Bedford Borough

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

and

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

Inspection date: 23 January 2017 – 16 February 2017

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Children's services in Bedford Borough 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	Good
	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 Board's (Review) Regulations 2013.

Executive summary

Children's services in Bedford Borough require improvement to be good. Following the child protection inspection in 2013, the director of children's services (DCS) and his senior leadership team have worked purposefully to implement systemic changes in order to improve outcomes for children. Key services implemented or further developed include an effective multi-agency safeguarding hub (MASH) and strong early help services. As a result, many children receive helpful intervention. Services for care leavers and children who are adopted are good. However, the DCS and his leadership team know that, in other key parts of the service, they have more work to do to strengthen core social work practice, which is challenged by high caseloads and inconsistent management oversight.

Professional and political leaders have a good understanding of the strengths and weaknesses of the service. Responding to deficits in the quality of frontline practice, they introduced an improvement board in 2014. This has helped to ensure effective oversight of performance and progress, strengthened by independent validation through external reviews. The improvement plan focuses on the right areas for development, particularly the need to reduce caseloads and to strengthen workforce stability. Political leaders have responded robustly to the improvement plan, committing substantial financial resources to increase the social work establishment. A coherent workforce strategy has resulted in the establishment of a permanent management team, including first-line managers. Despite this progress, social work caseloads and the use of locums remain high.

The senior leadership team has set clear expectations and maintained its focus on improving the quality of frontline practice. A comprehensive performance and quality assurance framework is in place, with audit and oversight of practice by child protection chairs and independent reviewing officers (IROs). However, quality assurance activity is not yet consistently leading to better practice, due to pressures in capacity across the workforce. Weaknesses in frontline management oversight and supervision in some teams mean that compliance with practice standards is not embedded. Although supervision takes place, it is not yet effective enough to ensure consistency of practice.

Families in need of help benefit from a wide range of well-coordinated support to prevent their needs from escalating. The MASH has enhanced partnership working. Thresholds are applied appropriately and result in a timely and proportionate response to children's needs. Strategy meetings are effective, and, where appropriate, they lead to child protection enquiries and conferences for those children most at risk.

Assessments do not always include children's experiences, in particular the influence of their cultural heritage. Many fail to capture the child's voice through observation or direct work. Weaknesses in case recording, including delays in uploading documents, are evident across the service and limit the effectiveness of management oversight. Many plans focus too heavily on the needs of adults and are insufficiently

specific or measurable. The quality of pre-birth assessments and plans is inconsistent. Managers have listened to the feedback of the courts and other partners and have taken steps to improve practice in this area, but this is yet to have a measurable impact.

Use of the Public Law Outline (PLO) is improving. The recent appointment of a case management officer and more focused tracking have increased oversight of practice in this area. This is beginning to strengthen planning for children.

The local authority looks after children when this is necessary. Almost all children looked after live in good-quality placements that meet their needs. Some care plans lack focus, which can dilute their effectiveness and result in delays in completing essential work. Planning notably improves once decisions are made about children's plans for permanence. Plans for children who return home from local authority care to live with their families are carefully considered in order to mitigate the likelihood of risks recurring. These children are well supported.

Work with children who have experienced or are at risk of sexual exploitation is largely effective, but responses to children who go missing from home or care are not robust and not enough children have return home interviews. For those who do, information from interviews is not consistently used to inform risk assessments. The local authority and police have very recently taken action to strengthen their response in this area, but this is too recent to demonstrate impact.

Services for children requiring adoption are good. Prospective adopters are assessed, trained and supported well. Support for children in transition to their adoptive families is well planned, ensuring a positive start for these new families. Children benefit from comprehensive support plans, but further work is needed to ensure that later life letters provide accurate and sensitive accounts of their histories.

Care leavers receive a good service. Young people make progress in education and training and are prepared well for eventual independent living. Young people hold their leaving care workers in high regard. The large majority of pathway plans are of good quality, but they are not always reviewed regularly enough or signed off promptly by managers.

The corporate parenting panel closely scrutinises performance and outcomes for children looked after, but its links with the Children in Care Council (CiCC) are underdeveloped. Evidence of impact of the panel is limited. For example, the council does not offer apprenticeships to care leavers within its own services, care leavers have not been included in the work to reshape the council, and children looked after are currently unaware of the authority's promises to them as the pledge has not yet been published.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates two children's homes, both of which were judged to be good or outstanding in their most recent Ofsted inspections.
- The previous inspection of the local authority's arrangements for the protection of children was published in February 2013. The local authority was judged to be adequate.
- The previous inspection of the local authority's services for children looked after was published in March 2012. The local authority was judged to be adequate.

Local leadership

- The DCS has been in post since March 2014.
- The DCS is also responsible for adult services.
- The chief executive has been in post since June 2009.
- The chair of the Local Safeguarding Children Board has been in post since March 2013.

Children living in this area

- Approximately 37,900 children and young people under the age of 18 years live in Bedford Borough. This is 23% of the total population in the area.
- Approximately 17% of the local authority's children aged under 16 years old are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 12% (the national average is 15%)
  - in secondary schools is 10% (the national average is 13%).
- Children and young people from minority ethnic groups account for 29% 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 or Asian British and Mixed.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 32% (the national average is 20%)

[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.

in secondary schools is 19% (the national average is 16%).

- Bedford Borough is a relatively prosperous and fast-growing borough, but has areas of significant deprivation.

Child protection in this area

- At 31 December 2016, 1,339 children had been identified through assessment as being formally in need of a specialist children's service. This is a slight increase from 1,301 at 31 March 2016.
- At 31 December 2016, 176 children and young people were the subject of a child protection plan (a rate of 46 per 10,000 children). This is an increase from 159 children (42 per 10,000 children) at 31 March 2016.
- At 31 December 2016, fewer than five children lived in a privately arranged fostering placement.
- In the last two years prior to inspection, four serious incident notifications have been submitted to Ofsted, and one serious case review has been completed.
- There are three serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 31 December 2016, 262 children are being looked after by the local authority (a rate of 69 per 10,000 children). This is an increase from 255 (67 per 10,000 children) at 31 March 2016. Of this number:
  - 117 (or 45%) live outside the local authority area
  - 23 live in residential children's homes, of whom 57% live out of the authority area
  - none live in residential special schools
  - 191 live with foster families, of whom 46% live out of the authority area
  - fewer than five live with their parents
  - 24 children are unaccompanied asylum-seeking children.
- **In the last 12 months:**
  - there have been 14 adoptions
  - 14 children became subject of special guardianship orders
  - 113 children ceased to be looked after, of whom 5% subsequently returned to be looked after
  - seven young people ceased to be looked after and moved on to independent living
  - eight young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that all work with children is recorded promptly on the social care information system and used to inform planning for children.

2. When children go missing from home or care, ensure that they are offered a return interview within 72 hours of returning home and that the interview is recorded to inform ongoing planning.

3. Create and sustain a supervision offer to frontline staff that has a focus on 'getting to good' and delivers well-recorded professional support on a regular basis.

4. Ensure that children's views are fully reflected in assessments and plans.

5. Improve the quality of plans for children and young people. Ensure that plans clearly set out what needs to change within specific timeframes, and are used to monitor progress, updated following each review, and are subject to timely scrutiny and authorisation by managers.

