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London Borough of Havering

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: 27 September – 20 October 2016

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

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

Executive summary

Children's services in Havering require improvement to be good. Services for children in need of help and protection and for children looked after were judged adequate when last inspected in 2011 and 2013. Service improvement has been slow as a result of a rise in demand due to an increase in families moving to the area from other boroughs, and significant staffing pressures.

The situation is now improving. There have been considerable and extensive changes to the senior management structure since August 2015, resulting in robust and systematic action to address operational weaknesses in the quality of services. The current director of children's services (DCS) was confirmed in post in September 2016, having been appointed as assistant director in June 2015. He implemented a process of change and transformation that is fully endorsed by the newly appointed chief executive (May 2016) and leading politicians, who have allocated appropriate resources to embed and improve services for children and young people. A newly recruited and experienced senior management team has started to make significant and sustainable changes to core social work practice and to key areas such as reducing the risks of child sexual exploitation. This means that children are receiving more consistent help and support and that outcomes are beginning to improve.

Action to stabilise the social care workforce has led to the recruitment of a higher proportion of permanent social workers. This means that a growing number of children have the benefit of seeing the same social worker. Staff are positive about working for Havering. Access to training is good and caseloads are manageable. The recruitment of new social work team managers and the implementation of systemic practice have begun to improve the delivery and quality of services to children. An improvement board is well established and is resourced to oversee and guide developments, although action planning is not sufficiently sharp.

While some of the systems within the multi-agency safeguarding hub (MASH) and the emergency duty team are weak, leading to delays in initial responses for some children and families, children receive a more robust response to their needs once they have an allocated social worker in the assessment team or in the intervention and support service (ISS).

The quality of assessment and planning for children and young people is too variable, and issues of equality and diversity are not considered in enough depth. Inconsistencies in pre-proceedings work and in permanence planning are being addressed, underpinned by a robust action plan.

Effective operational and strategic arrangements for children who go missing, who are at risk of child sexual exploitation or who are vulnerable to radicalisation, are established, although further improvements are being implemented to ensure the timeliness of return home interviews.

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Most children looked after live within Havering or nearby and benefit from good, stable placements. Children do well at school, though for some, attendance is not sufficiently regular. The corporate parenting board and the children in care council are established, but not fully effective, as representation is limited. Senior managers are aware that the local authority is not fully meeting its sufficiency duty, particularly in relation to accommodation for adolescents, care leavers, the recruitment of adopters and in-house foster carers. Access to advocates and to independent visitors is very limited.

Services for care leavers are inadequate. Care leavers are not all well supported and there are widespread weaknesses in achieving good outcomes. While opportunities and access to employment, training and education are positive, aspirations for care leavers have not been sufficiently ambitious. Senior managers have recognised that substantial improvement is needed and have secured funding to recruit additional experienced social workers to strengthen this service.

Adoption is considered appropriately for all children, although some children with complex needs are not placed with adopters quickly enough. The recruitment of adopters has not kept up with demand and numbers are small. New managers are now in place and they are systematically implementing improvements, such as the timeliness of placements and enhancing life story book work.

In order for children and young people to have continuity of social workers, and to improve management oversight and consistency of practice, the social work teams were restructured in June 2016. Early help services have been restructured and a new 'Families Together' team has been created for adolescents on the edge of care, to increase effectiveness. However, the quality of staff supervision at all levels requires further improvement to ensure that staff are properly held to account for their practice.

Quality assurance and case auditing arrangements, such as 'practice week', have been introduced by the DCS and are improving practice. Managers and staff learn from individual complaints, although service-wide changes are not well evidenced. The role of the independent reviewing officers and child protection chairs in scrutinising and influencing practice is underdeveloped.

The electronic recording system has been improved, and ongoing work and resources have been allocated to procure a new system, but it still does not support social workers well enough, or assist managers to oversee the work of their teams. For care leavers and the adoption service, the recording system is not appropriate for their needs.

Relevant performance information is produced and is shared across the right forums.

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The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The previous inspection of the local authority's arrangements for the protection of children was 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 in September 2011. The local authority was judged to be adequate.

Local leadership

- The director of children's services (DCS) has been in post since September 2016.
- The chair of the LSCB has been in post since September 2013.

Children living in this area

- Approximately 53,258 children and young people under the age of 18 years live in Havering. This is 21.7% of the total population in the area.
- Approximately 18.9% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 13.1% (the national average is 14.5%)
  - in secondary schools is 10.4% (the national average is 13.2%).
- Children and young people from minority ethnic groups account for 19.2% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Black and Black British, and Asian and Asian British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 15.3% (the national average is 19.4%)
  - in secondary schools is 9.5% (the national average is 15%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

Child protection in this area

- At 30 September 2016, 1,389 children were identified as being in need of a specialist children's service, which is an increase from 1,374 on 31 March 2016.
- At 30 September 2016, 285 children and young people were the subject of a child protection plan. This is a decrease from 302 at 31 March 2016.
- At 30 September 2016, three children lived in privately arranged fostering placements. This is an increase from two at 30 April 2016.
- Since the last inspection, seven serious incident notifications have been submitted to Ofsted and three serious case reviews have been completed or were on-going at the time of the inspection.

Children looked after in this area

- At 30 September 2016, 237 children were being looked after by the local authority (a rate of 43.9 per 10,000 children). This is an increase from 229 (42.4 per 10,000 children) at 31 March 2016.
- Of this number:
  - 119 (50%) live outside the local authority area
  - 15 live in residential children's homes. Three of these live outside the authority area
  - 11 live in residential special schools[3]. All 11 live outside the authority area
  - 171 live with foster families. Of this 171, 46% live outside the authority area
  - three live with parents. One of these three lives outside the authority area
  - 19 are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been five adoptions
  - 14 children became subject of special guardianship orders
  - 133 children ceased to be looked after. Of these 133, 17% subsequently returned to be looked after
  - 32 children and young people ceased to be looked after and moved on to independent living
  - no children and young people ceased to be looked after and are now living in houses of multiple occupation.

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

The casework model used in this area

- Signs of Safety

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Recommendations

1. Ensure that managers at all levels use management information effectively to oversee the work of their teams, and that performance reports include analysis, evaluation and commentary.
2. Ensure that partners understand thresholds, that they are applied consistently and that children referred to the MASH, or who require help out of hours, receive a timely and proportionate response.
3. Ensure that all assessments of children and care leavers consider all areas of need and risk, including equality and diversity issues and health needs.
4. Improve pathway plans, reviews of pathway plans and visits to care leavers to ensure that they meet statutory requirements. Ensure that all plans for children are specific, measurable and child focused and that copies are provided to parents and carers in a timely way.
5. Ensure that all care leavers are fully aware of their entitlements.
6. Ensure that all children and young people who go missing from home or care are offered prompt return home interviews and that the information obtained is used to support their safety plans.
7. Improve the sufficiency and availability of placements for care leavers, children looked after and children with a plan of adoption so that they are well matched according to their needs.
8. Ensure robust tracking and decision making for children who are subject to pre-proceedings and permanence planning, to avoid drift and delay, and that independent reviewing officers and child protection chairs provide sufficient challenge to these plans.
9. Take steps to ensure sufficient independent visitors for all children looked after who would benefit from this.
10. Ensure that the support needs of children subject to adoption and special guardianship are comprehensively assessed and result in a plan that addresses children's individual needs.
11. Improve the regularity and scrutiny of management oversight and the quality of staff supervision at all levels, ensuring that staff are properly held to account for their practice in providing appropriate help and support for children and reducing drift.
12. Increase the influence of the corporate parenting board, ensuring that the direct involvement of children is central to the board's work and that the membership and workplan target priorities effectively. Properly celebrate the achievements of children and young people.
13. Expedite the development or re-commissioning of the electronic system to ensure that it is fit for purpose, that it adequately supports the planning and recording requirements of the care leavers' service, the provision of management information and enables proper storage of adopters' records.

Summary for children and young people

- Children and families receive help quickly when they first have problems.
- If problems get worse, families are assessed to make sure that they receive the right help. Sometimes it takes too long for social workers to visit children to find out what their needs are.
- Most children and families who need a social worker are well supported and their lives start to get better. When things do not change quickly enough or children are at risk of being harmed, managers are not always helped by the right people, like the police, to decide what to do next.
- Social workers and managers make the right decisions about which children need protection, and which children need to be looked after in foster care or children's homes.
- Some children live a long way from home or in placements that don't meet all of their needs, as there are not enough suitable placements near to their home.
- Not enough older children are helped to stay with their foster carers until they are ready to live on their own. The range of accommodation for young people who leave foster care is not good enough and some young people do not get enough support to help them to manage their day-to-day lives.
- Young people over the age of 18 who have left care are not given enough help to live independent and successful lives.
- Children looked after can share their worries and views easily through the MOMO (Mind Of My Own) app. Senior managers listen carefully to this feedback.
- The children in care council does not represent the views of enough children and young people of all ages and does not make a difference to improving the experience of being in care.
- Children who are at risk of sexual exploitation, or who go missing from home or care, get the right help and this makes them safer.
- Many children have had too many changes of social worker and they find this difficult and upsetting. Managers are working hard to find more social workers and to keep them for longer. This hard work is starting to pay off, with more social workers wanting to work in Havering.
- Managers, social workers, personal advisers and family support workers care about the children who need their help. They want to make a difference to children. Managers are arranging extra training to make sure that social workers and other practitioners are good at understanding and helping children, young people and their families.

