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Havering
LONDON BOROUGH

CHILDREN & LEARNING OVERVIEW & SCRUTINY COMMITTEE SUPPLEMENTARY AGENDA

7.00 pm	Thursday 14 November 2013	Committee Room 2 - Town Hall

Members 14: Quorum 6

COUNCILLORS:

Sandra Binion (Chairman)	Nic Dodin	Frederick Thompson
Gillian Ford (Vice-Chair)	Robby Misir	Melvin Wallace
Wendy Brice-Thompson	Pat Murray	Keith Wells

CO-OPTED MEMBERS:	**Statutory Members representing the Churches**	**Statutory Members representing parent governors**
	Philip Grundy, Church of England, Jack How, Roman Catholic Church	Julie Lamb, Special Schools Anne Ling, Primary Schools Garry Dennis, Secondary Schools

Non-voting members representing local teacher unions and professional associations:
Margaret Cameron (NAHT), Keith Passingham (NASUWT),Ian Rusha (NUT)

For information about the meeting please contact:
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What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

They have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns of the public.

The committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations.

Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research and site visits. Once the topic group has finished its work it will send a report to the Committee that created it and it will often suggest recommendations to the executive.

Terms of Reference

The areas scrutinised by the Committee are:

- School Improvement (BSF)
- Pupil and Student Services (including the Youth Service)
- Children's Social Services
- Safeguarding
- Adult Education
- 14-19 Diploma
- Scrutiny of relevant aspects of the LAA
- Councillor Calls for Action
- Social Inclusion

AGENDA ITEMS

5 OFSTED ARRANGEMENTS FOR THE PROTECTION OF CHILDREN (Pages 1 - 28)

Follow up to meeting held on 19 September 2013. Original report attached.

Andrew Beesely
Committee Administration Manager

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Inspection of local authority arrangements for the protection of children

London Borough of Havering

Inspection dates: **25 February - 6 March 2013**
Lead inspector **Sarah Urding**

Age group: All

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Inspection of local authority arrangements for the protection of children

The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in London Borough of Havering is judged to be **adequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in London Borough of Havering, the local authority and its partners should take the following action.

Immediately:

- ensure that the tracking system for all referrals in the multi-agency safeguarding hub (MASH) service is embedded and that timescales for response outlined in the threshold to services document are met
- ensure effective consideration is given to a child or young person's ethnicity, culture, religion and language in assessments so as to inform planning
- ensure the timely completion and review of core assessments to ensure that children and young people are receiving the appropriate level of services when they need them
- ensure chronologies are clear, recorded and fit for purpose

Within three months:

- undertake a detailed analysis and evaluation, following the implementation of the newly formed MASH, to formally consider any early lessons to define the service and forward plan

- ensure that the common assessment framework (CAF) is sufficiently embedded in the reconfigured early help services within a required time frame and that this is evaluated by the HSCB
- record and analyse contact, referral and re-referral patterns in order to be better able to evaluate how effectively children's social care and its partners are applying the threshold criteria, meeting needs and reducing risks
- review and refine the performance management framework to include key indicators, including measures that are currently missing, as well as comparative data, trend information and projections, with commentary and key information broken down to team or pod level
- ensure the collation and analysis of performance management information to effectively interpret and monitor the quality and impact of all aspects of child protection practice and processes, and the effectiveness of help and support for children in need
- review the functioning and membership of the London Borough of Havering Safeguarding Children Board (HSCB) to ensure it is fully constituted and provides sufficient scrutiny and oversight of the effectiveness of child protection practice and the effectiveness of arrangements for children in need
- review the governance responsibilities and accountabilities to ensure there is communication and a formal link between HSCB and the Chair of the Children's Overview and Scrutiny Committee
- complete the roll out of the children's case management system (CCM) in order to ensure that managers and staff have the tools to do their job properly
- complete the overarching service plan for delivering against the corporate and strategic priorities for children's services and make clear through aligned operational plans the journey ahead for staff, members and partners
- complete the proposed re-commissioning of the emergency duty team (EDT) with minimum delay and as part of that process set clear and unambiguous performance and quality standards for the new service
- ensure the development of a workforce action plan in line with the transformation agenda and workforce strategy that can be monitored, reviewed and evaluated.

Within six months:

- continue to develop and adopt a more consistent approach to supervision in order to ensure that it provides the right level of critical challenge and opportunity for reflection and is a vehicle for driving up practice standards

- develop a more robust approach to quality assurance in order to be able to track qualitative improvements over time, for example the percentage of child protection plans that are outcome focused and/ or measurable
- ensure work is progressed to enable children and young people to access advocacy services which support them to attend child protection conferences
- ensure the views, experiences and feedback from children, young people, parents and carers are used to plan and improve service delivery. This includes implementing a system for the analysis of service user feedback in early help and preventative services.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of four of Her Majesty's Inspectors (HMI) and one seconded inspector.