6. Ensure that children looked after and young people leaving care are fully informed of their entitlements and are provided with greater opportunities to influence service developments.

7. Ensure that effective systems are in place to enable strategic oversight of all children who need permanence.

8. Ensure that later life letters provide a clear and comprehensive account of the child's history in child-friendly language, avoiding social work jargon and including all information about birth and adoptive families.

9. Ensure that children looked after receive timely health assessments.

10. Strengthen arrangements to identify and respond to children who are privately fostered, so that assessments are robust, include all required safeguarding checks and are properly overseen by managers.

Summary for children and young people

- Senior leaders and managers, the elected mayor and councillors have worked hard to improve services for children and families in Bedford Borough. Although services have got better, there is still more work to do to ensure that all children get the support and help that they need.
- Children are kept as safe as possible because social workers act quickly to protect them when they are at risk of harm.
- When children and their families have problems or worries, social workers, the police, health workers and other professionals work well together to make sure that they receive the right help.
- There are lots of different services in Bedford Borough for children and their families. Because most children and their families receive help quickly, their problems do not become more serious.
- Social workers ensure that children in need of support and children looked after have plans in place to improve their lives. These plans would be better if they reflected children's views and had clearer targets to work towards.
- More needs to be done to make sure that when children go missing, an independent person speaks to them when they return. This will help adults to understand the reasons for going missing and help to prevent it happening again.
- For children who cannot live with their families, social workers find the right permanent families for them, in which they can feel happy and safe.
- When adoption is the best plan for children, social workers work hard to make sure that they live with the right families quickly. Children receive bright and colourful life story books that help them to understand their early life experiences.
- When young people leave care, they feel well supported. They have a good choice of accommodation and receive practical support from staff to help them to live independently.
- Not all children looked after understand the support that they can expect to receive. Children looked after and care leavers have worked with social workers and managers to design a new pledge, which will help children and young people to understand what they are entitled to in the future.
- Although there is a Children in Care Council in Bedford Borough, not enough children and young people know about it or attend. This is a missed opportunity for them to meet new friends and to have their say about the service that they receive.
- Managers are working hard to improve the service, but there are not yet enough social workers. This means that social workers find it hard to do all of the things needed, particularly to make sure that they record what they are doing. Plans are in place to recruit more social workers so that all children get the help that they need.

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

Summary

Early help services are well targeted, coordinated and effective in Bedford Borough. This is ensuring that children and their families benefit from appropriate support and help when they need it. When early help is not improving children's circumstances, step-up to statutory social work services is timely.

When statutory thresholds are met, there is a timely and effective response by staff in the MASH. Information is shared appropriately and leads to sound decisions and oversight by managers. As a result, children receive the right support at the right time. The majority of partner agencies understand and apply thresholds for statutory intervention effectively. However, the lack of screening of low-risk incidents by the police puts inappropriate demands on the capacity of the MASH.

Children who are at risk of harm are identified appropriately, and swift action is taken to make sure that they are safe. Strategy meetings are thorough and make the right decisions that lead to robust child protection enquiries and, when necessary, initial child protection conferences. Professionals from partner organisations attend most multi-agency meetings and contribute to assessments. The timeliness of assessments has improved, but further work is needed to ensure that they are carried out within timescales proportionate to children's needs.

Most children are visited in accordance with their plans, though visiting is less consistent to children in need. Delays in social workers' recording or uploading information to children's records make it difficult to understand whether visits have taken place or whether actions are complete. The quality of management oversight, although improving, remains variable and is not always effective in driving planning for children.

Work with children in need is not as effective as work undertaken in child protection processes. Child in need meetings are not always held promptly and do not always consider progress against children's plans. This makes it difficult to monitor impact. The quality of plans, both for children in need and for children in need of protection, requires improvement. Plans are often too focused on adult behaviour and do not clearly differentiate the needs of individual children. They are not sufficiently outcome focused or used effectively to monitor progress. The response to children who live in private fostering arrangements is not robust.

Work to protect children at risk of sexual exploitation is mostly effective. Children benefit from support and targeted work, which helps to reduce risk and to improve their circumstances. Children who go missing receive an inconsistent response and not enough have a return home interview.

Inspection findings

11. The local authority's focus on developing an early help offer since the last inspection of child protection in 2013 has resulted in a substantial increase in the volume of early help assessments completed across the partnership. Agencies demonstrate increased confidence in supporting early help delivery, facilitated by training, for example on the recently refreshed threshold guide. Early help officers or family support workers attached to every school, general practitioner (GP) practice and children's centre, as well as access to named child and adolescent mental health services (CAMHS) professionals, enable children to benefit from specialist support before their needs escalate.

12. The early help worker based in the MASH ensures a timely response to children and families who need early help provision. Strong partnership arrangements, led by the early help and intervention service, ensure that support for children and families is effective. Early help plans feature specific, measureable targets and are regularly reviewed and overseen by managers. When early help is not improving children's circumstances, transfer to statutory social work services is timely.

13. Thresholds for accessing support from children's social care are appropriate. Management decisions about contacts and referrals are timely and informed by sound information gathering, but do not always include sufficiently detailed rationale for decision-making. Good partnership working is evident, with engagement by police, health and social care. However, a high volume of domestic abuse notifications relating to low-risk incidents are not screened effectively by the police before being referred to the MASH. This places inappropriate demands on MASH staff capacity. The police domestic abuse risk assessments (DASH), which accompany some referrals seen by inspectors, were superficial and of little value in assisting the MASH in identifying risk.

14. Child protection enquiries are timely, with evident management oversight in the majority of cases. Most strategy meetings are well attended and recorded. When the threshold is met for initial child protection conferences, these are held within appropriate timescales for the large majority of children. Children who present concerns outside office hours receive prompt, appropriate responses, including well-recorded strategy meetings from the pan-Bedfordshire emergency duty team.

15. The timeliness of assessments has improved considerably over the last 12 months. The local authority has begun to develop systems and processes in order to ensure that assessment timescales are proportionate to children's individual needs. Assessments are of variable quality; they focus on need and risks, but do not consistently take account of children's ethnic or cultural identities, and many lack sufficient analysis. Most demonstrate an understanding of the impact of issues, such as domestic abuse, neglect, substance misuse and parental mental health, but many lack focus on the experience of children living in the household.

16. Partner agencies have challenged the quality of pre-birth assessment and planning through the Local Safeguarding Children Board (LSCB). Planning is not always sufficiently proactive or progressed with the rigour and pace needed before children are born, which means that some intervention can be incident led. The local authority has taken decisive action in response to the concerns raised. This is beginning to have a positive impact on the quality of pre-birth planning, with better practice evident in more recent intervention for some children.

