CABINET

18 June 2019

Title: OFSTED Inspection of Children's Services and Improvement Plan	
Report of the Cabinet Member for Social Care and Health Integration	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
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Summary

In February the Council was subject to a Standard Inspection under the OFSTED Inspection of Local Authority Children's Service (ILACS) framework. Following initial feedback provided at the conclusion of the inspection the final 'OFSTED Letter' formally setting-out OFSTED's findings was published on 1 April 2019.

This report sets out the headlines from the published findings, including, but not limited to, the 6 named recommendations that OFSTED have made.

In response to these recommendations the Council is required to develop and publish an improvement plan by 9 July 2019. This report introduces the plan and describes how it will be delivered as part of the wider improvement programme.

The wider Children's Improvement Programme that sets out how the full gamut of improvement activity will be delivered, and includes detailed financial implications, will be presented to July Cabinet.

Recommendation(s)

The Cabinet is recommended to:

(i) Note the findings of the OFSTED Inspection of Children's Services in February 2019, as set out in Appendix A to the report;

(ii) Agree to the publication of the Council's Improvement Plan in response to the OFSTED ILACS by 9 July 2019, as set out at Appendix B to the report; and

(iii) Note that a report shall be presented to the Cabinet in July outlining proposals for a full Children's Improvement Programme.

Reasons

The OFSTED Improvement Plan is a key plank of the Council's plans to deliver the required improvement to Children's Social Care and secure an improved inspection outcome in 2021. The Council is required to publish the OFSTED Improvement Plan by 9 July 2019.

1. Introduction and Background

1.1 Between 18 February 2019 and the 1 March 2019, the Council was subject to a Standard Inspection under the OFSTED Inspection of Local Authority Children's Service (ILACS) framework.

1.2 During this two-week period inspectors met with key officers, including the Chief Executive and Director of Children's Services, as well as the Lead Member for Children's Services. In a welcome contrast to the previous inspection regime, inspectors spent considerably less time in formal, pre-arranged meetings with a wide range of officers, and much more time observing the direct work and practice of frontline Social Workers.

1.3 Following initial feedback provided at the conclusion of the inspection the final 'OFSTED Letter' formally setting-out OFSTED's findings was published on 1 April 2019. This report sets out the headlines from the published findings, including, but not limited to, the 6 named recommendations that OFSTED have made.

1.4 In response to these recommendations the Council is required to develop and publish an improvement plan by 9 July 2019. The proposed plan is appended to this document. How we will deliver the wider programme of improvements – including those directly in response to OFSTED recommendations - is also described.

2. Summary of Findings

2.1 The judgement from the OFSTED inspection is that services for children in Barking and Dagenham 'requires improvement to be good', as was the case in 2014. This judgement was consistent with our Annual Self-evaluation submitted to OFSTED.

Judgement	Grade
The impact of leaders on social work practice with children and families	Requires improvement
The experiences and progress of children who need help and protection	Requires improvement
The experiences and progress of children in care and care leavers	Requires improvement
Overall effectiveness	Requires improvement

2.2 Although services for children requires improvement to be good, OFSTED inspectors reported that strong and effective senior leadership was now in place under the recently appointed Director of Children's Services (DCS). The inspection letter states that the DCS and senior leadership team are creating a "culture of

mutual esteem and respectful challenge, holding heads of service and managers to account for the quality of practice in their teams".

2.3 Inspectors reported accelerated progress in the last 6 months and that this is leading to improvements in the quality and impact of social work practice. However, the quality and impact of social work practice remains inconsistent and children's health needs are not being met.

2.4 Senior leaders were found to know the service well, as shown by our recent extensive self-evaluation and had taken decisive action in the last 6 months to address concerns and risks. Inspectors reported that the improved rigorous performance management is now making a real difference and leading to improvements in the quality and impact of social work practice.

2.5 Overall, inspectors reported that leaders are highly aspirational for children and families and that corporate parenting arrangements had been improved in the last 6 months. They found that morale is good and that investment in training and development is impacting positively on recruitment and retention.