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. London Borough of Havering has a resident population of approximately 56,700 children and young people aged 0 to 19, representing 24% of the total population of the area. The 0-15 population is estimated to grow by 8.2% by 2016 and 21.1% by 2026. This means there will be 3,500 more residents aged 0-15 by 2016 (increasing from 42,600 in 2011 to 46,100 in 2016). The biggest population increase will be in the number of 5 – 9 year olds, which will have increased by 15% by 2015.

10. Havering has 83 schools comprising 59 primary schools (of which two are academies), 18 secondary schools (of which 12 are academies), three special and three pupil referral units. Early Years service provision is delivered predominantly through the private, voluntary and independent sector in 125 settings; there are 15 local authority maintained nurseries. In 2012, 24.2% of the school population was classified as belonging to an ethnic group other than White British compared to 25.4% in England overall. Some 9.4% of pupils speak English as an additional language. Yoruba and Lithuanian are the most recorded commonly spoken

community languages in the area, with 1.6% of pupils of Yoruba (0.9%) and Lithuanian (0.7%) background.

11. The Havering Children's Trust was set up in 2006 and is chaired by the Lead Member for Children's Services. The Trust includes representatives of London Borough of Havering Council, Havering Acute & Primary Care Trust and providers of community health services. Other representatives include police, probation, voluntary sector and representatives of local schools and colleges. The Havering Safeguarding Children Board (HSCB) is independently chaired. The Board brings together the main organisations working with children, young people and families in the area that provide safeguarding services. Commissioning and planning of health services and primary care are carried out by North East London & City Primary Care Trust (NELC PCT). The main provider of acute hospital services is Barking, Havering and Redbridge University Hospital Trust (BHRUT). Community-based and in-patient child and adolescent mental health services (CAMHS) are provided by North East London Foundation Trust (NELFT). NELFT also provides community health services, as North East London Community Services (NELCS).

12. Early help for children and families in Havering is provided through a range of directly provided and commissioned services. Children and Young People's Services, along with a range of partners, are responsible for the scope and range of the services offered. Services are arranged so that the majority of early help services, council or partners', are delivered through or by children's centres and integrated family support teams. Contacts are received and assessed by the multi-agency safeguarding hub (MASH), comprising social care, police, health and staff from a range of other partners. Services for children assessed to be in need of protection or requiring a child in need plan are managed and delivered by teams within Children and Young People's Services. There is a joint local authority emergency out-of-hours service with a neighbouring borough. At the time of the inspection there were 143 children who were the subject of a child protection plan. These comprise 83 females and 59 males (+ one unborn child). Of these children 45% are aged under five, 34% are 5 to 11 and 21% are 12 years or older. The highest categories of registration were emotional abuse at 46%, neglect at 38%, physical abuse at 15% and sexual abuse at 1%.

Overall effectiveness

13. The overall effectiveness of child protection services is **adequate**. There is an overarching strategy in place for the development of services for children and families in Havering. Priorities within the children's transformation programme have a clear focus on preventative action and early intervention as well as ensuring that the most vulnerable children are protected. Set against a backdrop of improving quality as well as providing savings and efficiencies, services to children and families were restructured in October 2012. A more streamlined management structure is providing the basis for continued improvement, strengthening accountability and moving the service forward.

14. Senior managers are managing change through a series of well attended briefings for staff and partner agencies. Staff are motivated and committed during a time of significant change. However, there is not a sufficiently clear understanding by staff and members of the journey ahead as the 2012/13 service plan does not align transformation plans with plans for improving the quality of services. There is an improved service plan in draft form for 2013/14. Operational plans are not being used by staff. The workforce strategy is not translated into a coherent action plan in line with the transformation of services.

15. The council's key priorities have been to ensure the protection of children during the restructure of services and that the service is appropriately prepared to move forward. This is with a view to integrating children and adult services under one directorate in April 2013. However, progress in meeting some recommendations made following the inspection of contact, referral and assessment arrangements in June 2011 and in the safeguarding inspection in September 2011 has been less effective. This includes some shortfalls in the embedding of the common assessment framework (CAF), implementation of a new electronic recording system and ensuring that responsive emergency duty team arrangements are in place. Although improvements in supervision are seen within the children with disabilities team, overall the quality of supervision is variable and is not providing consistent evidence of reflective practice.

16. The Havering Strategic Partnership (HSP) was replaced during the period of transformation by the overarching Corporate Transformation Board. Alongside the Children and Families Transformation Board and Adult Transformation Board these have been the fora for managing, monitoring and reviewing change. There has been a continuation of the meeting of thematic groups with new partnership groups emerging such as Troubled Families. The Corporate Management Team (CMT) has been the mechanism for bringing the partnership together during this period but the local authority recognises that the impact of the partnership has been reduced during this time. The authority is aware of the need to provide a central point for the coordination of all of this activity to move the service

forward. To this aim the strategic partnership is currently being revised with a view to establishing the HSP anew.