17. Social workers visit children subject to child protection plans, according to their individual needs and circumstances. However, visiting for children in need is less consistent. Social workers talk with warmth about the children they work with and know them well. Inspectors saw some good examples of direct work used to gain the views of children, but this is not explicitly recorded in assessments and plans and does not always inform the analysis of need. (Recommendation)

18. Recording is not always up to date on children's case files. Consequently, it is difficult to understand whether actions are complete or if plans are being progressed effectively. Inspectors raised several children's cases with senior managers, as it was unclear from their records whether children had been visited by social workers. These visits had taken place but had not been recorded onto the system quickly enough. (Recommendation)

19. When children are at risk of significant harm, decisive action is taken to ensure that they are protected. Child protection plans are reviewed regularly through conferences and core groups, although the quality of plans is not yet good enough. Too many plans focus on adult behaviour, rather than the impact of that behaviour on children, and they fail to differentiate the needs of individual children in the family. They are often not outcome focused and do not consistently have specific and measureable actions. This can result in visits to children lacking purpose, or an insufficient focus on measuring progress in reviews. Contingency plans are often not clear enough to enable families to understand what will happen if progress is not made. (Recommendation)

20. Intervention for children in need is not strong enough. Although improvements in child in need planning are evident across the service, which is leading to improved outcomes for some children, this is not always happening at the pace required. This is particularly evident in those parts of the service in which caseloads are higher.

21. A good range of services is available, and these are improving outcomes for children, including those who have experienced domestic abuse. The 'relay' scheme supports the early identification of children living in households where domestic abuse is present, ensuring that services are provided before needs escalate. The Space programme provides group support for children affected by domestic abuse. Children have given positive feedback on the impact that this service has had on their ability to cope with their home situations. Multi-agency

public protection arrangements and multi-agency risk assessment conferences are effective in protecting children who have contact with individuals who are considered to be the highest risk.

22. Concerted work has taken place to address historical drift and delay through use of child protection processes and the PLO but is not yet sufficiently consistent. At the time of the inspection, no children were the subject of a child protection plan for more than two years, and the number of those who were the subject of a plan for longer than 18 months has reduced significantly due to the local authority's focus on this area. There has been significant work by the local authority, supported by the LSCB, to strengthen the response to children exposed to chronic neglect. This has included a comprehensive response to neglect of children with disabilities, following two serious case reviews. This work is beginning to see impact, with improved assessment and planning evident for this cohort of children.

23. There have been recent improvements in the use of the PLO, with increased oversight through the appointment of a case progression officer and more focused tracking. Pre-proceedings letters to parents outline concerns and required actions clearly. Legal planning meetings are convened when concerns escalate but could, on occasion, be held earlier to ensure a more proactive response to escalating concerns. This is particularly evident in respect of planning for unborn babies, which is not always sufficiently robust. Escalation by partners and the court has resulted in increased focus on this area of practice.

24. Inspectors saw evidence of escalation from child protection chairs in response to delays in actions being completed for individual children. However, this is not always effective in rectifying shortfalls in practice with sufficient pace. While escalations are individually monitored, senior managers have only recently begun to collate these, limiting their ability to identify themes.

25. Work to protect children at risk of sexual exploitation is effective for the large majority of children. Risk assessments inform ongoing planning, with complex strategy meetings ensuring comprehensive multi-agency involvement. However, not all risk assessments are updated with sufficient regularity or used effectively to inform analysis. The local authority has commissioned services to respond to the needs of children at risk of sexual exploitation, and this has led to improved outcomes for some children. The introduction of a pan-Bedfordshire child sexual exploitation group has given greater scrutiny and understanding of issues and prevalence.

26. The local authority has responded to the police practice of recording children as absent rather than missing, introducing a missing coordinator in the MASH to review all absent and missing notifications. Effective processes are in place for responding to new contacts regarding children who are not currently supported by the local authority who go missing from home, and return home interviews take place when needed. However, the response to incidents of going missing

for children already in receipt of statutory intervention is less effective. A commissioned service provides return home interviews, but there is a lack of persistent follow-up to encourage children's engagement. This has resulted in a low rate of return interviews. Inconsistencies in social work recording and delays in uploading return interview documents mean that it is not always clear whether return interviews have taken place. As a result, the use of intelligence in risk assessments and plans for individual children is inconsistent. When concerns about incidents of going missing indicate the need for protective action, intervention is more effective, with the necessary action taken when required. (Recommendation)

27. Senior managers have acted to address identified weaknesses in respect of the response to missing children. Guidance has been refreshed and updated training provided to staff. Work is under way to review the contract with the commissioned provider for return home interviews. Escalation has taken place with strategic leads in the police. However, this is too recent to evidence impact. (Recommendation)

28. Arrangements for tracking children missing education are effective. Education welfare officers work closely with schools and other partners to return children to school or improve attendance. Alternative provision meets the needs of 68 children well, and virtually all are on full timetables. The manager with responsibility for children who are electively home educated maintains comprehensive records and undertakes appropriate safeguarding checks. Fifty-three electively home-educated children are known to the local authority.

29. Work with 16- and 17-year olds who present as potentially homeless and vulnerable is thorough. A specialist social worker completes very competent assessments with this group of children and attempts to maintain contact with those who are more vulnerable and unwilling to accept services elsewhere. The local authority does not currently collate the outcomes of advice and help provided, which limits its ability to understand the impact of the service.

30. The response to children who live in private fostering arrangements is not sufficiently robust. Notification of new arrangements identified by partner agencies has been consistently low, suggesting that knowledge and awareness are not widely prevalent. There is no lead worker responsible for these children, and this weakens promotion and awareness raising. Most assessments seen provided a coherent picture of children's needs and the carer's capacity to meet them, but important safeguarding checks are not always completed for all children. (Recommendation)

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

Summary

A range of services support children to remain living with their birth families. When children need to be looked after, most decisions are prompt and appropriate. Children who return home from a period in care receive appropriate support from social workers to ensure that they are safe and well.

The large majority of children looked after live in good placements where their needs are met. Children are supported to spend enjoyable time with their carers. Most children are visited regularly and enjoy positive relationships with social workers who know them well. However, some do not have stable placements, and a small minority experience unnecessary placement moves, particularly during their first few months in care.

The quality of assessments and planning for children looked after is inconsistent. Plans are not routinely updated with new information or when children's circumstances change. Despite recent improvements, a legacy of inconsistent oversight has delayed plans being progressed for some children. Work to improve timescales for the progression of children's cases through the courts is beginning to make a difference. Permanence planning for the majority of children is effective, and permanent care options are considered at an early stage for almost all children entering care. Plans for permanence are based on appropriate assessments of need and, for most children, are progressed in a timely way. However, a very small minority of children have waited too long for permanence to be secured for them.

The CiCC has recently been relaunched, with plans to widen participation to include care leavers. The children in care pledge has been refreshed and is about to be reissued. However, not enough children know enough about these important promises.

Services for children requiring adoption are good; these children benefit from early planning and good support. Prospective adopters are assessed, trained and supported well. Post-adoption support is readily available. Transitions to adoptive placements are well planned, giving children a positive start in their new homes.

Leaving and aftercare team workers build positive relationships with care leavers and support them well to become successful and independent adults. This includes good support to help them to find and sustain suitable accommodation, and, for an increasingly large proportion, to secure employment, education or training. Good pathway plans are in place to support this work, but some are not sufficiently up to date or authorised quickly enough by managers.