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

Summary

In most cases, outcomes for children improve following intervention from children's social care and early help services. The links between early help and social care are sufficiently established and children and their families have access to a range of well targeted preventative services. Thresholds are not consistently applied by all partners. The local authority and the LSCB are aware of this, and the application of thresholds is currently subject to ongoing awareness raising and audit.

Partner agencies are well represented in the multi-agency safeguarding hub (MASH). While overall this has enabled timely and helpful sharing of information, there are often delays in information-sharing by the police. Inconsistent management oversight and delays in initial responses to some children and young people mean that safeguarding plans for them are not robust enough.

Most children are seen regularly by their social workers, particularly once they are allocated to the assessment team or intervention and support services (ISS). Assessments are of variable quality and, while some good examples were seen, a high proportion lack well evidenced analysis of risk. Most plans are adequate; they are reviewed regularly and partner agencies contribute to the effective safeguarding of children. However, some plans are not child centred, specific enough, or include timeframes or outcomes, and contingency planning is poor. Ethnicity is recorded for most cases, but children's wider equality and diversity needs are not always well considered in assessment and planning.

Arrangements to tackle child sexual exploitation and cases of children going missing from home and care are prioritised, and most children receive a well-coordinated multi-agency response to their needs. The multi-agency sexual exploitation (MASE) meetings are purposeful and provide an effective framework to reduce risks. However, return home interviews are not always timely and some are not sufficiently thorough or analysed.

Abuse allegations against professionals are mostly well managed and result in effective plans to protect children.

The emergency duty team (EDT) has not consistently provided a timely response out of hours. However, senior managers have taken appropriate remedial action to challenge this, and provided training and clearer guidelines to staff.

Very few children are privately fostered in Havering, but arrangements to identify and support them are underdeveloped. Awareness raising has not been effective.

Inspection findings

14. Children's social care services have experienced a significant increase in demand since 2013, due to a rapid change in the demographic of the local population, with families moving into the area from other London boroughs. This is now stabilising, but has had a significant impact on the quality of social work services for children in need of help and protection. For example, the number of children on child protection plans more than doubled between 2013–14 and 2015–16.
15. New senior managers have been appointed and more effective ways of working have been implemented in the last year, but the quality of social work practice is still too variable. While inspectors found weaknesses in the MASH, children receive a more robust response to their needs once they have an allocated social worker in the assessment team or intervention and support service hubs.
16. Early help services have recently been strengthened and restructured following a full review, in order to improve targeted interventions and increase capacity. For example, a new 'Families Together' service was launched in September 2016 to focus on adolescents on the edge of care. This multi-agency service is intended to enable children and young people to stay within their families if they can be kept safe.
17. Most children in Havering receive a timely and purposeful response to their needs from early help services. Early help assessments and plans adequately address children's needs, and some are good. Children's centres offer a range of appropriate interventions for children and their families, through the implementation of a targeted approach. In cases seen by inspectors, thresholds for escalating cases by early help staff into social care were appropriately understood and applied.
18. The MASH is a single point of contact which is valued by partners. The quality of referrals to the MASH is variable but improving; in many cases they are not thorough enough. There is variability and inconsistency in the understanding and application of thresholds when referrals are progressed in the MASH, and by partners who are not always clear about thresholds and pathways into social care. While repeat referrals are low, those seen by inspectors showed a lack of consistently effective decision-making, including insufficient consideration of historical information, leading to some children and families receiving a delayed response from children's social care.
19. In cases where statutory thresholds are met, there are sometimes delays in ascertaining the safety of children through prompt initial visits. This is due to a number of factors, including a lack of effective information sharing, consent from parents being inconsistently sought or considered, an inconsistent application of the risk assessment tool and limited management oversight. In a few cases, children had not been seen quickly enough by a social worker to ensure that all safeguarding plans were robust. However, some cases within the MASH demonstrated clear, purposeful work and effective analysis of risk.

20. The local authority is aware of the deficiencies in practice in the MASH, having started work to improve it following a review in March 2016 and as a result of further issues raised via 'practice week' in September 2016. New managers have been permanently appointed, and are providing more robust management oversight and clearer guidance to staff. (Recommendation)

21. While the MASH has led to more effective engagement of health and education partners, the co-location with the police has not facilitated a smooth and timely exchange of information. Police attendance at key meetings, including strategy meetings, is inconsistent and this has led to delays in agreeing plans to protect children and in responding effectively to children's needs. Senior leaders in Havering have highlighted these concerns to the Metropolitan Police and improvements are expected, partly as a result of the local authority being part of a pilot project with two other neighbouring local authorities.

22. The quality and timeliness of assessments in Havering are variable. Some good quality purposeful assessments involving children and their families were seen during the inspection, but the majority are not sufficiently analytical and do not consider risks as well as protective factors. In some cases, inspectors saw sustained efforts to engage challenging parents successfully. However, in other examples, assessments reflected a lack of challenge to parents by social workers and partners and this had contributed to delays in decision making and in escalating concerns appropriately. (Recommendation)

23. Chronologies are present on most case files, but they are not systematically used to inform assessment and planning. Case recording is mostly up to date. However, case records do not routinely reflect children's experiences or whether children have been seen alone. The electronic recording system does not effectively support social work practice and is therefore being updated and re-commissioned to improve the ease of case recording, as well as capturing performance information more effectively.

24. Equality and diversity needs of children are not always recorded or considered by social workers, although inspectors did see examples of the positive impact for children of the systemic therapist working with cross-cultural issues. (Recommendation)

25. Child protection investigations identify risks to children and lead to appropriate plans so that risks are reduced. However, the quality is variable. For example, initial strategy meetings and discussions often do not include all relevant agencies such as health partners, but subsequent strategy meetings demonstrate better involvement. In some cases there are delays in completing child protection enquiries, for example social workers reported that cases held by the police in the child abuse investigation team cannot be accessed by police in the MASH. Senior managers in the local authority are currently in discussion with the police to resolve this issue. The majority of decisions following child protection enquiries are appropriate. However, the rationale for these decisions is not always clearly recorded. Overall, management oversight, guidance and direction for social workers in the MASH are not thorough

enough, leading, for example, to initial plans from strategy meetings for some children and their families not being timely or specific.

26. The timeliness of initial child protection conferences is improving and a high proportion (89%) of initial conferences result in a child protection plan. Most conferences are well attended by partners, who share key information effectively.

27. The quality of most child in need and child protection plans is adequate. Plans include the key issues and they are reviewed regularly. Children are seen, and seen alone, and their views are considered in accordance with the plan. Parents are mostly well engaged and social workers are establishing meaningful relationships with children and families. Core group meetings are well attended and systematically consider the child protection plan, but they do not routinely develop the plan to take into account what has changed, improved or got worse for children, and contingency planning is poor. Most plans seen by inspectors were not sufficiently measureable or outcome focused, for example not making clear whether risks for children were reducing. Some plans seen by inspectors were adult focused and did not sufficiently take account of all the needs and risks relating to children, particularly in cases when domestic violence was a feature. (Recommendation)

28. The role of the child protection chairs is underdeveloped. Chairs do not always challenge drift or delay or scrutinise casework and, as a result, the impact on children's experiences is limited. While this weakness has been identified by senior managers, activity to remedy the shortfall has not yet been implemented.

29. Step-up and step-down processes are mostly effective. While most children are stepped down from a child protection plan to a child in need plan appropriately, arrangements to monitor sustained improvement are inconsistent. The number of repeat child protection plans has increased; the proportion of children with open plans that had been subject to a second or subsequent child protection plan was 14% in 2015–16. This is a rise from 3% in 2014–15, and is now more in line with similar authorities. Step-down arrangements to early help services are well supported by the family coach team, who provide effective transitional support and monitoring for children and their families. The Families Together team additionally provides helpful support to children who are identified as being on the edge of care, as well as to young people returning home following custody or being looked after.

30. Staff turnover has begun to stabilise and most children enjoy the consistency of an allocated social worker. Almost all children who are subject to child protection or child in need plans are visited by their social workers in accordance with their plans. Most social workers spoken to by inspectors knew children and their needs and personalities well. However, children's wishes and feelings are not well reflected in children's files. In examples of better work, inspectors saw the effective use of direct work tools to gain the views of

children. Social workers have access to an effective family group conference service and this has contributed to improved outcomes for children.

31. The provision of advocacy services to children is not well utilised or sufficiently promoted by professionals. Few children attend important meetings, for example child protection conferences. However, when children do have this support, advocates effectively represent the voice of the children and ensure that their views are well considered.

32. Arrangements to monitor the welfare of children living with parents who experience mental ill-health, or who misuse drugs or alcohol, are mostly robust. A well-coordinated partnership response promotes collaborative working and ensures that the needs of children living in these households are effectively met. For example, services for victims of domestic abuse are sufficient to meet local need. A programme of support to children who live with domestic abuse is provided. Although there is no specific provision for perpetrators within Havering, services for these adults are accessed through other London boroughs. Children experiencing neglect are well monitored and tracked to ensure cases are escalated and reviewed. This prevents long term exposure of children to neglect.

33. Managers within the ISS provide consistent, purposeful and effective case direction to social workers, and this results in plans for children being progressed well and in good time. Social workers report good access to supportive managers and helpful consultation about casework decisions. While management oversight is not sufficiently rigorous or consistent within the MASH service, this has recently been addressed due to the appointment of a new group manager and a focus on the quality of management oversight provided by the deputy team managers.