17. Governance and scrutiny of child protection arrangements and the provision of early help are not facilitating robust challenge. While good progress has been made in improving the quality of practice in strengthening families' engagement in child protection processes, the impact of HSCB and scrutiny is less well developed. The HSCB is not providing full evaluation of the effectiveness of safeguarding and is not fully constituted. Elected member roles and responsibilities are developing but there has been insufficient scrutiny of the newly formed MASH and a delay in the evaluation of this service. Too much time is currently being taken to gather information and some lower level cases are not being managed within the prescribed timescales. The planned evaluation of this service has been agreed with partners. The time taken to complete core assessments remains below that of statistical neighbours. Advocacy arrangements for children subject to child protection processes are not yet available although plans are in place for this to be delivered. The engagement of children and their families is a key priority for children's services. While progress is being made in some areas, feedback from children and families to improve service delivery is not yet fully embedded. Needs arising out of culture and ethnicity are not consistently well considered within assessments. The Chair of Scrutiny has no formal contact with the Chair of the HSCB.

18. Underpinning some of the areas for development within the service is the absence of a comprehensive performance management framework that facilitates understanding and robust challenge of the quality of child protection arrangements. While some recent developments are strengthening the ability of elected members and staff to evaluate the impact of services, there is a lack of data collation across the full range of performance indicators and limited use of, and commentary about, comparative and projected data. Operational managers are currently unable to use this information effectively because of the limited capacity of the electronic system as it is rolled out. This is also hindering electronic production of chronologies on case records, resulting in less focused recording of significant events.

The effectiveness of the help and protection provided to children, young people, families and carers

19. The effectiveness of help and protection provided to children, young people and their families and carers in Havering is **adequate.** Arrangements in children's social care for identifying children and young people at risk of significant harm are provided by the recently established MASH. Prompt, effective action is taken to protect children and young people identified at risk of harm. The response to these children is timely and management direction and oversight is robust. However, for some

children who do not meet the threshold of significant harm the MASH team takes too long to gather background information which is leading to delay in assessing and meeting their needs.

20. The arrangements for the delivery of early help are being reorganised as part of the local authority's restructuring of children's services. The plan is to move away from universal to targeted provision with community-based services focused on the most vulnerable children and young people. This is part of a comprehensive strategy to deliver a range of preventative services to children and young people across all age groups. Although it is too soon to evaluate the impact, inspectors have seen emerging examples of help and protection that is both proportionate and well-coordinated for teenagers as well as young children. This help is readily accessible through schools, children's centres and universal youth provision.

21. Homeless teenagers are fast tracked through to the over-12s team and inspectors found high levels of awareness of the risks associated with children who go missing. When this occurs child protection procedures are implemented immediately. Similarly, concerns are routinely shared with police and social care about children who are believed to be at potential risk of sexual exploitation. The welfare and safety of children educated at home are monitored routinely via home visits and if concerns are identified they are referred to the MASH.

22. Previous inspections found that the CAF was insufficiently embedded resulting in poor coordination across organisations. As a result, the HSCB identified improvement in the understanding and use of the CAF across partner agencies as a key priority. However, progress in this area has been slow and an initial improvement in the number and quality of CAFs being completed by partners, partly as a result of the delivery of training, has not been sustained. The tracking and monitoring of CAF implementation is still at a very basic level as evidenced by a rudimentary approach to quality assurance. For example, while the council's own audit of closed CAFs found that 70% of families had their needs met the audit did not provide any information about outcomes for the remaining 30%. The recent introduction of a new data set for collating information about CAF outcomes has not yet been evaluated. The local authority is aware of this and plans are in place to recruit three early help advisors to provide additional capacity and coordinate this work.

23. There is some effective direct work with children, young people and their families leading to positive outcomes for children. Team around the child (TAC) reviews show that lead practitioners enlist support from a wide range of partners to prevent risks escalating. Practitioners build on positive relationships and demonstrate good skills in enabling parents to influence and shape the design of their plans and parents are commonly involved in deciding which practitioner is best placed to lead on the coordination of their plan. In one case for example, it was the parent of a

child with a disability who chose a school learning mentor to lead the TAC to help and support them when the child started school. Family support workers, attached to children's centres, have the flexibility to provide intensive work with families even to the point of being able to make daily visits, including during anti-social hours, if that level of support is needed. Practical support is focused on need, such as walking to and from school with a parent who is struggling to manage their child's behaviour and encouraging parents to play with their children. Practitioners use information arising out of their evaluations well to evaluate the effectiveness of services and are proactive in escalating cases to children's social care when more intensive support and protection is required.

24. Children's centre CAFs are variable in quality. One of the best examples seen demonstrated careful consideration of the impact on the safety and well-being of the children of a range of risks including parental mental ill health. However, plans are not consistently coherent and all too often focus on the tasks that need to be completed and services provided rather than what needs to change for the child. This reduces their effectiveness. Management oversight of common assessments is provided by lead professionals within each agency rather than being coordinated centrally so consistency of these arrangements across agencies is less clear. However, from the evidence of cases seen, information is shared effectively in TAC meetings, with good professional links between agencies working closely together in a local area.