Inspection findings

31. The local authority works hard to ensure that children who are at risk of becoming looked after remain with their families. A range of services provides support to help children at home and prevents them coming into care. Thresholds are appropriate; as a result, children only come into care when it is in their best interests to do so. For almost all of these children, decisions to look after them are made within the right timescales to meet their needs.

32. Social workers know their children well and have positive relationships with them. They visit them regularly, and the majority of children are seen alone. Direct work, although undertaken, is not used sufficiently to inform assessment and planning, and case recording does not always clearly reflect the child's voice. (Recommendation)

33. Pressures in social work capacity in some teams during the last year affected the quality of social work evidence presented in court proceedings. This issue, coupled with protracted proceedings in respect of several larger groups of brothers and sisters, has resulted in a decline in performance in timescales for proceedings. Following escalation by the courts, senior managers have strengthened oversight of proceedings work. This is beginning to result in more effective and timely progression of court work.

34. The majority of children looked after benefit from assessments that address their needs. Assessments completed when children first become looked after are comprehensive. Social workers use a range of assessment tools to inform their assessment of risk and need. However, assessments updated for the purpose of children's reviews do not fully consider diversity issues or the child's voice. They also lack consideration of the impact of recent changes in children's circumstances, and sometimes analysis is insufficiently robust.

35. The quality of care plans is variable; some good examples were seen by inspectors in respect of more recent care plans and those submitted to the court as part of proceedings. Less effective care plans lack clear actions and outcomes and are not sufficiently focused on timescales for delivery. Some are not being updated quickly enough following changes in children's lives. When management oversight is less effective, these weaknesses are not addressed. However, casework over the last six months indicates that managers have become more focused on scrutinising the quality of plans and ensuring that recording is up to date.

36. Almost all children's reviews are timely. IROs meet children between and before their reviews, to consider their thoughts, feelings and views. There has been significant improvement in the number of children participating in their reviews, and 98% have participated in the most recent reporting period. Review meetings are effective. Reports are individualised and child focused, using a format developed in partnership with the CiCC. IROs contribute to quality assurance and oversight of children's cases. When issues are identified,

concerns are escalated to managers, but this is not always effective in addressing shortfalls quickly.

37. The advocacy service commissioned by the local authority supported 52 children during 2015–2016. This service provides visits to children living in residential placements, a telephone helpline and additional legal advice for children looked after if needed. Too few children have benefited from an independent visitor during the last year. The local authority is in the process of recommissioning this service, to increase the volume of independent visitors from March 2017.

38. The vast majority of children live in good-quality placements with carers who meet their needs, and they are making good progress. The local authority has been successful in increasing the number of in-house foster carers and makes extensive use of carers from independent fostering agencies in order to meet the needs of all of Bedford Borough's children looked after. Independent fostering agency carers are engaged through a Bedfordshire-wide framework, and there are plans for further recruitment in the current commissioning cycle. This approach ensures that the large majority of children live close enough to home to maintain friendships, school placements and leisure interests. Assessments of foster carers are comprehensive, and their achievements are celebrated. Foster carers receive effective support from their supervising social workers.

39. When children need placements, late notifications from some social workers result in a small minority of children experiencing placement moves within the first few months of becoming looked after. The local authority has taken action to address this issue, requiring managers to increase their focus on timely notification when children become looked after.

40. Children placed in specialist residential provision outside of Bedford Borough are supported well and, as a result, they make good progress and their life chances are improving. This includes children at risk of sexual exploitation and other forms of abuse. Children report positive relationships with staff and have access to a range of leisure activities. They have appropriate access to education and health services, including mental health provision when required.

41. Children looked after, including those placed out of area, benefit from access to a range of health and mental health services, including access to a dedicated 'looked after' mental health service provided by CAMHS. However, further work is needed to ensure that children receive timely health assessments when they become looked after. Only 44% of initial health assessments and 61% of review health assessments were carried out within the required timescales at the time of the inspection. There has been increased focus by health and social care managers, including the introduction of a monthly joint health-tracking meeting, which is having a gradual impact, but progress is too slow. (Recommendation)

42. Contact for the majority of children who do not live with their families is considered and support provided where required. However, inspectors found that, for a small minority of children, assessments of arrangements lacked full consideration of contact with half-brothers and half-sisters. As a result, opportunities are missed for some children to maintain important relationships at a frequency that meets their needs.

43. When children's needs indicate that they cannot return home, planning for permanence for most children is strong. Social workers and managers work hard to secure children's permanence through adoption and special guardianship orders. When it is in children's best interests to remain with foster carers on a long-term basis, these are approved by the fostering panel. Inspectors saw effective joint working between children's social workers and supervising fostering social workers, resulting in sound appraisal of risk and sensitive planning for children. However, despite some good work by team managers to drive permanence planning, a lack of join-up between the various individual team trackers has hindered strategic oversight. (Recommendation)

44. For the majority of children with care plans to return home, robust assessment of risk and effective support services enable them to return to their families and remain there. For the few children who return to their parents' care contrary to their care plans, risks are properly assessed and efforts made to ensure a successful outcome.

45. Children at risk of sexual exploitation are identified, protected and supported. Interventions are based on robust assessments that identify risk, and services offered respond to children's needs. Engagement with children and their carers has resulted in reduction of risk and in children making good progress.

46. Children who go missing from care benefit from positive relationships with their social workers, but too few children receive return interviews following episodes of going missing. When return interviews do take place, they are not always well recorded or consistently used to inform the management of future risk. When risks increase, planning is more effective, with multi-agency strategy meetings held to ensure a partnership approach to minimising risk. (Recommendation)

47. The quality of work with unaccompanied asylum-seeking children is a strength. Specialist trained workers ensure that children's needs and vulnerabilities are assessed. They are placed in supportive placements and early action is taken to clarify their immigration status. Social workers provide effective support to ensure that their health and education needs are addressed.

48. The DCS and the senior management team took decisive action two years ago to ensure rapid improvement in the capacity and capability of the virtual school team. Good progress has been made as a result of close monitoring by the interim executive board, established to oversee improvement of the virtual school, and chaired by the lead member for education and early help. The large

majority of personal education plans (PEPs) are now of good quality. Managers have successfully introduced e-PEPs for all children looked after up to the age of 16. Appropriate training is provided for social workers and designated teachers, which is improving the quality of plans and the impact of PEP meetings. Virtual school team members attend all PEP meetings held for children at key transition points at schools within and outside of Bedford Borough. Headteachers from schools report that the virtual school team provides good levels of support and challenge to help them to ensure that their children looked after make the best possible progress.

49. The very large majority of children looked after are in good or better schools. Virtual school managers, the virtual school head and the chief education officer carefully monitor the progress of the very small number of children in schools that Ofsted judges as less than good. Working closely with social workers, they ensure that these schools continue to meet the children's education, placement and broader needs. They also ensure that pupil premium is used to support learning well, for example by providing one-to-one tuition, to give additional support where required.

50. The majority of children looked after are making at least expected progress as a result of the better support that they are receiving. Examination results for Summer 2016 demonstrate that the key stage 4 attainment gap is closing, with 25% of children achieving at least five GCSEs graded A* to C and including English and mathematics. The local authority expect the gap to close further once the November 2016 examination results are taken into account.