2.6 Although strategic partnerships were found to mostly well established, the provision and access to health services for children in care and for care leavers were judged as "poor" and a significant concern.

Areas of strengths and positive practice

2.7 Within the inspection report, there are many areas of strength and examples of positive practice. Our Multi-Agency Safeguarding Hub (MASH) was found to be strong and robust; working effectively to safeguard children in need or at risk. Contacts and referrals were found to be managed well, and strategy discussions and child protection enquiries were also timely, well received and management decisions clear.

2.8 The emergency duty team was praised in the inspection and judged as well resourced, experienced and effective.

2.9 Overall, our work with vulnerable adolescents and children at risk of exploitation and radicalisation was judged as positive with knowledgeable and skilled workers in this area. Inspectors felt that the effectiveness of the MASH had been further strengthened by the establishment and colocation of our new vulnerable adolescent and youth offending service. The risks of radicalisation among vulnerable children and direct work were also judged as effective in helping to protect children.

2.10 Inspectors reported that in many cases social workers have strong relationships with children, and "understand their lived experiences and take action to make changes that help and protect [them] and their families".

2.11 The Access to Resources team was also seen as a strength comprising of skilled and experienced workers making a real difference to vulnerable children; including those on the edge of care and children returning home from care.

2.12 Inspectors found that disabled children were being well supported by the all-age disability service, and this was enabling effective transitions into adult services. In addition, Local Authority Designated Officer (LADO) arrangements were robust

and well managed, as was the arrangements for managing children missing education and children electively home educated.

2.13 For children in care, inspectors noted the improvement made on the reduction of children coming into care on police protection and reported that social workers know their children well and had good trusting relationships overall. Contact with family was noted as well panned and positive.

2.14 Fostering and adoption were noted as strengths by inspectors with the Mockingbird model and adoption support both highlighted and praised in this inspection report letter.

2.15 Inspectors found evidence of strong relationships between staff and care leavers and that “most care leavers are in touch with the service”.

Areas of improvement including the 6 key Ofsted recommendations

2.16 Inspectors concluded that the quality, management oversight and impact of early help services require improvement, as those services were not targeted or coordinated sufficiently to meet the needs of some groups of children and young people in the borough.

2.17 The assessment teams were raised as an area of concern during the on-site inspection due to high caseloads and inconsistent management oversight. The DCS and senior leadership team, however, took decisive action and capacity increased and management oversight strengthened. Overall, assessments still vary in depth and quality and need to improve on assessing culture and identity in assessments.

2.18 Inspectors found that management oversight was not robust or challenging enough in assessment and care management teams, resulting in managers not identifying drift and delay.

2.19 Public Law Outline (PLO) thresholds were found to be inconsistent and children subject to pre-proceedings were found to spend long periods of time in pre-proceedings without effective review.

2.20 Inspectors concluded that the Local Authority has a lack of specific domestic abuse perpetrator programmes given the high number of children living in families with domestic abuse.

2.21 Inspectors reported that early permanence planning is underdeveloped. They also found that the quality of viability and special guardianship assessments was far too variable, lacking rigour and were mostly descriptive and analytical.

2.22 Our planning for children placed with parents on a care order requires improvement, as plans were judged to lack clarity and not reviewed sufficiently.

2.23 Inspectors reported significant health concerns for children in care and care leavers. The timeliness of initial health assessments was found to be very poor, resulting immediate health needs not being identified, while access to CAMHS for children in care was reported as “insufficient”.

2.24 Health arrangements for care leavers were also reported as “weak” and a “significant concern”. Health histories for care leavers were not available and inspectors found that care leavers are not provided with a health passport.

What needs to improve

2.25 In addition to the above, OFSTED identified 6 key recommendations where they felt improvement was most strongly required. These are:

- The quality, management oversight and impact of early help services.
- The quality and effectiveness of management oversight and supervision to ensure that children’s circumstances improve within their timeframes.
- The timeliness and effectiveness of public law outline (PLO) arrangements.
- Planning for children placed with parents.
- The strategic relationship with health services, and operational delivery across a range of health functions.
- The provision of help for children living with domestic abuse, or in neglectful circumstances.