34. The joint protocol for homeless 16- and 17-year-old young people has been implemented effectively and is resulting in young people being provided with appropriate accommodation in a timely manner.

35. The emergency duty team (EDT) in Havering is provided by the East London partnership. Reponses by this service are variable and children do not consistently receive a proportionate response to their protection needs. For example, children are not always seen by a social worker when they are accommodated or workers do not have the appropriate paperwork for foster carers. Senior managers in Havering have challenged the performance of the EDT service and the local authority is monitoring this arrangement to ensure that children receive a timely and appropriate emergency response. (Recommendation)

36. Multi-agency risk assessment conference (MARAC) arrangements are well embedded and understood across the partnership. Meetings are well attended, enabling information to be effectively shared. Professionals provide sustained and committed efforts to reduce the risks of domestic violence to children and their families. Multi-agency public protection arrangements (MAPPA) are well understood across the partnership and ensure that there is

effective supervision of offenders in the community. Potential risks to children are well monitored.

37. Abuse allegations against professionals and carers who work with children are taken seriously and responded to promptly by the designated officer. Strategy meetings are well attended, with good multi-agency information sharing; decision making is timely and appropriate.

38. Child sexual exploitation is a key priority for the local authority and its partners. There is a good awareness of child sexual exploitation among family support workers and social workers, and the quality of practice appropriately safeguards the needs of children and young people. The local authority is refining the risk assessment tool to be more specific and to capture information more robustly. Mapping meetings for individual children ensure that information is shared effectively and there is a well-coordinated response to risk in most cases. In cases seen by inspectors, children at risk of sexual exploitation who are subject to child protection plans receive well-targeted help based on a thorough multi-agency understanding of risk.

39. Arrangements to respond to child sexual exploitation at a strategic level are well established through multi-agency sexual exploitation (MASE) meetings and there is evidence of detailed mapping of intelligence and appropriate disruption activity to safeguard children and young people. Partners have an increasing understanding of the local profile, which informs planning. However, cross-borough intelligence sharing and mapping have not yet been implemented.

40. The local authority monitors effectively those children who are electively home educated. Specialist staff provide good advice and guidance and clearly record the details of each case. The local authority focuses well on ensuring that children in alternative provision are getting a good education and staff closely monitor their progress.

41. Arrangements to identify and monitor children missing from home, care or education are well embedded and mostly comprehensive. However, the quality and regularity of return interviews are inconsistent. The 'missing from home' coordinator has significant knowledge of all children missing and is able to provide up-to-date information which is not always captured on the electronic case files. In relation to children missing from education, the local authority works well with partners to find these children. All cases of children missing education are recorded electronically and case files are uploaded to the local authority database. (Recommendation)

42. The partnership has worked effectively to ensure that staff are well aware and equipped to identify girls at risk of female genital mutilation. Training is provided to professionals and clear protocols are in place; this has ensured that girls are receiving a timely response when they are identified as being at potential risk.

43. Coordination of services to combat radicalisation is effective and this work is well supported by the 'Prevent' officer, who works purposefully and in

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partnership with social care services to reduce risks to young people as well as to raise awareness. Work with children involved in gang activity is developing, aided by a gangs specialist who is based within the MASH.

44. Private fostering arrangements are underdeveloped. While awareness raising has taken place, this has had a narrow focus and has not been delivered to all professionals or across the wider community effectively. Case work seen was thorough and supportive, although subject to a delay in an initial response in the MASH.

45. Senior managers seek feedback on the service provided through a number of measures, including telephone calls to families on cases audited during practice weeks. Responses are reported to be largely positive, with families saying that they benefit from respectful relationships with workers and that the support they receive is helpful to them.

46. Services for children with disabilities are of good quality; they are child centred, timely and compliant with all statutory processes. A stable and experienced team with reasonable case-loads works holistically with families and with partner agencies. Good supervision arrangements and management oversight are in place. Transition arrangements into adult services are being developed further.

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

Summary

Recent decisions for children to become looked after are appropriate and well considered. However, the Public Law Outline processes are not used well and decision making within court proceedings is not timely, leading to delays in some children becoming looked after. Most children looked after live within or near Havering and benefit from good, stable placements. Most children experience improved or improving outcomes. They do well at school, although for some, attendance is not regular enough. Children's educational attainment and progress are effectively supported by the virtual school.

Some children have had too many changes of social worker, which makes it difficult for workers to form consistent, positive relationships with them. Permanence planning, particularly for older children, has not been sufficiently tracked, leading to delays in long term matching for some children. Although the regularity of reviews for children looked after is good, independent reviewing officers are not effective enough in challenging or escalating concerns about poor practice or delays in ensuring that plans for children are being achieved.

The response to children who go missing or who are at risk of sexual exploitation is mostly effective, although the quality of return home interviews is not consistently good. The timeliness of health assessments is improving, following the appointments of a consultant paediatrician and nursing staff.

The children in care council is not yet effective at representing the views of all children looked after. Advocacy for children looked after is limited and no children have the support of an independent visitor.

Adoption is considered for all children who are unable to live with their birth families, although the number of children placed for adoption is small. The appointment of experienced and knowledgeable managers is improving the quality and timeliness of adoption work by setting standards and establishing systems and processes for the service.

Services for care leavers are inadequate. Young people are rarely involved in pathway planning, and plans are not of sufficient quality. Care leavers are not able to access a suitable range of accommodation, leading to some care leavers living in independent accommodation before they have the skills to support themselves. Care leavers' health needs are not sufficiently assessed and they are not provided with enough information about their health histories. Senior managers have identified the weaknesses and are beginning to make improvements.

Inspection findings

47. The local authority makes concerted efforts to ensure that children remain with their families if it is safe to do so. Inspectors saw no cases where children were looked after unnecessarily and in the majority of cases, decisions that children should become looked after were made within a timescale that met the children's needs. However, for a small minority of children, an over-optimistic determination that they remain with their families meant that they experienced delays in becoming looked after. Unaccompanied asylum-seeking children are well supported, with good consideration of their needs, culture and language.

48. When the plan is for children or young people to return home, the majority have appropriate plans to support them, with risks clearly understood and minimised. A small minority of older young people have returned to local authority accommodation as a result of plans not being sufficiently effective or where family arrangements have disrupted.

49. Children who are subject to the pre-proceedings phase of the Public Law Outline are not reviewed regularly enough. Letters before action, which are sent to parents to explain what will happen if their children's circumstances do not improve, are clear. However, a lack of effective intervention, such as prompt assessments of parents and family members and review means that progress is not tracked, plans are unclear, and actions are not always updated. As a result, some children and families spend too long at this stage, leading to delays in issuing proceedings. (Recommendation)

50. The local authority maintains positive and productive relationships with the judiciary and with the children and family court advisory and support service (Cafcass). Social work reports are consistently of sufficient quality and are accepted by the courts. Care proceedings are not completed in a timely way; the average time for completion in 2015–16 was 30 weeks, which is outside the threshold of 26 weeks, but is similar to other London boroughs. When some cases come to court, viability assessments of potential carers have not always been completed, resulting in delay for some children while these assessments are undertaken.

51. The use of special guardianship orders (SGOs) is increasing, enabling children to live with extended family members when it is not safe for them to live with their birth parents. In the year 2015–16, 17 children left care through the granting of SGOs. This number has increased between April and September 2016, when 11 children became the subject of SGOs, with a further 26 predicted for the remainder of the year. Assessments undertaken thoroughly assess the strengths and vulnerabilities of family members to care for children as special guardians. However, this process is not systematically established and relies on workers' knowledge of individual children and families. This means that the local authority cannot be fully assured that progress is always timely and robust.

52. The local authority has 102 children looked after (over 40%) who are the subject of voluntary, section 20 arrangements. The use of such arrangements has, for some children, adversely impacted on the timeliness and quality of permanence planning. Inconsistent use of permanence planning meetings has been a key factor in delaying permanence plans for children. An audit was undertaken by the local authority in July 2016, which considered 94 cases where children were the subject of section 20 arrangements. The audit identified that, in 54 of these cases, regular permanence planning meetings had not taken place, particularly for 42 young people over 15 years old, and in 40% of cases some element of delay was identified in progressing the plan to permanence. In response to these issues, a robust action plan across the whole service has been implemented and this is ensuring more timely permanence planning for children.

53. At the time of the inspection, a number of children who were settled and thriving in long-term stable placements had not been permanently matched with their current carers. The local authority recognises the uncertainty that lack of permanence can cause and is taking the necessary steps to formalise these arrangements via the appropriate panel.

54. The educational attainment and progress of children looked after are supported by a well led virtual school. Children looked after do well at school. Current local authority data shows that outcomes for primary school children are high and in many cases similar to the figures for all children nationally. At key stage 4, children looked after do not do quite so well, but still do better than their peers nationally.

55. The number of school changes for Havering children looked after is low, with 90% of children looked after having attended only one or two schools in the past year. This helps to contribute to consistency of education provision for children. Personal education plans (PEPs) are generally fit for purpose, identify barriers to learning and the strategies to overcome these barriers. They contain detailed information about educational attainments. Actions are clear, well defined and based on a sound analysis.