51. The CiCC was relaunched in January 2017. There are now two age groups, to reflect the need to engage both younger and older children. A new participation team is in place, and the pledge to children looked after and care leavers has been revised. Children who met inspectors were confident that their social workers advocate on their behalf and ensure that they receive the support that they need. However, as the local authority has not yet disseminated the recently refreshed pledge, not all children are aware of the authority's important promises to them.

52. Children from the CiCC do not attend the corporate parenting panel, limiting opportunities for children looked after to engage with political leaders and decision-makers, and this restricts its impact despite an ambitious participation strategy. (Recommendation)

The graded judgement for adoption performance is that it is good

53. Permanence is a priority for children in Bedford Borough. Adoption is considered at an early stage for all children who cannot be cared for by their birth families. Plans for adoption presented to the agency decision-maker (ADM) are timely and in some cases exceed expectations, with permanence plans considered before the child's second looked after review. During the first three quarters of 2016–17, eight children were placed for adoption and 11 adoption orders granted. An additional 11 children are provisionally matched with prospective adopters, with only three children awaiting matches to be identified and proactive work under way for them.

54. The local authority ensures that children receive an effective service through a well-established team of experienced permanent social workers. The team manager understands well the needs of children awaiting adoptive placements. Managers maintain good oversight, with robust tracking of children awaiting permanence.

55. The local authority has taken time to achieve successful adoption for two groups of brothers and sisters who have complex needs. While this is a positive outcome for the children concerned, it has affected the authority's overall performance in relation to the timeliness of adoption. Setting aside the impact of this small cohort, most children have a decision for adoption, matching and placement with prospective adopters within national timescales.

56. The assessment and approval of applicants to adopt is timely. Assessments are comprehensive. They robustly analyse children's wishes and feelings and the effect of adoption on children within the adoptive household and thoroughly consider ethnicity and diversity. By working closely with neighbouring local authorities, Bedford Borough has extended the availability of adopters for brothers and sisters, those who have complex needs and older children.

57. Adopters spoke positively about the support that they have received during the assessment, matching and placing processes, stating that this prepared them to become parents and understand and manage their child's behaviours on placement.

58. The recently introduced 'foster to adopt' policy is beginning to demonstrate success. As this has gained prominence, this option is actively promoted with prospective adopters. Consequently, several children are benefiting from these early permanence arrangements while they go through court processes.

59. For the vast majority of children, staff work closely with birth families, foster carers and IROs to find suitable adoptive families for children through effective family finding meetings and planning for placement. For some children,

provisional matches are made prior to the final court order, enabling children to achieve early permanence.

60. Good child permanence reports identify current and future needs, and family finders regularly visit children and their foster carers. Assessments to inform decisions as to whether to place brothers and sisters together for adoption are comprehensive and thorough. These provide a comprehensive overview of children's needs to inform placement decisions. Children from minority ethnic backgrounds are carefully matched with appropriate adopters. Children over the age of five are considered for adoption and placed successfully. Children benefit from assessed and planned contact with their birth families post adoption.

61. The appropriately constituted adoption panel provides good scrutiny of adoption plans and considers potential matches carefully. The panel and its chair have been effective in challenging weaknesses in the quality of matching reports and support plans. The ADM maintains regular contact with the panel chair, who is managed by a neighbouring local authority, to ensure a focus on any areas of concern or areas for improvement.

62. Post-adoption support is meaningful and effective. Children and adopters benefit from a wide range of services from within the local authority's own resources or the adoption support grant. In the last year, these have included individual or family therapy, attendance at training conferences, targeted group work and multi-systemic therapy. A quarterly newsletter ensures that families are kept informed of the adoption support fund, support groups, events and research. Birth parents access support individually or in group settings at a time that suits their needs. The local authority assures itself of the effectiveness and impact of this support through regular discussion with children and their families.

63. Children are provided with colourful and informative life story books and later life letters in the early days of their adoptive placement. However, the quality of later life letters is too variable. Only some provide a clear and concise account of the child's history in child-friendly language, avoiding social work jargon and including sufficient information about birth and adoptive families. (Recommendation)

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

64. The leaving and after care team currently works with 111 care leavers. Social workers and a personal adviser in the team have manageable caseloads. They work closely and effectively with the very large majority of young people to support them on their journeys to independent adulthood. Social workers in the team start working with young people from the age of 15, which enables smooth transitional support for young people as they move on from being a child looked after. It also helps to establish earlier trust and understanding between young people and the workers who support them. Plans are in place to increase capacity in the service through increasing the number and proportion of personal advisers. This will reduce caseloads further and provide more opportunities for building relationships with young people.

65. The local authority is in touch with almost all of its care leavers. Staff know the young people they work with well and meet with them regularly, proportionate to young people's needs. For some young people, this involves frequent visits by their social worker or personal adviser, which young people find supportive. Staff respond to contact from care leavers between planned visits. If contact is lost, social workers are tenacious at trying to re-establish contact.

66. The content of the very large majority of pathway plans is good. Pathway plans provide detailed information about young people and reflect their views well. They record in detail the support that young people need to make good progress towards becoming independent and self-sufficient adults. Plans include clear targets and are regularly reviewed, which reduces drift and delay in meeting the needs of young people. However, a small minority of plans are not authorised in a timely way by managers, and not all are updated at a frequency consistent with young people's changing circumstances. (Recommendation)

67. Young people told inspectors that they feel safe in their environment and their accommodation and that they are well supported. Social workers are clear about the risks that young people may face and put appropriate plans in place to reduce the risk of harm. Young people develop good relationships with their social workers, who also help them to understand the boundaries of acceptable behaviour and to take responsibility for their own actions.

68. Staff support young people well to find and sustain appropriate accommodation. The very large majority of young people live in suitable accommodation, which meets their needs well. Bed and breakfast accommodation is not used. Young people are aware that they can stay put in their foster care arrangements beyond the age of 18, and a small but increasing proportion are benefiting from this option. They are pleased that this allows them to leave care at a time that is right for them.

69. Social workers and key workers are effective at providing support to young people to help them to develop essential independent living skills. These include being able to budget and to cook for themselves. Young people are confident that support will be available for as long as they need it; there are examples where this has extended beyond the age of 21 when needed.

70. Social workers provide effective support to unaccompanied asylum-seeking children leaving care, helping them to develop the skills that they need to make good progress towards becoming independent. Their cultural needs are considered in planning, their health needs are prioritised and they are supported to learn English.

71. Due to a vacancy in the designated nurse post for children looked after and care leavers, not all young people have received their recorded health histories. Senior managers responded decisively when this shortfall became known during the inspection, ensuring that pathways are clear and that all young people have them. Despite this problem, the large majority were aware of their health histories, because social workers had ensured that the health sections of pathway plans were completed and shared with them.

72. There have been significant improvements in the proportion of care leavers who benefit from education, employment or training (EET) over the last two years. The council has significantly improved its performance in this area, to levels well above the last calculated national and statistical neighbour rates in 2015−16. Almost all young people who met inspectors said that social workers had supported them well to make good decisions about their futures. As a result, they are in education, training or employment that meets their immediate and longer-term goals. Twelve are in higher education. Despite this positive progress, the local authority has not set aside apprenticeships within the council specifically for care leavers.