3. Next Steps: Improvement Plan

3.1 We are required to publish an Improvement Plan by 9 July 2019. This plan should outline our response to the recommendations made by OFSTED, and progress against delivery will be reflected in our Annual Self-Evaluation and monitored by OFSTED at the Annual Engagement Meeting.

3.2 Our Improvement Plan has been produced. This includes work already underway, augmented by refocusing as a result of the findings from OFSTED. The headline improvement themes for our plan – with the corresponding observations and recommendations made by OFSTED that each will address highlighted beneath each – are as follows:

Improve the quality, management oversight and impact of Early Help services

- Early help services are not sufficiently targeted or coordinated with partners to meet the needs for specific groups of children.
- Referral pathways for homeless 16- and 17-year-olds are not understood by partners, resulting in an inconsistent response.
- Early help QA is not fully embedded so difficult for managers to measure whether neglected children and those living with domestic abuse receive interventions that make a sustainable difference.

Strengthen the quality and effectiveness of management oversight and supervision to ensure that children’s circumstances improve within their timeframes.

- High caseloads in the assessment teams and inconsistent management oversight mean that some children do not receive help and protection quickly.
- Social workers are allocated additional work as they are also responsible for going on duty so pick up more cases every 4 weeks (this was escalated during inspection and action plan was developed. This is a significant area for improvement given current events).
- Records of assessment visits vary in depth and quality of detail.
- Need to improve the exploration of culture and identity in assessments.
- Some children subject to multiple and ineffective assessments and interventions, sometimes over many years.
- Management oversight in both the assessment and care management teams is not enough or challenging enough and this leads to drift and delay.

- Supervision is not analytical and lacks clarity.
- Managers do not consistently identify drift and delay, and, consequently, some children who have experienced neglect wait too long for a service.

Increase the timeliness and effectiveness of public law outline (PLO) arrangements.

- Inconsistent thresholds for instigating PLO.
- Children spend too long in pre-proceedings without effective review.
- A lack of robust tracking and delays in commissioning assessments have hampered timely decision-making about applications for family court orders.
- Inspectors identified some children now in care who had been left in neglectful circumstances for too long.

Improve planning for children placed with parents.

- Plans for children placed at home with parents on a care order are insufficiently reviewed, and limited consideration is given to the early discharge of care orders.
- Overall, there is a lack of clarity around planning for children placed with parents.
- IROs are not proactive in escalating concerns about the quality of care being provided for these children.

Strengthen the strategic relationship with health services, and operational delivery across a range of health functions.

- The timeliness of initial health assessments is extremely poor. Many of these children have experienced abuse and neglect. The poor timeliness of assessments means that children's immediate health needs are not understood quickly enough.
- Children in care do not have enough access to CAMHS.
- Social workers and their managers described situations where children who have suffered serious childhood trauma wait too long for services. This is unacceptable.
- Health arrangements for care leavers are weak. Health histories for young people are not available. Care leavers are not provided with a health passport or with specific targeted support to address mental health or emotional concerns.
- Effective action has not been taken to ensure timely initial health assessments when children come into care and the provision of health passports for care leavers.

Increase the provision of help for children living with domestic abuse, or in neglectful circumstances.

- Early help QA is not fully embedded so difficult for managers to measure whether neglected children and those living with domestic abuse receive interventions that make a sustainable difference.
- High levels of domestic abuse, but specific domestic abuse perpetrator programmes are not available. This means that risks posed by perpetrators are not fully understood or addressed quickly enough.
- Targeted parent support classes like Caring Dads are available but insufficient to address persistent domestic abuse.

3.3 The full version of the OFSTED Improvement Plan is attached as Appendix B.

3.4 In addition, there are several specific areas for improvement are made in the OFTSED report that require a corporate response although not formally a key recommendation. These are as follows:

- Insufficient focus by the virtual school to target young care leavers with more complex needs means that some do not access employment or training.
- Leaders have not yet evaluated the effectiveness and impact of the virtual school.
- Care Leavers told inspectors that staff are not consistently ambitious on their behalf. Senior leaders agree that they need to do more improve the local offer and to increase opportunities for employment and training.