25. When children meet the threshold for children's social care, information is shared in a timely way making it possible to identify and assess risks as part of an effective approach to protecting children. Child protection plans are routinely reviewed and progress is updated by core group members. The council has recently implemented the 'strengthening families' model for use in child protection conferences which enables staff to capture the perceptions of children and young people and be more focused on the experiences of the child. All parents seen following case conferences, core groups and children in need meetings understood the reasons for and intentions of the help and protection provided; understood what they needed to do to protect their child and the consequences if this did not happen. Parents spoke positively about the effectiveness of the help and support. For example, one parent was able to explain simply and easily how the 'strengthening families' model had been used to grade the level of risk in the family. This had contributed to the reduction of risk in this case.

26. The step down from child protection and children in need to CAF is insufficiently planned in some cases; this is currently under review as part of the early help reorganisation. Inspectors did see examples of cases stepping down prematurely without effective agency coordination to support families to sustain the changes they had achieved. In contrast help offered to families identified as part of the Troubled Families

programme is well coordinated. Inspectors have seen evidence of proactive intervention, for example using a whole family approach to reduce anti-social behaviour and improve school attendance.

27. Children with disabilities receive a responsive and high quality service. The short break team demonstrates good quality interventions that address complex family needs and prevent escalation from targeted to specialist services. Parents of children with disabilities are actively involved in commissioning these services. The young befriender's service is having a positive impact on participation in a range of activities for children and young people. Their views are evaluated and feedback about the quality of service is positive. When children with disabilities require a social work service they receive a responsive service because assessments clearly identify their needs, risk is well defined and interventions are appropriate and proportionate. Thresholds for significant harm are understood by the team and the work is focused on outcomes. Management direction is clear and consistent. There is a strategic approach to transition for young people from the age of 14 upwards involving commissioners from health, education and adult services. Inspectors saw interpreters being used to good effect to promote full engagement of parents, carers and children but arrangements for advocacy are currently underdeveloped. There is insufficient analysis of the impact of ethnicity, cultural, linguistic and religious needs which means that for some children their needs are not fully identified or met.

28. Help and protection is well coordinated, responsive and proportionate to need for the majority of children. Case work panels provide a transparent decision making forum for escalating cases to the Public Law Outline and initiating care proceedings. Numbers of looked after children are below that of statistical neighbours and there is accessible support provided to children on the edge of care. Professionals in health, midwifery and adult services have sufficient support from duty social workers to identify risks, for example in cases of adult alcohol and substance abuse and domestic violence, and they escalate cases when necessary. Longer term group work with some vulnerable children, such as that commissioned from Barnardo's for young carers and in the family intervention project (FIP), provides effective help to reduce risks to those children. An inspection of private fostering arrangements in November 2012 found this service to be inadequate and offering a poor response to children. The authority has since taken prompt action to ensure that arrangements are improved by introducing a more robust assessment process and a strengthening of management arrangements. However, numbers of children who are known to be privately fostered remain low and the authority is aware of the continued need to raise awareness of the service amongst the public and professionals.

The quality of practice

29. The quality of practice is **adequate.** The new MASH is having a significant impact on the way in which contacts and referrals are managed. Children at risk of significant harm are identified quickly and social workers based in the assessment team are able to carry out section 47 enquiries without the distraction of having to deal with contacts and referrals where the level of risk or need is less acute. The MASH currently encompasses police, health visitors, probation and a virtual youth service practitioner and there are moves to extend the arrangement to include housing and education in the near future. In the absence of a formal evaluation of the new triage arrangements, the feedback from partners is generally positive. They report that they feel more confident in the responses they get from children's social care, although some partners have indicated that there are still delays in getting feedback from the MASH after making a referral.

30. Thresholds for access to services are clear and the local authority is active in trying to increase awareness and understanding of them. Partners are encouraged to explore their concerns before making a referral and are able to access advice and guidance from social workers in the MASH. A multi-agency referral form (MARF) has improved the quality of information provided by referrers. However there are still too many inappropriate referrals. In the absence of a comprehensive analysis of contacts and referral activity, the local authority's efforts to influence and change partners' practice are not sufficiently targeted.

31. There are good links with the EDT which, despite previous inspection recommendations, continues to provide an emergency only social work service for children and adult services across Havering and Barking and Dagenham at evenings and weekends with minimum staffing. However, the initial screening of calls has improved and EDT social workers have appropriate access to senior managers at all times. The service is due to be re-commissioned before the end of the current financial year.

32. An effective transfer system between the MASH and the assessment team ensures that strategy discussions and section 47 enquiries are timely. Inspectors also saw evidence of the appropriate and timely use of strategy discussions and section 47 enquiries elsewhere in children's social care, including the children with disabilities team. However, some lower priority cases are remaining in the MASH longer than the prescribed timescales and there is also a backlog of amber and green RAG-rated cases waiting for police background checks to be completed.

33. Management oversight of social care referrals is readily evident at every stage with management decisions and case directions clearly recorded on case files, although there is evidence of some duplication at the point of transfer between the MASH and the assessment team. Cases transferring from the assessment team to either the under- or over-12s teams are

allocated within 24 hours. However, because of delays in implementing the new electronic recording system, managers have to use spread sheets to track cases and manage caseloads.