73. Young people know that their social workers have high aspirations for them, helping them to take pride in themselves. Those who met inspectors were pleased that their achievements were celebrated. This includes a well-attended annual awards event which is supported by carers, social workers, senior leaders, the elected mayor and councillors, which young people are positive about. They also feel that it would be good to create case studies, which would show that care leavers can be just as successful as other young people.

74. Care leavers said that their social workers had made their entitlements clear to them, but they do not have them written down anywhere. Managers and social workers have developed a children looked after and care leavers' pledge, following workshops which included care leavers. The resulting document covers the entitlements well and provides helpful explanations, using age-appropriate language. However, the final draft is yet to be formally endorsed and distributed, and, as a result, young people have nothing to assure them that they are receiving all the support that they are entitled to. (Recommendation)

Leadership, management and governance	Requires improvement

Summary

Senior leaders and the elected mayor set up an improvement board in 2014, having recognised the need to take robust action in response to identified concerns about the effectiveness of children's services. This has brought additional scrutiny and challenge, helping to ensure strategic oversight of performance and progress. As a result, senior officers and political leaders have a good understanding of the overall strengths and weaknesses of services to children and families in Bedford Borough.

Significant work has been undertaken in the last two years to put in place a comprehensive early help offer to families and to ensure a robust initial response to concerns about children and their families through a MASH. A programme for improvement has been pursued, but, despite progress being made, a number of core services for children and families are not yet good enough.

The capacity of staff to respond to children's needs is challenged by high caseloads in some areas of service. Inconsistent frontline oversight and poor-quality supervision for some social workers mean that progress in improving practice is slow. Gaps in the recording of work undertaken, poor-quality plans for some children and a lack of timeliness in response have led to some drift and delay in a minority of children's cases.

The local authority, together with its partners, is able to identify and improve outcomes for children at serious risk of sexual exploitation. However, it has not yet established a robust process to ensure that all children who go missing are spoken to on their return and that information gathered is collated to better inform the overall assessment of risk of individual children and associated risk across the borough.

More needs to be done to ensure that the voice of the child is better recorded in casework and taken into account in assessments of need and plans to achieve better outcomes.

The local authority has been slow to engage children looked after and those leaving care in the work of the corporate parenting panel. The panel has had limited impact; not all children looked after are aware of the pledge to children in care, and there are no apprenticeships available to care leavers within the local authority. Adoption services are good, and adoption is considered, when appropriate, for all children at the earliest opportunity. There are a range of good support services available to all adopters.

Work with young people about to leave care and those who have already left care is good. Young people feel well supported by leaving care staff, and many have positive outcomes as a result.

Inspection findings

75. The DCS and his senior management team provide strong strategic leadership. Together with the chief executive and elected mayor, they have a clear vision for service improvement. They know what good services should look like and how outcomes for children and families need to be improved. They know the strengths and weaknesses of children's services, having already identified almost all of the deficits seen in this inspection. They are seeking to ensure progress through a robust improvement board and have made good use of peer reviews to provide external validation of practice as a measure of improvement. However, significant challenges remain, and the local authority is not yet providing good enough services for all children and families in Bedford Borough.

76. Following significant changes in senior and middle management within children's services, the local authority has strengthened the frontline response to children and families in need of services. It has established a robust MASH, which ensures an effective response to the identification of risk to children. A strong early help offer is now reaching substantially more families from a very low base in 2014–15. When children come into care, outcomes for the vast majority are positive, with plans for permanent solutions for them considered at an early stage. Almost all children in need of alternative families are placed, including with adopters, in a timely manner. For many children who remain in the care of the local authority, services for them in preparation for leaving care lead to better outcomes.

77. Partners have a clear vision and commitment to working together to improve outcomes for all children in Bedford Borough. There are clear and established links with the Health and Wellbeing Board (HWB), the clinical commissioning group and the LSCB. Chaired by the elected mayor, the HWB is focused on ensuring better outcomes for children and is influential in demonstrating where to develop, maintain and invest in services to achieve the greatest impact. The children and young people's plan (CYPP) sets out the priorities for children and young people and is aligned with the joint strategic needs assessment (JSNA). Vulnerable children are a high priority, and there is a focus on early prevention and intervention and in relation to child sexual exploitation.

78. Links between the chief executive, the DCS and the LSCB independent chair are well established, and regular meetings are in place. The chief executive meets regularly with the LSCB chair, as does the DCS. Respective roles are clear and understood.

79. Performance information is well developed, and monthly scorecards detail progress against targets across a wide range of indicators. These are available to a range of staff including at team level. This ensures that managers are

aware of underperformance, both internally and in relation to statistical neighbours and national performance.

80. An established quality assurance framework includes a range of audits undertaken, focusing on all areas of children's services on a rolling four-month programme. The local authority's audit tool is robust and is able to demonstrate both compliance with service processes and practice quality. However, frontline managers are not yet responding to audit findings quickly and fully enough, contributing to further delay in ensuring remedial action.

81. Child protection conference chairs and IROs are becoming more effective in identifying and escalating issues of concern and are beginning to make a significant contribution to quality assurance processes as a result. Escalation processes are in place, and there is evidence of use across all areas of practice. However, responses are inconsistent and, in some cases, lead to further escalation due to a lack of timely response.

82. The local authority has struggled to establish and maintain workforce stability in children's services. In particular, staff turnover has been significant in recent years, at 38% in 2015–16, and 50% of current social workers are locums. This, together with high caseloads in assessment and family support teams, has placed significant strain on the ability of the service to ensure consistent quality of practice.

83. Senior managers have proactively responded to these challenging circumstances with a workforce strategy designed to improve recruitment and retention. This includes a career progression pathway for social work staff, competitive salaries, a comprehensive training and development programme and a newly qualified social worker training academy. As a result, there has been a sizeable reduction in turnover, to 15.6% in the first six months of 2016–17. Almost all management posts, including those of the senior leadership team, are now filled by permanent staff. The high ratio of locum posts is in part a consequence of the authority increasing the overall social work establishment.

84. The authority has recognised that further investment is necessary to reduce caseloads and has committed substantial additional funding for a further 19 social work posts. Current high caseloads have limited social workers' capacity to ensure timeliness of recording and overall responsiveness. Work undertaken is not always recorded and, in many cases, there is a considerable delay before it is placed on the social care information system. This has limited the ability of managers to oversee progress and to ensure that children and families are receiving the right support. (Recommendation)

85. The quality of recording is inconsistent and demonstrates that, in some instances, social workers are unclear about the purpose of their interventions. The voice of the child is not consistently well evidenced in case recording, although there are some examples of good-quality direct work. Children's plans

lack clarity in actions and timescales. In a minority of cases, this leads to drift or delay, although almost all children eventually have a positive outcome. The current structure exacerbates the number of different social workers that a child will have and leads to pressure on family support teams, in particular, contributing to compliance and quality of practice issues. (Recommendation)

86. Relationships with the Child and Family Court Advisory and Support Service (Cafcass) and the family court are effective. The court identified concerns regarding weaknesses in the local authority presentation of cases, which have resulted in a deterioration in the length of proceedings to 35 weeks for the year to date. The local authority has sought to tackle this with the introduction of a detailed court tracker, regular weekly meetings with heads of service to drive planning and close monitoring by a newly appointed case progression worker. Senior managers are responsive to the court's concerns, and Cafcass reports more recent positive work in relation to revocations of placement orders.