- Corporate parenting work is being re-invigorated, as leaders recognise that it is not as effective as it needs to be. Some key issues have not been addressed quickly enough, for example the limited range of opportunities for accessing education, training and employment for care leavers.
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4. Next Steps: Delivery (and the Children's Improvement Programme)

4.1 Whilst we have a set deadline within which to respond to OFSTED, the requirement – and need – to improve is, of course, wider than the delivery of a single action plan. It is, naturally, equally focused upon improving outcomes and ensuring that we have a sustainable care service. To this end a wider programme of improvement (the Children's Improvement Programme) is being developed, of which responding to the recommendations made by OFSTED will be but one strand.

4.2 The programme itself will comprise four strands of improvement activity woven together into a single, over-arching body of work and formally constituted as a programme within the wider Council Transformation Programme. The methodology and approach will be consistent with the approach taken for all Council transformation activity to ensure that governance, oversight and accountability is clear and transparent.

4.3 A formal Project Definition Document has been developed and considered by Corporate Strategy Group. It is proposed that a dedicated Programme Manager will be appointed to support the DCS in leading such a significant body of work that will have wide-ranging impacts across the Council, and that significant project resources will be required.

4.4 Given the need to respond to OFSTED by 9 July, the OFSTED Improvement Plan is presented to Cabinet to ensure this deadline is met. Approval is sought to publish *subject to the financial implications being resolved*. These are being finalised in tandem with the production of the proposed Medium-Term Financial Plan (MTFP).

4.5 The full Children's Improvement Programme – including financial implications – will be presented to June Cabinet.

5 Consultation

5.1 The OFSTED Improvement Plan was developed in conjunction with key stakeholders across the Council, including the Lead Member for Children's Services. This included colleagues outside of Children's Care and Support who will play a significant role in delivering the improved outcomes for our children and young people.

5.2 Colleagues from the Barking, Havering and Redbridge Clinical Commissioning Group were integral to responding to the specific OFSTE recommendation concerning the delivery of health provision in the borough.

5.3 Findings from the inspection have also been presented to the Local Safeguarding Children Board. Once published the LSCB will be briefed on the part they must play, both now and in future in the form of the new Multi-Agency Safeguarding Arrangements. This Improvement Plan will also be formally presented to the local Health and Wellbeing Board.

6 Financial Implications

Implications completed by Murad Khan (Group Accountant)

6.1 This report is largely for information and sets out the findings of the recent OFSTED inspection of our Children's services. The report seeks for approval for publication of the Ofsted inspection report and the improvement plan. Therefore, there are no direct financial implications to this report.

6.2 It must however be noted that there may be financial implications that arise in the delivery and implementation of the improvement plan highlighted in this report, in any such case finance will expect to have oversight of the financial implications for comments.

7 Legal Implications

Implications completed by Lindsey Marks, Deputy Head of Legal

7.1 The recent inspection was undertaken under the new Framework, Evaluation Criteria and Inspector Guidance for the Inspections of Local Authority Children's Services (ILACS). The Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007 requires, a Local Authority to prepare an improvement plan that responds to the findings in the report.

8. Other Implications

8.1 Risk Management – there is significant risk in failing to deliver a good Children's Service. There are considerable risks to the children and young people who we have a duty to safeguard, as well as the risks to the Council of failing to adequately discharge statutory duties. As part of our governance and programme management arrangements, risks are being identified and will be managed through this process.

8.2 Staffing Issues – any staffing issues will be outlined in the wider Children's Improvement Programme Cabinet report to be presented in July 2019.

8.3 Safeguarding – safeguarding children is a core focus of the OFSTED Improvement Plan.

Public Background Papers Used in the Preparation of this Report: None

List of Appendices

- Appendix A: *London Borough of Barking and Dagenham: Inspection of Children's Social Care Services (OFSTED Letter)*
- Appendix B: *Children's Care and Support OFSTED Improvement Plan*