34. Morale is good and social workers say they feel supported by managers who are highly visible and accessible. Working in small 'pods', each with its own senior practitioner, social workers and advanced practitioners receive regular supervision. The quality of that supervision varies from adequate to good. Decisions taken and action agreed in supervision are routinely recorded on case files and, with input from the principal social worker, there is increasing evidence of a more reflective approach to supervision. Caseloads are manageable. A strict limit on the number of cases that social workers carry means that on average they are working with between 18 and 25 children.

35. There is a strong ethos of corporate parenting and social workers are encouraged to establish effective relationships with children and young people. Children are seen, and are routinely seen alone. There is increasing evidence of their thoughts, wishes and feelings being taken into account in assessments and plans. Most statutory visits are carried out in a timely manner and inspectors saw some good examples of direct work with children and young people carried out not just by social workers but also by family support workers attached to children's centres and specialist group workers supporting some vulnerable young people

36. Most initial assessments, and initial and review child protection conferences, are timely. However only 56% of core assessments are completed within the required timescales. Inspectors also saw evidence of slippage in some children in need cases where, in the absence of a formal monitoring system, managers are reliant on supervision to make sure that children in need meetings are held and plans are updated regularly and on time. The introduction of multi-agency panels to facilitate and oversee step-up and step-down arrangements are planned to address that issue.

37. While the quality of assessments is variable, risks and protective factors are consistently identified by social workers. There is increasing evidence of a more robust approach to analysis resulting in children in need, and child protection plans that are clear and coherent. Inspectors saw some examples of good assessments that were comprehensive, coherent and child centred.

38. Child protection plans are reviewed and updated regularly. Most plans seen by inspectors, including CAF plans, are at least adequate, concentrating on key risks and listing actions to reduce those risks. However, they tend to be task and service oriented rather than outcome focused, and the extent to which they are measurable is limited in most cases.

39. Most multi-agency conferences, core groups and children in need meetings are well attended and are effective, not least because of the rigour in tracking progress against decisions taken and action agreed previously. Since November 2012, the 'strengthening families' methodology is systematically being used in all initial and review child protection conferences. This promotes robust risk analysis, shared understanding of aims and objectives, and a firm focus on outcomes for children and young people. Led by the principal social worker, this initiative recognises the central importance of independent reviewing officers as agents of change. It is demonstrably starting to have a very positive impact on the way in which social workers and other professionals think, engage, plan and work with children and families.

40. The quality of case recording is mostly adequate. Some case records are clear and succinct although others are too descriptive and over lengthy. Because of the delays in commissioning, and rolling out, an electronic recording system, managers and staff are having to navigate between one live and two 'read only' systems in a way that is extremely time-consuming. As a result case records are fragmented and there is considerable potential for error. It also means that social workers are generating chronologies manually on Word documents, some of which amount to little more than abbreviated running records rather than summaries of significant events.

41. A key priority for children's services is to improve engagement with children and families. Increasingly, children and families' views and feedback are sought on their experiences of early intervention and statutory interventions, although the overall impact on service delivery is currently limited. The existing advocacy service is aimed specifically at looked after children but is about to be re-commissioned in order to make advocacy support available to children and young people involved in child protection processes. The local authority has very recently introduced 'twilight' child protection conferences in order to facilitate children and young people's attendance without disrupting their education. Last year only seven children aged 12 or over attended a child protection conference in Havering. An interactive on-line system to engage with children and young people is creative but in its infancy.

Leadership and governance

42. Leadership and governance are **adequate.** Havering has undertaken an ambitious agenda to transform the structure of children's services and the way in which services are delivered to vulnerable children and young people in the most cost efficient way. The children's trust arrangements are retained. The priorities within the children's transformation agenda have a clear focus on protecting children and providing a strong, coordinated early help offer to respond to children's needs at a lower level. The management structure is more streamlined to focus on moving

plans forward through strengthening responsibilities and accountability towards the merger of the adult and children directorates. Appropriate steps are being taken for transition as the current director retires and an appointed group director will assume director responsibilities in April 2013. The recently formed senior leadership team understands well the vision for the service and the areas of strengths and weaknesses. However, there remain interim arrangements at service manager level during this period of restructure.

43. The Children and Young People's Service Plan for 2012/13 is, by the local authorities own admission, insufficiently robust. The service plan does not sufficiently incorporate all the core work streams in a joined-up and overarching plan for delivery. This results in three separate plans to respond to: inspection findings, a review of safeguarding practice and the transformation plan. This results in fragmentation for monitoring, review and evaluation purposes. A strengthened service plan is in draft form for 2013-14 and incorporates links to Havering's corporate plan 2011-14 and to the council's 'living ambition'. The plan is currently in draft and is beginning to streamline the core work streams and provide a more coherent direction of travel to demonstrate how strategic priorities are to be met. There are currently no detailed operational plans for the delivery of objectives and as a result staff understanding of the journey ahead is inconsistent.