56. Staff in the virtual school robustly monitor the impact of pupil premium spend. Schools have to apply for the funding based on PEP targets. School staff report that staff in the virtual school challenge them to provide evidence of the impact of the use of this money to improve the educational outcomes for children looked after. School attendance of secondary-aged children who are looked after is not yet good enough, at 86%, although primary school attendance is high, at 98% overall. While attendance figures have improved year on year, current data indicates that only 64% of children looked after have attendance figures of 95% or better. This is an increase from 57.7% in 2014–15.

57. The local authority keeps records of children looked after who attend alternative provision, with staff at the virtual school effectively monitoring the arrangements. At the time of the inspection, there were no school-aged

children looked after who received education provision of less than 25 hours a week.

58. Assessments of children looked after are not always regularly updated to reflect significant changes in their circumstances. This means that, in a minority of cases, there is no current up-to-date assessment of children's needs. Some assessments lack detail or are insufficiently focused on the current needs of the child. Assessments seen by inspectors did not consistently consider diversity issues for children looked after. (Recommendation)

59. Case recording in the majority of cases is clear and up to date and includes children's wishes and feelings. Information relating to work being undertaken with children to help them understand their journey into and through care is less well recorded.

60. Challenge by independent reviewing officers (IROs) is not consistent or effective. Numbers of recorded challenges are low, with only 19 informal and five formal challenges having been made since January 2016 for issues such as delays in issuing legal proceedings. Critically, informal and formal escalation procedures are not used when concerns about children are identified. Challenge is not rigorous or decisive for some children to ensure that permanence plans are acted upon without delay or that actions from looked after reviews are progressed. (Recommendation)

61. Caseloads for IROs are manageable. Reviews of children looked after are consistently held within timescales and are appropriately brought forward when changes in children's circumstances necessitate a review of their plan. IROs see children prior to reviews to ensure that children understand their purpose and have good opportunity to express their views. Children are encouraged effectively to take part, with their wishes and feelings well recorded. Care plans are not always specific or detailed in terms of the actions required to ensure children's well-being. This means that professionals, children and their families are not always clear that actions are being taken or that progress is being made. Carers and other adults working with children reported to inspectors that delays in minutes of reviews being sent out means that they, or the children themselves, do not always have a record of the current care plan. (Recommendation)

62. Performance in relation to the timeliness of initial and annual health assessments has recently improved from a low base, but is still not implemented effectively for all children. Current data for July to September 2016 indicates that 67% of initial health assessments were completed within the 28-day timescale. For review health assessments for the same period, the number completed within timescale was 74%. The successful appointments of a consultant paediatrician to complete initial assessments and of two nurses to complete review assessments have enabled this improvement, but difficulties and delays in the commissioning process have historically resulted in too few children having assessments completed in good time. A lack of comprehensive

data for the date of the most recent dental check means that there is no effective process to ensure that children's oral health needs are met.

63. Arrangements for meeting children's emotional health needs are adequate. The provision of an emotional health worker within the children looked after service is having a positive impact on the range of services being offered. In the 12 months prior to the inspection, 40 children looked after had benefited from support from child and adolescent mental health services (CAMHS), with a further 32 accessing support from the commissioned counselling service. However, a lack of qualitative data relating to the services offered means that the local authority cannot judge the effectiveness of this provision. Inspectors saw some good examples of emotional health support for children and a number of children were clearly benefiting from CAMHS support. There are gaps in the provision of support when the threshold for CAMHS is not met, a deficit recognised by the local authority.

64. Social workers visit children regularly and see them alone, when appropriate, at least within minimum timescales. However, the quality of these visits is variable. In some, there is clear detail relating to the purpose of the visit, with children's voices well recorded and information about what work is being done. In others, the purpose of the visit is less clear. Children and foster carers told inspectors that some children have had too many changes of social worker. For a minority of children, this has impinged on their capacity to build trusting relationships with social workers who know them well. One young person told inspectors, 'I am tired of having to repeat my story to different people.' In order to address this, in June 2016 the local authority re-structured the social work teams to provide more continuity for children and young people, and has made considerable progress in recruiting permanent staff in the last three months.

65. The needs of children at risk of, or engaging in, substance misuse are met through a commissioned service. Screening processes for this service ensure that when concerns about other risks, such as child sexual exploitation, are identified, these are appropriately shared.

66. Risks relating to children looked after who are at risk of sexual exploitation and missing are mostly well managed. Links between missing episodes and potential child sexual exploitation risks are appropriately considered. Risk assessments are routinely completed and reviewed when risks escalate. Strategy meetings are appropriately held to coordinate multi-agency responses when children are missing more than three times, or when children are at risk of harm through sexual exploitation. Return home interviews take place in the very large majority of cases, but the numbers taking place within 72 hours of a child returning home are low. The local authority's own data indicates that from April to September 2016, 41% of return home interviews were completed within 72 hours. This means that the gathering of information to help protect children from future missing episodes is potentially lost. In a number of cases, prompt decisive action to accommodate young people in good quality residential provision is having a significant positive impact on the

number of missing episodes and reducing the risk of sexual exploitation. (Recommendation)

67. Arrangements for children to have contact with their families and friends are well considered. Contact arrangements for children are clearly identified at looked after reviews. Contact arrangements are well facilitated by the contact service.

68. Sufficiency planning of local placements for children who are looked after is not effective enough. Strategic plans to identify future needs based on the previous and current children looked after population have improved but are still not sufficiently well developed. A shortage of in-house foster placements and commissioned independent sector placements has resulted in some young people being placed in semi-independent supported residential provision not consistent with their assessed need. At the time of the inspection, 28 young people aged 16 or 17 and three 15-year-olds were placed in such accommodation. While not ideal, inspectors found that the three 15-year-olds were well supported, with effective risk management plans. The need to increase the number of local foster placements is clearly recognised by the local authority and while recruitment initiatives are in place, they are showing little impact. (Recommendation)

69. Senior managers are committed to ensuring that children and young people are placed within their localities and local authority data indicates that at the time of the inspection 74% of all children looked after were placed within Havering or neighbouring authorities. In cases seen by inspectors, children placed at a distance from Havering were well supported by social workers. Regular and effective liaison with providers and a swift response to any emerging concerns contribute to the stability of these placements. Generally, children's health and education needs are well met and placements are effective in meeting children's often complex needs.

70. Fostering services meet the needs of children well. Foster carers benefit from a wide range of training courses and support groups. Foster carers spoken to by inspectors were positive about the support they received, particularly the easy accessibility of support and dedicated help and advice out of hours. Foster carers exercise delegated authority on an individual basis, making day-to-day decisions for children in their care, and this helps to normalise children's experiences.

71. Children are carefully matched to carers and their wishes and feelings are considered well. Brothers and sisters are consistently placed together unless their plans identify that it would not be in their best interests. The large majority of children benefit from stable and positive placements. Short-term placement stability is good, with 88% of children looked after having only one or two placements in the 12 months prior to the inspection. However, an increase in the number of foster placement breakdowns, particularly those for older young people, is having an adverse impact on the figures for longer term stability for children looked after.

72. Children and young people enjoy a good range of leisure activities that support their wider emotional and social development, both at home and in school. Carers support children and young people well to become involved in social, recreational and friendship building activities. Passes are provided to enable them to use local authority leisure activities.
73. A focus on individual youth crime prevention through the youth offending service ensures that children at risk of offending are identified early and receive a timely and focused intervention. The corporate parenting board reported in 2016 that, while 12% of all youth offences were committed by children looked after, only one young person subsequently re-offended.
74. The participation of children looked after in service development is not sufficiently embedded. Some positive efforts to facilitate communication with children and young people have been introduced, such as the use of the Mind Of My Own (MOMO) app. Efforts to undertake wider participation have been limited, meaning that there is little evidence of how the voices of children and young people have contributed to changes in the service they receive.
75. The children in care council is underdeveloped. The group is very small and communication between the council, the corporate parenting board and the rest of the children looked after population is ineffective in ensuring that children's voices are sufficiently heard. The impact of the children in care council in improving the quality of service that children receive is therefore limited. (Recommendation)
76. At the time of the inspection, no children in care were matched with an independent visitor. This means that no children had the benefit of the support such provision could offer to advise, assist and befriend them during their time in care. This support is particularly relevant for children and young people who are placed out of area. (Recommendation)
77. Advocacy support to children is limited. Support is delivered through a commissioned provider but only nine children looked after were in receipt of this at the time of the inspection. Children are aware of the opportunity to make complaints about services. However, the impact of learning from complaints to improve their experiences is insufficiently embedded to achieve whole service change.

The graded judgement for adoption performance is that it requires improvement

78. Adoption is considered for all children who are unable to live with birth family members. However, some children with complex needs or from specific ethnic minority backgrounds have waited a long time for their permanent arrangements to be identified. Permanence planning meetings, chaired by the recently appointed team manager for adoption, are bringing earlier

consideration of adoption for children, and dedicated family finders are enabling more timely matches to be made.

79. The authority's performance against the Department for Education's adoption scorecard shows that timeliness in the three key indicators on the three-year averages 2012–15 does not yet meet the government's thresholds for performance. The average time in 2012–15 between a child entering care and moving in with their adoptive family had reduced from 651 days to 607 days, compared to the 2011–14 period, but this still means that children were waiting 120 days longer than the government threshold of 487 days. Unvalidated local authority data for 2016–17 shows an average time period of 726 days. However, this figure is impacted by the placement of four children with complex needs. Of the six children placed with their adoptive families and awaiting orders in 2015–16, the average is 438 days, demonstrating recent improved performance in this area, and almost in line with the adoption scorecard threshold of 426 days for 2013–16.