87. There is evidence of recent improvement in respect of the frequency of supervision. Management oversight and case supervision are evident on the majority of children's case files. These vary in quality, with some good examples of comprehensive case management but inconsistencies in respect of ensuring reflection or clear actions to drive planning for children. The quality of staff supervision is more variable, with little evidence of reflection or focus on improvement. This means that senior managers' messages about getting to good are not having the impact intended and are not consistently being reinforced. (Recommendation)

88. Political and professional leaders demonstrate a commitment to further strengthen practice in respect of child sexual exploitation. Work has been undertaken under the pan-Bedfordshire missing and child sexual exploitation group to develop a local child sexual exploitation problem profile and child sexual exploitation strategy. In 2015, the local authority commissioned a review of its approach to tackling child sexual exploitation and more recently, the external charity commissioned to undertake the review returned and provided a positive report on progress. The local authority chief executive chairs a Bedford Borough vulnerabilities subgroup, which ensures multi-agency ownership to tackle child sexual exploitation in Bedford Borough.

89. There is active awareness raising about child sexual exploitation, including training of taxi operators and drivers. Disruption work has been undertaken with hotels, fast food outlets and licensed premises across Bedford Borough. Information about the risks of sexual exploitation has been included in a programme of input to local schools, which has focused on healthy relationships and issues associated with domestic abuse.

90. Despite a clearly defined strategic approach and an appropriate response to children recognised as being at risk of sexual exploitation, the response to children who go missing is not yet effective. The approach by police to define many children as absent rather than missing means that the MASH has to

triage all notifications to determine risk. The local authority has not been able to ensure that all those children who should have return home interviews have had them and, when they have been completed, they are not consistently recorded or uploaded to children's electronic records. This means that not all relevant information is available to inform the local authority and its partners about the extent of all risks to children. (Recommendation)

91. The local authority has recently taken action to respond to these identified weaknesses, including making a decision to re-commission the return home interview provider, as well as making the appointment of a missing coordinator in the MASH, but it is too soon to measure impact. The local authority senior management team and the police, with the additional scrutiny of the LSCB chair, have very recently agreed a range of further actions to strengthen safeguarding for children who go missing.

92. A strategic needs analysis completed in April 2016 provides a basis for future commissioning but has not informed the current 2016–2020 children looked after sufficiency commissioning strategy. The strategy lacks an evidential base to support the stated priorities, and the local authority was not able to provide an action plan for implementation. There is, however, a more robust internal review and re-tendering process of currently commissioned services and a willingness to end contracts when service delivery has not been sustained.

93. The lead member for children's services chairs the corporate parenting panel. Membership is appropriate and includes foster carers. It has access to a range of reports concerning services to children looked after, but links with the CiCC are underdeveloped. No children sit on the panel, and representatives from the council do not attend regularly. This limits the opportunities for the panel to hear directly from children and does not help to promote engagement with those children whom the local authority cares for. Evidence of impact of the panel is limited. Insufficient corporate support has frustrated the panel's efforts to secure in-house apprenticeships for care leavers, despite the lead member and DCS supporting this.

94. Children spoken to are confident that social workers advocate for them and ensure that they receive the support that they need. However, not all children are aware of the authority's pledge to children looked after. This has recently been refreshed but has not yet been disseminated. Care leavers who met inspectors were unaware of the CiCC or the care leavers' charter. The local authority has taken some steps to engage children and young people, for example in staff recruitment and training, but has been slow to ensure that all children looked after have a voice and are involved in developing the service. (Recommendation)

95. The authority has a clearly defined complaints process, with almost all issues resolved at an informal level. Very few complaints require a formal investigation, and there has been only one complaint that required a stage 3 independent investigation and panel adjudication in recent years. While an

annual report is provided, which includes actions arising from complaints and lessons learned, there is no separate analysis of young people's complaints. This is a missed opportunity to focus on children's issues.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

Effective leadership by the independent chair has led to the development of a strong partnership and a shared commitment to improvement. The Board maintains a clear line of sight to frontline practice, helped by a proactive and visible chair who engages directly with frontline staff.

The Board's system of assurance monitors and evaluates frontline practice effectively. A comprehensive multi-agency dataset informs the business plan, but it requires strengthening to include more robust analysis and commentary. Early help performance information is well embedded and used well to monitor the effectiveness of early help delivery across the partnership.

Frontline professionals have access to a range of single-agency and multi-agency safeguarding training, which enhances their skills, knowledge and confidence. The detailed approach to training evaluation and quality assurance evidences the Board's continual efforts to improve course content and relevance.

There is an established multi-agency audit programme. Findings from audits are disseminated effectively to subgroups to inform work plans. However, action plans arising from multi-agency audits are not currently monitored, although work is in progress to rectify this shortfall.

The LSCB has given priority to engaging children and young people more effectively in its work, commissioning a voice of the child report to inform its business plan and priorities. As a result, the Board has commissioned a new theatre production ('In the Net') focusing on online safety and cyber bullying.

The Board is rigorous in ensuring that lessons are identified and learned from serious case reviews. Healthy debate is evident and learning reviews are used to good effect when a case does not meet the serious case reviews criteria. Practitioner briefings are produced following reviews, and the LSCB training programme includes termly half-day briefings, which draw on learning from both local and national serious case reviews.

The Board has given safeguarding children with disabilities a high priority in the past 12 months, hosting a spotlight event on safeguarding children with disabilities and providing challenge to the Children's Services Improvement Board is resulting in improved practice.

Recommendations

96. Ensure rigorous analysis of performance information received by the LSCB across the partnership, to inform impact evaluation.

97. Ensure that action plans arising from multi-agency audits are monitored so that the LSCB understands their effectiveness and impact on practice.

Inspection findings – the Local Safeguarding Children Board

98. Robust governance arrangements support effective partnership working in Bedford Borough. The strong independent chair provides effective leadership and a rigorous focus on safeguarding vulnerable children. This is a maturing board with focus on challenge and impact assurance from partners.

99. The chair has sought to ease the burden on partners who work across several local authority areas, by ensuring that the Board and subgroups share resources across Bedfordshire in key areas of common concern. These include child sexual exploitation, training and procedures. This has resulted in better engagement and accountability across the partnership. There is a clear line of sight from the strategic Board to frontline practice. Particular strengths are the introduction of a frontline practitioners' group and a proactive, visible chair who engages directly with frontline staff to assure herself of practice and to fully understand any barriers to improvement.

100. The Board works well with other strategic partnerships, providing particular challenge to the Children's Services Improvement Board, Community Safety Partnership and Health and Wellbeing Board. Priorities align with other strategic plans, and partners are clear that these drive plans in their own agencies. An ambitious business plan contains clear progress measures, but is not yet effective in consistently evidencing what difference is being made for children.