44. Political support and commitment to vulnerable children in Havering is good but is less effective because there is not a shared understanding of the quality of child protection arrangements or the provision of early help. Governance arrangements have been strengthened recently through the formation of a Child Safety Performance Board. This forum is used by the Chief Executive and the Leader of the Council to hold the Lead Member, Director of Children's Services and senior managers to account and is providing members with improved commentary on performance data. However, the data provided is limited and is not yet facilitating robust or focused challenge. The local authority plans to further strengthen this through the implementation of an on-going corporate review of the 'top six' performance indicators. Members' understanding of their roles and responsibilities is not yet sufficiently embedded and, although the Lead Member is an observer on the HSCB, the Chair of the Scrutiny Committee has no direct contact with the Chair of HSCB. There has been drift in the scrutiny of the new MASH arrangements and as a result members do not have a realistic understanding of current service delivery.

45. There is strengthening of partnerships at a strategic level since the safeguarding inspection in September 2011 achieved by improved understanding of service priorities, commissioning, and integrated working. The voluntary and community sectors are well represented on the Transformation Board and in partnership work streams but faith groups are not currently represented. Monthly communications meetings

are in place and joint briefings have been provided in relation to developing a shared understanding of service priorities and the journey ahead. There has been full consultation with partners and joint working groups regarding the roll out of the MASH and the review of children's centres. Attendees at key strategic groups are facilitating some effective multi-agency work, for example, domestic violence and drug and alcohol initiatives. Work is currently underway to identify local themes in relation to child sexual exploitation, with a view to developing a multi-agency risk assessment tool. The embedding of the CAF remains an area for development. The Havering Strategic Partnership was replaced during this period of transformation by the overarching corporate Transformation Board. This has not achieved the full impact required. The partnership is currently under review and the local authority is considering the most appropriate membership for a reconstituted strategic partnership in line with the transformation of services.

46. The HSCB is not fully effective in all its core duties. The Board is led by an independent Chair and includes the majority of appropriate partners at senior levels. However, there is currently no representation from the voluntary sector and only one lay member to provide independence from statutory agencies. While the Board is active in its wider safeguarding responsibilities and developments, there has been insufficient focus on all areas of child protection. As a result the Board is not sufficiently knowledgeable about the effectiveness of child protection in the borough. The Board has challenged the quality of the information provided by children's services but this challenge has not been sufficiently robust to provide a comprehensive evaluative overview of the effectiveness of safeguarding arrangements in the borough. This includes an evaluation of the rise in domestic violence and an understanding of the effectiveness of private fostering arrangements. Positively, the recently formed sub-groups are focusing and driving key priorities to develop strategies such as children at risk of child sexual exploitation. The sub-groups are chaired by London Borough of Havering employees. This is a reflection of the level of working partnerships at the current time. A comprehensive multi-agency training programme is underway. However, the impact of this is yet to be evaluated.

47. Leaders and managers use performance data regularly to monitor and evaluate aspects of the service. However, arrangements to collate and analyse performance management data are not sufficiently robust. The way in which information in the monthly children's social care performance monitoring report is presented makes it difficult to readily identify key issues. The report does not sufficiently set targets, include information about trends and projected outturns or provide a coherent commentary. The report is also not broken down to team and 'pod' level. Therefore, this limits its functionality as an effective strategic and operational management tool. The performance management data set that is reported to senior managers and to the Child Safety Performance Board is

incomplete in the sense that it does not include information about the timeliness of initial child protection conferences, children and young people who come off a child protection plan after three or six months and re-referrals within 12 months. Consequently the level of scrutiny by children's social care and the HSCB is not sufficiently robust. The delays in implementing an effective ICS system have compounded these difficulties and resulted in managers working between both manual methods and the two systems during this transition period. The local authority does have a staged plan to align all information streams and is well aware of the current challenges for staff.

48. There are good initiatives to improve the quality of practice and the experience of children and families receiving services. The 'strengthening families' framework is positively transforming the quality, structure and effectiveness of case conferences. This approach is enabling parents to be more responsive to interventions and have a better understanding of the concerns for their children. A manager post and a principal social worker post have been created to improve social work practice and respond to national developments for improvement and this is facilitating learning in the authority. The quality assurance framework is less developed and a qualitative analysis of the newly formed MASH has not yet taken place but is planned. While some opportunities have been taken to address early implementation issues as the service embeds, this has not been consistently applied.

49. The local authority is committed to, and sees the value of learning from, a range of sources. The authority is outward looking and looks to secure quality services for children. Leaders seek to continually improve the quality of services for children and families in relation to safeguarding practice through the London Safeguarding Children Board and corporately in relation to peer review of the transformation agenda. Following an inspection of private fostering arrangements which was judged inadequate, prompt action has been taken to improve management oversight of this service and to establish a more robust assessment process. Positive action has been taken to strengthen the quality of the Youth Offending service in relation to shared management arrangements with Barking and Dagenham.

50. The lessons from serious case reviews are disseminated across partnerships and briefings are well attended. Although an overview of serious case reviews from other areas is collated, the opportunity to learn from these wider lessons is not as robust. A number of internal and multi-agency themed audits are undertaken, for example on the quality of case conferences and core groups. These have identified key learning points which have been taken forward to improve, for example, hearing the child's voice in case conferences. The council adequately learns from complaint outcomes, although in some examples the actions and responsibilities for completing them are not clearly defined.