80. Children in Havering wait too long between placement orders being granted by the court and securing an appropriate adoption match. This means that for some children there is delay in knowing where they will live and who their adoptive parents will be. The published figures for 2012–15 show the average number of days between receiving court authority to place a child to be adopted and the authority deciding on a match to an adoptive family was 180 days. This is higher than the Department for Education target of 121 days, but better than the national average of 223 days.

81. In Havering, 64% of children wait more than 16 months between entering care and moving in with their adoptive families. However, the numbers are small and of the seven children who had their adoption orders granted in 2015–16, and the five placed for adoption but awaiting orders, four waited less than the government's revised threshold of 14 months.

82. In the last year, there has been a reduction in the numbers of children adopted in Havering. Seven children had an adoption order granted in 2015–16, which is three fewer children than in 2014–15. However, the local authority proactively considers a wide range of family members as special guardians, including active and appropriate exploration of extended family overseas; this resulted in 20% of children looked after in Havering leaving care for permanent placements in 2015–16.

83. The recruitment of adopters has not been sufficient and a lack of proactive recruitment in the last 12 months has resulted in few in-house prospective adopters currently undergoing assessments of suitability. This has not prevented family finding for children in Havering, as the local authority has placed eight of the 10 children placed or adopted in the last 12 months with interagency adopters. However, a lack of any targeted recruitment has resulted in delays for some children finding their permanent family, and adopters can wait too long to have children placed; they are then often used by other local authorities. Timescales to progress the few recent adopters' assessments through stage one and stage two are not timely, and the local

authority does not have an accurate assessment of why this is the case. (Recommendation)

84. Fostering to adopt is not yet embedded as a core element of adoption work. However, inspectors saw that permanency was achieved within 12 months for one child who was placed with interagency adoptive carers from four months old, enabling security and consistency of care from a very young age.

85. In the last 12 months, the appointment of experienced and knowledgeable managers has begun to improve the quality and timeliness of adoption work by setting standards and establishing systems and processes for the service. While some child permanence reports (CPRs), prospective adopter reports (PARs) and adoption support assessments seen during the inspection were comprehensive, overall the consistency of work is not yet sufficiently of a good standard. The recent introduction of a range of direct work tools, including story stem work and creative early life storybooks, is helping young children to understand the circumstances of their transition to their adoptive homes.

86. Dedicated focus on family finding activity is starting to improve the timescales for securing appropriate and timely matches for children. In the majority of cases seen, matching reports carefully consider the needs of children in relation to the strengths and qualities of prospective adopters. For one adopter spoken to, a recent life appreciation day '… brought the child to life', enabling a successful match of a child with complex needs. Information provided by professionals enabled her to effectively piece together the child's early experiences and better equip her to understand and meet his needs.

87. An established and robust system is in place to consider adoption as a best interest decision. The agency decision maker provides appropriate challenge to social workers and managers to ensure adoption is the right plan for the child and that children go to live with the most appropriate families. While in the last 12 months eight children with plans for adoption had their plans changed, this was mainly due to positive special guardian assessments and orders to family members that enabled children to remain within their birth family. In only one case was this due to no suitable adoptive family being identified within reasonable timescales for the children, who remained within their foster placement with a view to permanency.

88. The fostering and adoption panel chair is experienced and knowledgeable and brings learning from her work chairing other local authority panels. The combined panel sets appropriate standards, applicable to both areas of work. Appropriate and experienced panel members include a young person with a care history who brings a real focus on the experience of children and effective challenge to practice. The panel provides individual feedback on the quality of the CPRs and PARs and the panel chair reports that, while the quality of written work to the panel is variable, in recent months this has improved and is now mostly of a good standard. Effective quality assurance provided by the new team manager is bringing improved consistency of compliance, comprehension, and timeliness to the work in the service.

89. Adopters who spoke to inspectors felt well prepared for the assessment, panel, and placement. In particular, well-facilitated training helped them to consider issues about the challenges adoption brings in relation to some of the experiences adopted children face. This prepared them well for the reality when their child came to live with them.

90. Information held on adopters' files is currently stored on two electronic systems, making it difficult for the local authority to have a robust overview of compliance in this area. In files sampled, required information on disclosure and barring service (DBS) checks, health checks, medicals, and references was located, but not stored in a consistent way and place by each worker. As a result, the service cannot easily assure itself that information is up to date, current and meets statutory requirements. (Recommendation)

91. An accessible 'Guide to adoption and adoption support' is available for children and young people, and this includes space for them to write down their worries. It contains useful contact numbers of organisations for those who may be feeling confused, wondering about their birth family, or are struggling to know how to tell people they are adopted. Assessed adoption and special guardian support needs result in a support plan. However, not all support plans are comprehensive, and some lack clear and specific details of individual children's needs. This means that adopters or carers do not all have a good overview of their child's additional or likely needs in the future. A range of effective support is available, including direct work with families, letterbox contact, direct contact supervision, and general advice, resulting in no adoption or special guardians breakdowns in the last three years. (Recommendation)

92. Life story work has not had sufficient priority for children in Havering. In response to this, managers proactively established the 'Life Story Project' to offer support to 19 adopters who expressed an interest, to prepare and improve life story books and 'later life letters' for their children. Although retrospective, adopters valued the work; one commented that this service had helped them to support their daughter who has recently started to question her history and the decision to place her for adoption. All recently completed life stories seen during the inspection were age appropriate, detailed, and with difficult and sensitive information well written, helping the child to know about and understand their early experiences.

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

93. There are widespread failures that result in care leavers not having their welfare promoted. Since July 2016, staff and managers have been aware of many of the issues that inspectors have identified. In a few areas, improvements have already been made. For example, the increase in the

number of staff who help young people find education, employment or training, which has resulted in an increase in the number of apprenticeship opportunities for care leavers. The local authority is now in contact with almost all of its care leavers. A new manager has been appointed, and senior managers are in the process of recruiting experienced social workers to strengthen the service. However, these measures are yet to have a demonstrable impact and inspectors found too many examples of insufficient oversight, guidance and training for staff. A number of recommendations from the 2011 inspection are still relevant today, for example regarding the quality of pathway plans.

94. Pathway planning is of poor quality. It is not compliant with statutory guidance or effective. Plans lack detail, many sections are not completed or reviewed regularly and young people spoken to by inspectors were not aware of plans to meet their needs or were sufficiently involved in developing them. Targets and actions, when they do exist, lack clarity and urgency. They are not based on an analysis of the young person's history or current position. Staff acknowledge that the case management system is not fit for the purpose of recording their work in supporting care leavers. (Recommendation)

95. Plans to assess risk and pre-empt crises are not always in place. Pathway plans do not contain sufficiently detailed contingency plans. For example, all care leavers spoken to by inspectors reported occasions of being placed in semi-independent or independent accommodation before they had the skills needed to support themselves, such as being able to cook. They had all had periods living in accommodation where they felt unsafe. On an individual level, staff take seriously the safety of young people and react promptly with protective action when young people are at risk of harm.

96. Case records for care leavers are not sufficiently comprehensive, related to the pathway plan or based on an up-to-date assessment of need. Senior managers are aware of this as their own audit in July 2016 judged that 54% of the pathway plans sampled either required improvement or were inadequate. Advisers use case notes to record issues not covered in pathway plans, but these notes are not detailed and do not provide sufficiently clear information about the young person. However, many advisers do know their care leavers well and work tenaciously to support them. One care leaver told inspectors about the excellent support they had received. Inspectors saw evidence where advisers provide good support to care leavers who are parents, to help them to care for their children or support them when their children become looked after.

97. The analysis and recording of care leavers' health histories and needs are very poor. Care leavers are not given a summary of their health needs when they leave care and health needs are not considered in the pathway planning process. In too many cases, care leavers are simple advised to: 'Make sure you are registered with a GP and a dentist.' One care leaver told inspectors of a significant medical condition which was not mentioned in their records. (Recommendation)

98. Care leavers' health needs are not sufficiently well assessed and their experiences are too variable. Transitions for young people with disabilities are not managed well. While staff have very recently been trained in the C-card, to give sexual health guidance, there is no clear programme of sexual health education based on assessed needs. The local authority is planning to provide care leavers with a pack containing their health information, but at the time of the inspection there was nothing in place. Advisers are aware of the challenges for care leavers to access adult mental health services, and work hard with care leavers to help them engage with appropriate support. Care leavers who met with inspectors reported specific instances of good help.

99. The draft care leaver service action plan is not sufficiently rigorous. Targets are not comprehensive and lack clarity about how they will be achieved and by whom. Statements are too vague and are not supported by evidence of analysis.

100. Senior managers have made recent improvements in providing care leavers with the opportunity to give feedback on their experiences. The previous system was used infrequently. For example, in the three-month period from April to June 2016, the authority received only five responses. They have introduced an application for mobile electronic devices called 'Mind Of My Own' (MOMO), for both children in care and care leavers. Staff have managed the implementation of this project well. Results are analysed well and issues now go direct to the complaints department. In the period from July to September 2016, the authority received 89 responses.