101. All key partners contribute to, and provide quarterly commentary on, a comprehensive dataset. There is evidence that this has led to improvements in practice. For example, the decision made, in response to increased incidence of self-harm presentations, to locate a CAMHS worker in the local accident and emergency department is ensuring quicker access to children's mental health support. Analysis of performance information could better highlight areas of weakness across the partnership, to ensure a focus on the critical areas for development. (Recommendation)

102. A system of assurance reporting is employed by the Board to monitor and evaluate the effectiveness of frontline practice. Assurance reporting continues until the Board is satisfied with progress. Examples of where this has led to improvements include work on the threshold document, to improve understanding and the quality of referrals to the MASH, and challenge to the Children's Services Improvement Board, resulting in work to strengthen capacity and the quality of work in the children with disabilities team.

103. A move to a pan-Bedfordshire LSCB training unit in April 2016 has led to greater consistency of learning and understanding across the partnership. A wide range of training opportunities are on offer, including e-learning, which is well embedded with increasing uptake and completion over the past year and high satisfaction ratings from partners. The training offer clearly links to the Board's priorities, reflecting themes from serious case reviews and audit activity. Frontline professionals have access to a range of single-agency and multi-agency safeguarding training. The Board has identified the need to develop a better understanding of training needs across the partnership, to avoid duplication and make best use of resources. A survey of partners to find out unmet need and what staff are accessing has been completed, and analysis of this is under way to inform the 2017–18 work plan.

104. There is a sophisticated process of evaluation and impact analysis in place that takes the form of a three-stage process: feedback on the day, at day three and six months post-training. Direct interviews with staff and managers held after six months show positive and sustained impact on trainees' skills, knowledge and confidence. A clear system of quality assurance of the training provided is in place, which is reviewed regularly to inform the training plan and to improve content.

105. A significant amount of work has been completed by the pan-Bedfordshire procedures and practice group, chaired by the assistant director (chief social worker) in Bedford Borough, to ensure that there are effective procedures in place. Gap analysis has informed its work plan, and the ambition is to have one set of pan-Bedfordshire procedures.

106. Multi-agency audits link with LSCB priorities and are informed effectively by learning and issues arising from other subgroups. All key partners contribute to audit, despite capacity issues. To ease the burden on partners who service all three LSCBs in Bedfordshire, there is some coordination of audit and shared learning. Single-agency audits complement the programme of multi-agency audits and link to performance information and findings from learning and serious case reviews. Findings from audits feed into the executive group of the Board that identifies themes and ensures that learning is disseminated to the other subgroups to inform their work plans. Action plans arising from multi-agency audits are not currently monitored. The Board recognises this weakness, and new monitoring arrangements with the executive group are being put in place. (Recommendation)

107. Each agency has a single point of contact to cascade Board messages and learning. Individual agencies are responsible for ensuring that their frontline staff are up to date with key LSCB messages and know how to access policies, guidance and training. The Board satisfies itself that this is happening through the frontline practitioners' group, asking the 'Have you heard…?' question. Inspectors found that social workers were aware of these important messages and know how to access policies and procedures through the LSCB.

108. Agencies value the scrutiny provided by the Board through the pan-Bedfordshire section 11 audit process. The use of multi-agency challenge events ensures dynamic discussions and rigorous overview of individual agencies' self-assessments, informing the multi-agency action plan monitored by the Board.

109. The Board has made safeguarding children with disabilities a high priority in the past 12 months. Actions taken to respond to concerns about practice include a thematic review, practitioner briefings and training, and a recent spotlight event on safeguarding children with disabilities. The Board receives ongoing assurance reports on the work of the children with disabilities team and triangulates information from other sources, for example the chair of the Board 'walking the floor' and speaking directly to social workers, to maintain challenge to improving the quality of services. This, coupled by challenge to the Children's Services Improvement Board, has resulted in improved capacity, and timeliness and quality of assessments in the children with disabilities team.

110. The Board recognises the importance of facilitating children's participation and has recently secured funding to commission a consultation with children and young people. This work provides clear feedback about children's and young people's views about child sexual exploitation and their personal safety, which the Board is using to inform the development of the business plan. There is evidence that the activity of the Board in awareness raising of safeguarding issues is having a positive effect on young people feeling safe and knowing where to go to ask for help. The Board has established an ongoing relationship with a social enterprise to support the influence of children and young people on its business. It is planning a participation strategy to strengthen this further.

111. The child sexual exploitation group provides effective scrutiny and informs strategic responses well. A child sexual exploitation problem profile has been used to identify a specific area in Bedford Borough and to inform disruption strategies, targeting hotels, fast food outlets, licensed premises and private companies in that area. These disruption activities, coupled with awareness raising and education, have resulted in an increase in contact from a wide range of sources in that area. There has been slower progress in relation to child sexual exploitation training, although an ambitious training programme commissioned for the next two years is about to commence.

112. Through its multi-agency performance dataset, the LSCB monitors the incidence of children going missing from home or care, return home interviews with children and numbers of children missing from education. However, qualitative information is limited. The Board has taken a particular interest in children who are home educated and the processes around them to keep them safe. There is a high level of ongoing scrutiny and challenge by the LSCB in relation to missing children. The chair is proactive in holding the police and others to account in relation to their response to missing children. However, despite monitoring evidence of progress, return interview rates remain low.

113. There has been focused activity to raise awareness of female genital mutilation over the past 12 months, including the development of leaflets and online training. In cases they sampled, inspectors found that agencies' responses to concerns regarding female genital mutilation are appropriate. New procedures for forced marriage and honour-based abuse are in place, but there is limited understanding of the scale of these issues in Bedford Borough. The Board has recognised this and is reviewing its dataset to include information on these issues, in order to target awareness raising.

114. There is an effective child death overview panel, which covers all three LSCB areas in Bedfordshire. Referrals to the serious incident review group are timely, and outcomes and learning from serious case or learning reviews are shared across both groups. The annual report provides an overview and includes Bedford Borough specific information, but the analysis is underdeveloped, and information on the previous five years' data is limited. There is some analysis of modifiable factors, but this would be strengthened by ensuring that patterns and trends are identified locally. Work carried out by the group in response to concerns regarding safe sleeping has led to increased awareness and consistent advice being given across partners.

115. The Board is rigorous in disseminating learning from serious case reviews. Practitioner briefings are produced following reviews; two published in the last 12 months provide comprehensive coverage of learning points and offer links to further support and training opportunities. The LSCB training programme includes termly half-day briefings, which draw on learning from both local and national serious case reviews. Social workers spoken to are aware of the key messages from serious case reviews and thematic reviews. Inspectors saw how this learning had influenced the social work approach to assessment and case planning.

116. All improvement plans following a serious case review need to evidence impact before sign-off and are reviewed at six and 12 months. Governance of these plans sits with the executive group of the Board to ensure robust review, and, if the group is not satisfied with progress, escalation of challenge is swift.

117. The LSCB annual report is comprehensive and clearly identifies achievements and challenges over the reporting period. Evidence of challenge and impact as a result of this is detailed. For example, it includes improved threshold understanding and quality of referrals to the MASH, and partners' understanding and joining up of services concerning domestic abuse.

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 that 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 whom 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 six of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

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