51. A workforce strategy is in place but there is no clear or specific action plan for its delivery. While the Transformation Board has taken responsibility for meeting overarching milestones during the restructuring of services, there has been no detailed plan that can be monitored, reviewed and evaluated by operational managers. Currently, there are two interim posts at service manager level, a vacant team manager post and eight social work posts filled by agency workers. A recent recruitment campaign has been successful in recruiting to six of the vacant social work posts. Social work caseloads in teams are manageable and overall, given the significant changes, staff morale is good and staff report they are well supported. The resourcing and staffing of the MASH has been a priority and the council has considered effectively how best to deploy experience within the new structure. A key priority is to continue the professional development of social workers following an analysis of training needs. Through the principal social worker and social work improvement manager, there are clearly defined training plans. The local authority pro-actively offers student social work placements and progresses newly qualified social workers to their first progression in the pay scale, as ways of attracting new talent.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate

Havering
LONDON BOROUGH

CHILDREN AND LEARNING OVERVIEW & SCRUTINY COMMITTEE

Subject Heading:	Title **Follow up to Ofsted Inspection of Safeguarding February 2013**
CMT Lead:	Name **Joy Hollister**
Report Author and contact details:	Name **Kathy Bundred** Tel no. **01708 433002** Email kathy.bundred@havering.gov.uk
Policy context:	

SUMMARY

Ofsted made a number of recommendations following inspection. Some of these have been fully implemented and some partially implemented but others are still in the planning stage.

The main progress since the inspection has been evident in addressing MASH timescales, reviewing the LSCB and its links to Overview and Scrutiny and the establishment of the Children's Society service for advocacy and for following up on Missing Children.

Other areas have been more difficult. Workforce has possibly been one of the more challenging areas, especially as there is a London wide and to an extent a national shortage of experienced social workers who are willing and able to undertake child protection work.

RECOMMENDATIONS

That members note the report and ask for any further detail they require.

REPORT DETAIL

Summary of action taken since Ofsted inspection February – March 2013

Ofsted made a number of recommendations following inspection. Some of these have been fully implemented and some partially implemented but others are still in the planning stage.

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I have reviewed progress against each of the recommendations and grouped them into categories. I have also provided a summary of the evidence behind each category.

Fully implemented

- **Review the functioning and membership of the London Borough of Havering Safeguarding Children Board (HSCB) to ensure it is fully constituted and provides sufficient scrutiny and oversight of the effectiveness of child protection practice and the effectiveness of arrangements for children in need .**

  Evidence

  The Board has been under review and a new chairperson, Brian Boxall was appointed in the summer with a planned transition between the outgoing chairperson, Sue Dunstall and Brian. Brian has been actively engaged in finding out where there are areas of difficulty and has already made his presence known and thereby raised the profile of the Board.

  There is now voluntary sector representation on the board from the Children's Society and work is in hand to encourage partners to chair subgroups. A successful Board Development Day was held in October 2013.

- **Review the governance responsibilities and accountabilities to ensure there is communication and a formal link between HSCB and the Chair of the Children's Overview and Scrutiny Committee**

Evidence

The Chair of Children's Overview and Scrutiny receives the papers from the LSCB and a reporting arrangement for O and S to receive the Annual Report has been implemented. O and S received the 2012-2013 report in September and arranged this further special meeting to drill down further into activity and progress against the Ofsted recommendations.

The Chair of the LSCB has agreed to annual meetings with Overview and Scrutiny so that the committee will have opportunities to share their work and hear from the LSCB chair directly about the work of the LSCB.

- **Continue to develop and adopt a more consistent approach to supervision in order to ensure that it provides the right level of critical challenge and opportunity for reflection and is a vehicle for driving up practice standards**

Evidence
Since the inspection there has been a focus on developing supervision skills which has included mentoring of the group managers by experienced social work consultants alongside mentoring of practice managers by the Principal Social Worker. Auditing of supervision records and of case files has shown improvement in this area.

- **Ensure work is progressed to enable children and young people to access advocacy services which support them to attend child protection conferences**

Evidence

The Children's Society are now providing an advocacy service which has been widely advertised in the department and which young people can easily access for support . This service is open to all children in need.

- **Ensure that the tracking system for all referrals in the multi-agency safeguarding hub (MASH) service is embedded and that timescales for response outlined in the threshold to services document are met**

Evidence

Since the inspection a number of improvements have been made to MASH processes. The tracking system is now fully in place the timescales for MASH responses are being met almost 100% of the time. In the last three weeks only one case went slightly over timescale. We had considered purchasing a large screen with live data of waiting times but have instead gone for a low tech solution whereby anyone in MASH can see if there are cases at risk of missing timescales.

- **Undertake a detailed analysis and evaluation, following the implementation of the newly formed MASH, to formally consider any early lessons to define the service and forward plan**

Evidence
The review of the first year of MASH implementation has been completed and will be presented to Overview and Scrutiny and the LSCB shortly. Although there have been challenges, there is clear evidence that MASH has improved working relationships between a range of partners and that benefits have been achieved for children.