101. There is no structured programme of skills development for children in care and care leavers to develop independent living skills and confidence. While staff arrange some training when a specific need is identified, there is no detailed analysis of each care leaver's need and a strategic summary of this. The local authority is over-reliant on foster carers to provide this development prior to children leaving care, and as fewer than 10% of care leavers 'stay put' with their foster carers, many are unable to take advantage of this support. While the proportion of children staying in care until they are 18, at 73%, is higher than the figure nationally, the local authority does not monitor sufficiently well the development of necessary skills. Staff are aware of this and in the last four months have introduced a range of initiatives. For example, 'Spark 2 Life' involves 12 care leavers being mentored to help them develop employability skills.

102. Leaders and managers work well to increase the proportion of care leavers in education, employment or training. This proportion has increased year on year and the local authority reports that this is currently at 66%. Of these, 5% are at university, 35% are in other further education, 3% have apprenticeships, 20% are in employment with training and 3% are in 'other' options. Of the 34% who are not in education, employment or training, 21% are not in a position to seek education, employment or training due to a range of factors, including illness or disability. A recently appointed placement coordinator is establishing apprenticeship opportunities for care leavers in the area.

103. The local authority has established a wide range of initiatives to offer young people good work experience. While these are directed at all children in the borough, many of the programmes have high numbers of care leavers taking part. The authority has introduced 'City Walks', a programme of work experience with small- to medium-sized enterprises and major firms. Thus far, 62% of the participants have been children looked after and care leavers. A few of the care leavers have gone on to work experience and apprenticeships as a result. In addition, 15% of the participants involved in the 'Baby to Briefcase' programme of training are care leavers. This programme is aimed directly at young people with children.

104. In its role as corporate parent, the local authority does not celebrate care leavers' achievements and does not hold any group activities such as an annual celebration event. Care leavers state that they do not feel their achievements are celebrated well as a group or that the local authority is particularly proud of them. For example, 'When you are under 18 they look after you because they have to, but then they don't. The level of care when you turn 18 drops a lot'. Another care leaver reported: 'I don't feel they show they're proud'. Advisers acknowledge individual success, for example by sending the young person a card and gift voucher. (Recommendation)

105. While the reported figure for the proportion of care leavers in suitable accommodation has increased this year to 97%, the local authority does not work sufficiently strategically to ensure that a suitable range of accommodation is available to make appropriate placements. Strategic plans to identify future needs, based on the current children looked after population, are not sufficiently well developed. The local authority has no specific provision for emergency accommodation. Staff have to find ad hoc arrangements for each case of placement breakdown. The sufficiency statement predicts an increase in care leavers. However, it does not identify how the accommodation needs of these young people will be met. In the last few months, the local authority has begun to work more closely with housing and accommodation providers, with emerging evidence of improved planning for accommodation. (Recommendation)

106. In the last two years, the local authority has used hotel accommodation for three care leavers due to either risk or placement breakdown. These cases were carefully managed and young people were appropriately supported. A few staff are not sufficiently aware of the need for visits after placement moves and do not update pathway plans as required or properly identify risks of tenancy breakdowns. However, good partnership working with the housing department ensures that care leavers have the highest possible priority for accommodation and for arranging financial support through benefits.

107. Care leavers are not provided with sufficient information about their entitlements and benefits. Many report that they had to research the issue themselves and they found out about more benefits than they had previously been told. In a very few cases, care leavers have had to lobby the local authority to access accumulated savings and set up home allowance funding. Care leavers report great difficulty accessing their records, some waiting for

many months after making the request. The local authority used to provide a leaflet for care leavers but one adviser stated that they no longer do this. The local authority is aware of this and staff have recently held meetings with care leavers to speed up access to their records. The care leavers’ pledge is brief and does not set out how the local authority will honour its pledge. (Recommendation)

Leadership, management and governance	Requires improvement

Summary

Services for vulnerable children in Havering have not been good enough for some time, and a few areas have not sufficiently improved since the last inspection. Children have not been able to rely on support that will consistently meet their needs, and for some, such as care leavers, practice does not meet minimum standards. Substantial changes in the senior and political leadership team over the past 18 months, including the recruitment of a permanent, experienced senior management team, are positive. The DCS has brought renewed focus and drive. Social work teams have been successfully restructured. Political and financial support for recruitment and retention and for the 'Face to Face' approach is strong. Staff are positive about working for Havering. Training is good and caseloads are manageable. Since April 2016, agency rates have fallen by 25 percentage points.

The improvement board is addressing weaknesses, such as delays in health assessments and the timeliness of single assessments, although in some instances, actions have not been urgent enough, for example improving pathway planning for care leavers. Extra resources and management capacity have been put in place in recognition of the scale of the task. Quality assurance arrangements are well articulated, and case auditing arrangements are strong, but the learning cycle is not well embedded and improvements are not always rigorously tracked. Managers and staff learn from individual complaints but service-wide changes are not well evidenced. The role of the IRO in scrutinising and influencing practice is underdeveloped.

The management oversight of casework is adequate and sometimes good, but supervision and appraisal are not effective in holding staff to account.

Although the electronic recording system has been improved, it still does not support social workers well enough, or assist managers to oversee the work of their teams. Relevant performance information is shared with the right strategic groups and forums. Improvements are planned to improve analysis and ensure a focus on outcomes.

Senior leaders have taken positive steps to understand better what it is like to be a child in care in Havering, but they have not utilised the corporate parenting board well enough to engage with children and young people to improve their lives.

The approach to sufficiency is improving, helped by a better understanding of what children need, but the local authority is not yet meeting its sufficiency duty, particularly in relation to accommodation for care leavers and the recruitment of adopters and in-house foster carers.

The operational and strategic arrangements to respond to children who go missing, who are at risk of child sexual exploitation or who are vulnerable to radicalisation are effective.

Inspection findings

108. The DCS was permanently appointed in September 2016, after a period of 11 months as assistant director for children's social care. Twelve months before the inspection, children's services experienced a significant increase in demand due to an unexpected change in the demography of the borough, with more families moving in from other London boroughs due to lower housing costs. Workforce instability and agency rates were high. Senior and political leaders acknowledge that the approach to improvement over time has not been sufficiently focused on the key service weaknesses or organised or systematic enough, leading to vulnerable children receiving an inconsistent service. During the inspection, the legacy of this was evident on children's case files. Social workers told inspectors that this had been a difficult period for them in terms of workloads and reliability of management support.

109. The DCS has brought renewed energy, insight and extensive social work and management experience to the task of service development. He has drawn on external resources to diagnose service weaknesses and has demonstrated his commitment to achieve cultural and practice changes. With the firm support of political leaders, he has made a promising start.

110. Services have been successfully reorganised to simplify the structure and to increase the number of first-line managers through the creation of pods in core social work teams. This was in recognition of the need to improve the management oversight of casework. A critical remedial step was to review the effectiveness of previous senior leaders and to appoint new, experienced permanent senior managers; this team is now in place. A new chief executive and lead member for children's services were appointed in May 2016. Although the senior and political leadership team is now stable, the level of instability and change has slowed Havering's improvement journey.

111. Over the past six months, the children's service improvement board, now the transformation board, has overseen a wide range of practice issues through fortnightly meetings, chaired by the DCS. Minutes evidence detailed discussion and careful consideration of data, feedback from young people, and audit findings. The board appropriately reports to the cabinet, overview and scrutiny committee and the health and well-being board. However, the extent and scale of the areas for improvement are considerable. As a result, some priority matters, such as the quality of pathway planning, which has been raised in previous inspections, have not been afforded the right level of urgency. Despite recent progress, almost all areas of practice still require improvement in order to be good, and a few do not adequately meet the needs of children.

112. The children's services improvement plan addresses all the key issues identified in the local authority's self-assessment and broadly mirrors the strengths and weaknesses highlighted through the inspection, but it is not always clear which areas are considered the most critical or the highest priority. It is also not always explicit who is accountable and how improvements will be monitored. Some service improvement plans are

appropriately focused on key changes that are needed, such as actions arising from the recent audit of section 20 cases. Others do not address critical weaknesses well enough, such as the leaving care draft action plan. Some positive changes can be evidenced, such as better processes that are ensuring the right children are progressed through the MASH to children's social care. Senior managers acknowledge that a sharper and better coordinated approach is needed, and as a result, a transformation manager has been appointed. Although a positive step, the impact of this appointment is not yet evidenced.

113. The quality assurance framework and policy are up to date. They outline well an appropriate range of activity, including case auditing, complaints and the scrutiny provided by IROs. The accountability of managers at all levels is explicit. The policy and accompanying framework describe the cycle of case auditing, and the reporting and improvement processes for this activity are well embedded. However, in other respects, the application of the policy and framework is less effective. The role of the IROs and child protection conference chairs is underdeveloped, limiting the impact of their scrutiny on practice. Learning from complaints on a case-by-case basis works well, but it is not sufficiently embedded in the quality assurance cycle. Overall, managers do not sufficiently track specific actions resulting from quality assurance activity to ensure changes in practice are sustained. Senior managers acknowledge that although they took appropriate steps to strengthen practice within the MASH following a review in March 2016, this subsequently 'slipped' due to a lack of rigour in overseeing, for example, how quickly children were seen following referral. This led to some children not being seen quickly enough, although immediate plans to safeguard them were in place. (Recommendation)

114. In April 2016, the DCS launched twice-yearly 'practice weeks', to embed the culture of learning from case auditing. This has been largely successful. All members of the senior management team, including the chief executive, chief operating officer, DCS, the principal social worker and heads of service were involved in the most recent practice week in September 2016. They viewed case records, spoke with practitioners, asked family members about their experiences and observed key meetings. This effectively brought senior managers closer to the experiences of children, young people and families. One hundred children were considered, with 50 case files audited. Findings have enabled managers to draw comparisons with the previous practice week, with important areas for development identified, such as the need to improve the management oversight of early help casework. Follow-up of findings from the first practice week was robust, for example every case when visiting was not sufficiently regular or children were not seen alone was re-audited, with learning appropriately disseminated.

