At a strategic level, the board has made a strong contribution to the continuing development of the pan-Bedfordshire child sexual exploitation and missing children strategic group, which has increasingly effective oversight and understanding of the area-wide picture of vulnerable children. The board has also worked well with the local authority, which has been extremely active in raising awareness and understanding of the nature and extent of child sexual exploitation and children who go missing from home, school and care.
154. One of the LSCB's major successes in the last 12 months has been the development of the Luton pledge on safeguarding children from child sexual exploitation. Launched at the local football club in order to gain maximum publicity, the pledge was a product of some very sensitive work with various community groups, including representatives from the faith sector. The board also led on a significant piece of work involving the airport, local airlines, the police and the Border Agency to develop a memorandum of understanding on trafficking and sexual exploitation. The plan now is to provide training for cabin crews to help them to identify children who may be being trafficked. With a protocol already agreed, the training is expected to take place very soon.
155. Increased awareness and stronger strategic partnerships are leading to better sharing of intelligence and higher levels of activity to safeguard children and young people who may be at risk of, or are being, sexually exploited. For example, there are currently four police operations in progress and police and local authority partners are working with 90 young people across the county where child sexual exploitation is a concern. The police are also making greater use of their powers to disrupt potential perpetrators. In 2015, the police child sexual exploitation team and missing person's unit issued seven child abduction warning notices (CAWNs) between them. The child sexual exploitation team alone has already issued six CAWNs since the start of 2016.

156. Well supported by a participation worker, young people involved in the LSCB's challenge group are beginning to have an impact. Conversations between the challenge group and the LSCB executive, for example, about how adults can keep up to date with the latest issues affecting young people, involved some very strenuous debate. This experience convinced Board members that they needed to reach out to young people and hear regularly and directly from them. With monies from NHS England, young people from the challenge group are now engaged, with others, in developing video material that will focus on issues and concerns of interest to young people.
157. At the most recent meeting of the LSCB executive, members of the challenge group were invited to share their findings on young people's thoughts and feelings about neglect, based on a consultation exercise that they had carried out. Members of the LSCB executive were so impressed that they plan to publish the results so that some of the key messages can be shared with professionals across the partnership. The LSCB's forward plan is now being developed in such a way as to facilitate and encourage increased input from young people, through a series of quarterly themed meetings.
158. Perhaps not surprisingly, given the issues associated with management and leadership capacity for most of last year, the Board's influence on other strategic groups and partnerships has been limited. The one exception is the Children's Trust Board, which the outgoing chair of the LSCB attended regularly and where the LSCB was able to help shape the development of the Flying Start strategy and programme, not least by emphasising the critical importance of effective partnership working. Otherwise, the LSCB has not had much impact in terms of the design, development and delivery of services for children and young people (Recommendation).
159. The Annual Report for 2014–15 requires improvement. Although it provides an overview of key activities and learning and includes information and data on the work of the local designated officer, the CDOP and the multi-agency risk assessment conference, it lacks robust analysis of the effectiveness of local safeguarding practice, processes and procedures. The report does not include any data on, for example private fostering or the take-up of safeguarding training.

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

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