- **Complete the roll out of the children's case management system (CCM) in order to ensure that managers and staff have the tools to do their job properly**

  Evidence
  CCM is fully rolled out across all the children's social work teams and all active cases are on the system.

- **Complete the overarching service plan for delivering against the corporate and strategic priorities for children's services and make clear through aligned operational plans the journey ahead for staff, members and partners**

  Evidence

  The service plan was completed within the corporate timescales and was shared with partners via the LSCB. There is a mid-year refresh under way at present.

Partially implemented or in progress

- **Complete the proposed re-commissioning of the emergency duty team (EDT) with minimum delay and as part of that process set clear and unambiguous performance and quality standards for the new service**

  Evidence
  The new EDT arrangements are being commissioned across 4 boroughs. We are close to getting approval through our respective decision making arrangements and the new service should be in place early next year under the management of LB Redbridge

- **Ensure effective consideration is given to a child or young person's ethnicity, culture, religion and language in assessments so as to inform planning**

  Evidence

  The new client database enables managers to run reports on a range of areas which includes recording of ethnic and cultural data, language and religion. Compliance is improving. However, we cannot yet report this as fully met pending more auditing activity which is planned for next month.

- **Develop a more robust approach to quality assurance in order to be able to track qualitative improvements over time, for example the percentage of child protection plans that are outcome focused and/ or measurable**

Evidence

Our approach to quality assurance in respect of tracking quality of practice was at a relatively early stage when the inspectors were here. This has continued to develop both within our service and with partners under the auspices of the LSCB. We have incorporated user feedback as a routine practice. We have been auditing child protection plans to assess outcome focus both during CP processes but also in respect of step down CIN plans.

- **Review and refine the performance management framework to include key indicators, including measures that are currently missing, as well as comparative data, trend information and projections, with commentary and key information broken down to team or pod level**

Evidence

Our performance data is now more comprehensive and includes for example workforce data. Also data is now benchmarked against comparators and includes better trend data. More work is going on in this area between the new head of Business and Performance and CYPS senior management team to develop a good quality performance management framework which will meet all the requirements of Ofsted in respect of this inspection and the new inspection framework.

- **Ensure the collation and analysis of performance management information to effectively interpret and monitor the quality and impact of all aspects of child protection practice and processes, and the effectiveness of help and support for children in need**

Evidence

As above.

- **Record and analyse contact, referral and re-referral patterns in order to be better able to evaluate how effectively children's social care and its partners are applying the threshold criteria, meeting needs and reducing risks**

Evidence

As above. There have been improvements in this area but like the previous recommendation it is one where we have made some progress but need to review and agree a comprehensive framework which will meet Ofsted's recommendations fully.

- **Ensure the timely completion and review of core assessments to ensure that children and young people are receiving the appropriate level of services when they need them**

Evidence

Assessment timescales are not yet timely in terms of completion. Some of this is due to carrying over 'old' processes into a new system and is being addressed. Also some

individual performance issues have been addressed in recent months. We are seeing some improvement and this is an area that is being closely monitored. However, allocation of services and early help are not dependent on completion of assessment.

- **Ensure chronologies are clear, recorded and fit for purpose**

  Evidence
  The new CCM system has a feature which can be used to select significant event to populate a chronology which would meet the required standard in all cases. However, this is not yet consistently understood and in use. Meetings are planned for November to take this forward as part of our move from implementation to Business as usual.

- **Ensure that the common assessment framework (CAF) is sufficiently embedded in the reconfigured early help services within a required time frame and that this is evaluated by the HSCB**

  Evidence

  We have replaced the CAF with an Early Help Assessment which was designed with our partner agencies. Training has been rolled out across all agencies and is being supplemented by fortnightly drop in sessions for staff. Take up has increased by 50% with 46 assessments undertaken in 6 weeks from 1st September this year against 30 at the same time last year. It has been pleasing too that adult agencies including adult mental health and probation have asked for dedicated training for adult professionals and this is being provided. Feedback on the training has been positive.

At the planning stage

- **Ensure the development of a workforce action plan in line with the transformation agenda and workforce strategy that can be monitored, reviewed and evaluated.**

  We are still at the discussion stage on wider workforce strategy although elements are in place including Early Help Assessment training above and new training for social workers. A social worker recruitment and retention strategy has been drafted and work is taking place with HR.

- **Feedback from children, young people, parents and carers are used to plan and improve service delivery. This includes implementing a system for the analysis of service user feedback in early help and preventative services.**

  Although progress has been made in this area there is still a lot to do. Since the inspection . Viewpoint has been launched with Looked After children and more recently for children aged over 8 years who have a child protection plan. However, this is not yet at the stage where it can be claimed that it is impacting positively on service delivery. There is not yet a comprehensive system for analysing service user feedback in Early Help although there are elements of this in the Troubled Families programme and Early help audits.

IMPLICATIONS AND RISKS

Financial implications and risks:

Legal implications and risks:

Human Resources implications and risks:

Equalities implications and risks:

BACKGROUND PAPERS

Inspection of LA arrangements for the protection of children. See attached.

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