115. The greatest challenge facing Havering children's social care in recent years has been instability in the children's social care workforce, with high rates of agency staff at social worker and first-line manager levels. In 2015–16, the proportion of agency staff stubbornly remained at around 50%, and this led to one third of children experiencing three or more changes of social worker in a

year. For some time, rates of pay in Havering have been lower than in neighbouring authorities, but this has now been rectified through a market supplement.

116. Over the past 12 months, the response to the recruitment and retention of staff has markedly improved, with the implementation of a multi-layered strategy to attract and retain social workers and managers. The Face-to-Face vision, launched in May 2016, is central to this strategy. Its purpose is to enable practitioners to spend more and increasingly effective time with children and families, and to establish Havering as a unique social work employer. The council has invested significant additional funds, with 200 staff already briefed in systemic practice, and all permanent staff programmed to attend accredited training in the coming year. In a small number of complex cases, inspectors saw the positive impact of this approach. Social workers consistently told inspectors that they feel positive about the vision. Some recently appointed permanent staff told inspectors that this is why they chose to work for Havering.

117. Social worker caseloads are manageable, at an average of 16 children, enabling them to spend the time with families that they need. Social workers say that they are well supported; they have good access to training and benefit from regular supervision. They value the provision of good quality mobile equipment. The range of measures is steadily taking effect, with the proportion of permanent children's social care staff rising to 75% at the time of the inspection. This is an increase of 25 percentage points over a six-month period, and is a notable achievement.

118. Senior managers have learned from the previous approach to the recruitment and support of social workers in their first, or assessed and supported, year of employment (ASYEs). In 2014–15, just 11 of 25 ASYE social workers remained in Havering, primarily because first-line managers were too busy to support them properly. The current cohort of 22 ASYEs, three 'Step up to social work' students and eight 'Frontline' practitioners are supported well by additional practice supervisors and consultant social workers. Supernumerary social workers enable these staff to hold low caseloads. ASYE social workers and students told inspectors that they are receiving the right help to develop and consolidate their practice skills.

119. Social workers told inspectors that they have good access to training, including the briefings, conferences and courses provided by the LSCB. The career progression framework is a comprehensive professional development offer for social workers and managers at all levels. However, managers do not consistently analyse the learning needs of their services in a systematic way, and appraisals are weak. Leaders have not ensured that staff in the leaving care service are supported to become sufficiently skilled or confident to fulfil their statutory responsibilities, particularly in relation to pathway planning.

120. Most case supervision records seen by inspectors were appropriately regular and were of an acceptable standard. Some good examples were seen of detailed case supervision, using a 'Signs of Safety' approach to identify risks,

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needs and strengths, leading to meaningful plans for children. However, inspectors also brought to the attention of the DCS a small number of cases where managers had not effectively driven plans or fully recognised risks. This left children at risk of harm. Formal supervision records do not evidence that staff are sufficiently held to account for the quality of their practice. (Recommendation)

121. The electronic recording system has been substantially improved since the last inspection but it is still not fully fit for purpose because it does not properly support social workers to maintain and share a meaningful record of their work. It is a particular challenge for the adoption service, where adopters' electronic files are disorganised and difficult to read, and in the leaving care service where the system does not support effective pathway planning, a key statutory duty of the service. Managers acknowledge that a wholesale review is needed, and this is underway, but a solution is likely to take some time to achieve. It is positive that the lead member for children's services is championing this issue, but progress is too slow. (Recommendation)

122. The electronic recording system does not facilitate easy access to live performance information. In particular, it does not enable first-line managers to oversee closely the work of their teams. The performance team produces and circulates weekly reports, and this includes most of the key information that managers need, but the layout is not helpful, and not all managers use it well. A notable gap is the timescale for children being seen following referral; senior managers swiftly addressed this gap when it was highlighted by inspectors during the inspection. Key forums such as children's scrutiny, monthly lead member briefings, the improvement board and the corporate parenting board receive appropriate management information, and overall they use this data well to scrutinise performance. However, the frequency of visits to children looked after and those subject to child protection plans is not routinely included. Some data lacks depth because it is primarily the reporting of headline numbers with little analysis, for example regarding adoption performance. Senior and performance managers have ensured that data is consistently accurate, and when commentary is provided, this is helpful. The next step is to make performance information more meaningful to enhance the way it is used to understand and improve the experiences of children. For example, further improvements are planned to improve analysis and ensure a focus on outcomes, such as through the implementation of the 'Outcomes Star' model to support and manage change. (Recommendation)

123. Governance arrangements are clear and are used well, with established formal and informal links between the chief executive, the DCS, the chair of the LSCB, the leader of the council and the lead member for children's services. The chief executive and the lead member take an active interest in progress, and are aware of individual cases on a 'need to know' basis. The lead member, appointed in May 2016, is already championing some key issues, such as the need to provide care leavers with apprenticeships within the council. Minutes of the monthly formal meetings between the chief executive, the DCS and the chair of the LSCB evidence appropriate and effective

direction, careful consideration of plans for improvement and mutual support and challenge. The chief executive demonstrates a thorough knowledge of the challenges facing children's social care and has forged helpful links with other boroughs through the wider London chief executive group.

124. Although participation and advocacy for children and young people are not well developed, senior managers have taken steps to hear what children looked after have to say about their lives through the MOMO app. Complaints from MOMO now go directly to the complaints officer, which is positive.

125. Children looked after and care leavers do not have a strong presence or voice on the corporate parenting board, and the forum has not prioritised the experiences of care leavers over time. The board does consider the views of young people by carefully analysing feedback, and it oversees key performance issues such as placement stability. However, its impact is impaired because children and young people do not sufficiently influence its work plan, and because the membership is not wide enough. The board has not prioritised the celebration of children looked after and care leavers' achievements, and this is an important weakness. (Recommendation)

126. The sufficiency strategy 2016–19 is up to date and is relevant to the current care population, with appropriate and analysis of trends, challenges and gaps. It is less clear about how achievements will be measured. Progress against some targets, such as improving the range of accommodation options for care leavers, has been slow. Over the last six months, senior managers have taken decisive steps to address gaps, for instance by strengthening the edge of care service and increasing activity to recruit more in-house foster carers. However, targets for 2016–17 are unlikely to be achieved, and the number of these carers fell from 88 at 31 March 2016 to 75 at 31 August 2016. The use of supported accommodation for young people who are not ready to live in this type of accommodation, and the very small number of children who have been placed in unregulated provision, are a legacy of this. Overall, the approach to sufficiency over time has not been robust enough, and recent measures have yet to have a measurable impact.

127. It is positive that senior managers have worked with partners to create a Joint Commissioning Unit and a children's commissioner post to oversee and coordinate commissioning activity on behalf of the clinical commissioning group, public health and children's social care. Although now in place, it is too soon to judge the impact of these ventures, particularly in relation to mapping commissioned services against need. Current commissioning arrangements effectively ensure that the quality of provision is overseen and tested. Senior and commissioning managers have made appropriate decisions to de-commission, re-commission or bring services back in-house where quality has been compromised or where providers have not met demand.

128. The strategic and operational response to children who go missing and children at risk of sexual exploitation is well established, although the recently updated strategy has not yet been published. Partners have taken careful account of the child sexual exploitation peer review, which was published in

April 2016. The review affirmed local arrangements overall, mirroring the positive findings of this inspection in relation to disruption activity, multi-agency practice and the development of the Havering problem profile. The review highlighted the need to strengthen the strategic and operational coordination of the local response to child sexual exploitation. As a result, partners have invested in a strategic lead with operational oversight for child sexual exploitation and missing. Although the post holder has only been in place since 1 August 2016, she has already further strengthened the operational response, ensuring that plans for children are followed through, that intelligence is used well and that professionals have access to the right support and advice to identify and assess risk.

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The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board requires improvement

Executive summary

The board meets all of its statutory functions as defined in Working Together 2015. Key partner agencies are represented, and the board is seeking to appoint a second lay member. The board demonstrates open and honest challenge between board members. However, the board is insufficiently informed about the quality of frontline practice. There is limited data and analysis provided by agencies in the Havering Safeguarding Children Board (HSCB) annual report 2015–16. This inhibits the board's monitoring function to fully understand the overall effectiveness of safeguarding services.

The board has been effective in raising some practice standards by providing challenge to multi-agency partners, but this has been hampered by inconsistent data. However, the board has worked effectively to influence increased staff resources to improve timeliness of the health assessments of children looked after.

The HSCB provides effective leadership in tackling child sexual exploitation at both strategic and operational levels. This ensures that work focuses effectively on the most vulnerable children. Oversight of arrangements to tackle child sexual exploitation and children and young people who go missing is robust.

The board and its partners receive good quality information on how emerging trends are linked to related issues such as gang violence, and where groups are moving across police force boundaries to extend their drug dealing networks (known as the 'County lines' model). This has enabled a high level of disruption activities, effectively targeted and coordinated between agencies.

The annual safeguarding report provides clarity and depth on a wide range of issues. For example, there is a helpful commentary on the positive impact of early help initiatives. Early help activity is tracked and monitored by the board, which has supported the development of a wide range of services delivered by partner agencies. This has resulted in families receiving better quality services.

The chair routinely meets with a wide range of partner agencies and is proactive in raising issues appropriately. All agencies report their operational risk issues transparently, via the 'risk register'. This results in effective support from other agencies, as well as challenge, to resolve wide ranging safeguarding issues. An example of this is the effective resolution of the delays in child sexual exploitation contacts being dealt with appropriately. Thresholds into early help and statutory services are inconsistently understood by partners and this is reflected in the quality of referrals to the MASH.

Monitoring of private fostering arrangements is not sufficiently strong.

Recommendations

129. Ensure that the board receives comprehensive, accurate and timely data and performance information to enable effective monitoring and evaluation of key safeguarding services, including those for disabled children.
130. Ensure that partner agencies evaluate their performance as part of their contribution to the safeguarding board's annual report to enable effective action planning.
131. Ensure that thresholds are well understood and are operated effectively by partner agencies, and identify where there are areas for improvement.
132. Strengthen the oversight of private fostering arrangements to ensure that children who are privately fostered are identified and supported effectively.

Inspection findings – the Local Safeguarding Children Board

133. Governance arrangements are well established. The chair of the board meets regularly with the chief executive and lead member, as well as senior managers from partner agencies. This ensures that key priorities for children are shared at the most senior level. The chair of the board attends the Health and Well-being Board, and presents the HSCB's annual report. The chair provides appropriate challenge, ensuring that children's issues are highlighted. The Health and Well-being Board has reviewed a limited number of issues in detail, such as services for disabled children and the provision of the health assessments for children looked after. This led, for example, to a marked improvement in the timeliness of these health assessments.
134. The HSCB is chaired by an experienced and independent person, jointly appointed as the independent chair of the Havering adults' safeguarding board. This has resulted in some effective joint working, such as auditing and local service planning and the creation of 86 champions against domestic violence. The board is financially sound and members make appropriate contributions on time.
135. The board has appropriate multi-agency membership and is attended by sufficiently senior officers from a wide variety of relevant agencies. Board members are committed to improving the life chances of children. The one lay member is involved at board level and contributes effectively. The relationship between the board and the lead member has been strong for a number of years.
136. Building upon mature existing partnerships, there is a commitment to ensuring high quality safeguarding services. The board is effective in raising practice standards by holding multi-agency partners to account on some issues, but this is limited due to inconsistent data. Partners are also able to share relevant

concerns to aid understanding, for example the need to increase the staffing levels of police officers in the MASH, and to ensure enough health professionals and permanently recruited social workers are in place to undertake core safeguarding duties. The board has worked effectively to influence the increase in the staffing resources of health providers in order to successfully improve the timeliness of the health assessments of children looked after.

137. The five subgroups of the board are chaired appropriately by a variety of agencies. The board has recognised shortcomings regarding the level of practice focus and critical enquiry. As a result, the tasks of the groups are currently being reviewed, to increase their effectiveness. The minutes of the working groups do not provide a concise record of activity; this has been recognised by the chair, and action is being taken to improve the quality of the records.

138. A well-designed joint adults' and children's 'risk register' is used to track and provide oversight to senior leaders regarding the 13 areas that have been identified as presenting the highest risks. While the risk register is reviewed routinely at board level, it has not prevented some issues from being overlooked. For example, the quality of reports from some agencies to child protection conferences is unsatisfactory and lacks analysis of risk.

139. Partners' understanding of thresholds and pathways into early help and statutory services is inconsistent and this is reflected in the quality of referrals into the MASH. The board has recognised the need to refresh training on the application of thresholds with partners and this work is about to commence. (Recommendation)

140. The dataset used by the board has been in place since early 2016 and agreed at a senior level. However, it has not been an effective tool as the data provision has been inconsistent, and some areas lack analysis and commentary. The data does not enable a full or accurate picture of the differences that agencies are making for children, or help to identify gaps in safeguarding services, for example services to care leavers, to children who are being privately fostered, or disabled children. During the inspection, it became clear that the police from the child abuse investigation team were not consistently attending strategy meetings. The board was not aware of this, as this information is not included in the data that the board receives. Weaknesses in data provision therefore reduce the board's influence on the planning and commissioning of services as it cannot systematically monitor and evaluate quality. (Recommendation)

141. Consultation with children and young people is beginning to influence safeguarding practice. The chair and senior managers on the board have recently met with a wide range of young people, including young people looked after and young carers, to talk about what made them feel unsafe in the borough, and how services could be improved. The information gained from young people has subsequently been used to inform a safeguarding event in October 2016.

142. The annual report for 2015–16 is both detailed and wide-ranging, identifying some areas of progress as well as board challenges. It includes commentary on early help services, allegations against professionals, private fostering, the independent reviewing officer service, audit and performance, the MASH and an update on the previous year's challenges. The analysis by each partner agency of their contribution to safeguarding activity is inconsistent and limits the usefulness of this report in understanding what works well and what needs to change. While the priorities and the vision statement are reflected in the accompanying business plan, the action plan is not sufficiently robust, and information relating to children with disabilities is absent. (Recommendations)

143. The chair routinely meets with the designated officer and reports on the improvements and developments of this service within the HSCB's annual report. Challenge has been effective, and referrals have increased.

144. An established learning and improvement framework is used to determine the initiation of serious case reviews (SCRs) and case management reviews. The series of training sessions provided following a recent SCR was of high quality and welcomed by multi-agency partners, but turnover of social workers has meant that some more recently appointed staff are unfamiliar with the lessons learned. Learning to support improvements to practice is therefore limited. Two SCRs have been progressed in the last year and one has been published. The board proactively seeks to learn lessons before completion of reviews and put changes in place quickly before a serious case review is published, to ensure that children are safeguarded. Following the findings of a recent SCR, which has yet to be published, action was taken to improve arrangements for children who attend accident and emergency units, to ensure that relevant cases are always fully reviewed by senior paediatricians before discharge.

145. The board works positively using a whole systems approach to develop responses to SCRs that cross all agencies, such as the implementation of an effective escalation policy. A recent neglect strategy was launched in October 2016, but it is too early to see the impact of this positive approach.

146. The child death overview panel (CDOP) operates effectively. The annual report is concise and contains all relevant information. None of the small number of child deaths during the last year were linked to safeguarding issues, and plans are in place to improve this report by linking findings to a wider population in order to improve the quality of information provided. The CDOP report appropriately challenged the local authority's decommissioning, because of budget constraints, of a smoking cessation service, due to the known risks to pregnant mothers and the risk of miscarriage.

147. The board receives confirmation from partner agencies that section 11 audits are completed and evidence of action plans is submitted for scrutiny. However, this relies too heavily on self-reporting. There is no scrutiny or analysis of the findings of section 11 audits by cross-referencing them with other multi-agency audit findings. The board receives assurance about safeguarding practice in schools via section 175 reports.

148. The board has undertaken two multi-agency audits in 2016, focusing on the MASH and return home interviews. Both audits appropriately identified the need for improvements. However, modifications made within the MASH were not tracked to ensure sustained improvement. As a result, quality assurance processes in the MASH team are still underdeveloped and do not ensure that key information, or the rationale for decisions taken, are clear to social workers in progressing their work. The board's audit of the quality of return home interviews resulted in the appropriate de-commissioning of a previous service. The board has not established a system for the oversight of relevant single audit findings. This means that the board does not have a coherent view of quality of work by respective partners or the level of demand for services.

149. The child sexual exploitation working group of the board has provided good quality localised information by extensive use of the 'problem profile' on child sexual exploitation in Havering. This means that all partner agencies are supported to be an effective conduit for sharing best practice within their workforce. This 'problem profile' has helped each agency review and improve training around child sexual exploitation. The board has improved multi-agency practice in understanding, awareness and effectiveness by focusing on the most vulnerable children. For example, within the local hospital, training on child sexual exploitation is now targeting all clinical areas where children may attend. Additionally, some schools now offer sessions to Year 6 children around the dangers of grooming on the internet and via smart phones. The board and its partners also receive high quality information on how these emerging trends in Havering are linked to related issues such as gang violence. This is enabling effective targeting of disruption activities.

150. Social workers who spoke to inspectors valued the multi-agency training provided by the board. During the period April 2015 to March 2016, 55 courses took place, with over 700 participants from various agencies. Training is evaluated, but the board recognises that this process requires further development to begin to measure the impact of learning. Training is responsive to changing needs as it combines learning from Havering's own SCRs, as well as nationally published SCRs and research findings, into current training programmes. The board has an accessible and informative website, which also has various sites for different aged children with relevant good quality links on a range of safeguarding issues. The website also holds the pan-London LSCB policies and procedures, which the board has adopted.

151. The board has supported the drive on early help developments and the progress on early help assessments and the impact is reported within the board's annual report.

152. There are low numbers of children identified as living in private fostering arrangements and awareness raising campaigns have had limited effect. Private fostering assessments are not timely, resulting in privately fostered children not being initially seen within statutory timescales. (Recommendation)

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Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of seven of Her Majesty's Inspectors (HMI) from Ofsted.

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