London Borough of Redbridge Council

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

and

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

Inspection date: 12/09/2016 to 06/10/2016

Report published: 25/11/2016

Children's services in London Borough of Redbridge are good.		
1. Children who need help and protection		Good
2. Children looked after and achieving permanence		Good
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Good

[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 Redbridge are good and improving. Senior leaders and elected members demonstrate passion, ambition and commitment in order to improve the lives of children and their families. Services continue to be well managed and resourced. Sound practice has been further strengthened since the last inspections for children in need of protection in 2012, when services were judged to be good, and for children looked after in 2010, when services were judged to be adequate.

The chief executive officer has been in post for eight months. He is already demonstrating a clear strategic vision to drive forward change and service improvement, with a particular focus on the council's corporate parenting responsibilities. He is keen to maximise the involvement of young people and work in partnership with them as services evolve. During the period of inspection, there was an interim director of children's services who, supported effectively by a stable senior management team, has ensured that the service continues to work well and be strengthened. The clarity provided by the transition arrangements has protected local authority children's services at a potentially vulnerable time.

A responsive senior management team is led by an assured and reflective operational director. Elected members have recently approved significant investment to ensure that caseloads remain manageable. Morale within the workforce is high and staff feel valued. Frontline practitioners are well trained and supported effectively by diligent and available frontline and middle managers. Management oversight is strong. Recent necessary recruitment activity, while commendable, has meant too many changes of social worker for some children and higher support needs for newly qualified social workers.

The 'front door' services are exceptionally strong, demonstrating a clear understanding and response to risk, strong multi-agency working and a timely, well-assessed understanding of need. Inspectors found that clear analytical reasoning underpinned every decision that they observed in the duty team. Children and their families are well supported by the offer of a wide range of early intervention and assessment services. Thresholds to services are very clear, appropriately applied and embedded across all agencies.

Children looked after in Redbridge live in stable homes and achieve good outcomes in their education, including when placed out of the local authority area. The virtual school is proactive and has a very positive impact. Tenacious efforts are made to achieve adoption for children who require this, and changes of plans away from adoption and the disruption of adoptive placements are few. The quality of assessment for children requiring adoption is a strength, including consideration of placing brothers and sisters together. Permanency planning needs to be further strengthened to ensure that the progress for every child is regularly monitored.

Particular service strengths are evident in consultation and partnership working with young people and the quality of advocacy services for both child protection and

children looked after. The local authority is in the process of expanding the availability of this valued service. The local authority is excelling in practice under the 'Prevent' duty and in work undertaken in 'Families Together', Redbridge's 'Troubled families' service. Broader partnership working is strong, as demonstrated through the commissioned services for adopter recruitment, domestic abuse services and well-embedded relationships with the voluntary sector.

The combined role of the child protection conference chairs and independent reviewing officers is not consistently effective, as evidenced by written plans that are not always clear about what needs to be achieved, when and by whom. The escalation process is not consistently used to raise concerns and the annual report on the effectiveness of the service is overdue. Senior managers have already identified this as an area for improvement.

A wide range of data and performance information are routinely collated and used to guide and inform service delivery. This could be further enhanced in order to develop a clear understanding of the effectiveness of practice for children who go missing or are at risk of child sexual exploitation. Senior managers have an appropriate overview of the growing issue of young people affected by and at risk, due to gang activity and affiliations.

The understanding and delivery of services for those affected by domestic abuse are very strong. Within a safe standard of practice overall, the local authority needs to give greater focus to the specific and separate issues in honour-based violence and ensure that health professionals are directly involved in safeguarding from the outset in cases of female genital mutilation.

Senior managers understand and celebrate the diverse population within Redbridge, and practitioners routinely record and consider this in their work. Diversity is clearly recorded for every child and considered sensitively in work undertaken. Individual needs of large groups of brothers and sisters are carefully considered. Practice could be strengthened further to understand consistently the individual experience of each child in casework in relation to ethnicity, culture and religion.

Services for care leavers have a number of strengths, but are not yet consistently good. The local authority is in touch with the vast majority of care leavers. They know their entitlements and the majority are appropriately placed and in employment, education or training. Support from personal advisers is variable, pathway plans are not yet consistently helpful and the service needs to have a closer oversight of outcomes. A small number of care leavers report that they do not always feel that their successes are celebrated. A small minority have expressed concerns regarding their accommodation, which the local authority has responded to promptly.

Contents

Executive summary 2

The local authority 5

Information about this local authority area 5

Recommendations 7

The experiences and progress of children who need help and protection 9

The experiences and progress of children looked after and achieving permanence 17

Leadership, management and governance 31

The Local Safeguarding Children Board (LSCB) 36

Executive summary 36

Inspection findings – the Local Safeguarding Children Board 37

Information about this inspection 43

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of the local authority's arrangements for the protection of children was in October 2012. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in January 2010. The local authority was judged to be adequate.

Local leadership

- The interim director of children's services (DCS) has been in post since August 2016, following the retirement of the previous DCS, who had been in post since May 2005.
- The chair of the Local Safeguarding Children Board has been in post since August 2014. At the time of the inspection, an interim chair had been in post since August 2016, as the substantive chair was acting as the interim DCS.
- The local authority has commissioned out the leaving care service. The service has been managed by a national charity since 2014.

Children living in this area

- Approximately 75,000 children and young people under the age of 18 years live in Redbridge. This is 25.43% of the total population in the area.
- Approximately 23.4% of the local authority's children were living in poverty in 2010.
- 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 16.9% (the national average is 13.2%).
- Children and young people from minority ethnic groups account for 72.3% 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 Asian or Asian British and Black and Black British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 65.8% (the national average is 20.1%)
  - in secondary schools is 57.48% (the national average is 15.7%).

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

- Redbridge is the fourth most ethnically diverse local authority in the UK, with around a third of residents stating that they were born outside of the UK. Almost half of all children and young people in Redbridge are Asian or Asian British. It has the second fastest population growth in the country and the second largest average family size.

Child protection in this area

- At 31 August 2016, 2,343 children had been identified through assessment as being formally in need of a specialist children's service. This is a 7% reduction from 2,519 at 31 March 2015.
- At 31 August 2016, 342 children and young people were the subject of a child protection plan. This is a 27.6% increase from 268 at 31 March 2015.
- At 31 August 2016, 10 children lived in a privately arranged fostering placement. This is an increase of one from nine at 31 March 2015.
- Since the last inspection, three serious incident notifications have been submitted to Ofsted and no serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 31 August 2016, 235 children are being looked after by the local authority (a rate of 31.3 per 10,000 children). This is an increase from 215 (28 per 10,000 children) at 31 March 2016.
    - Of this number, 161 (or 69%) live outside the local authority area
    - 22 live in residential children's homes, of whom 82% live outside the authority area
    - three live in residential special schools,[3] of whom all live outside the authority area
    - 198 live with foster families, of whom 67% live outside the authority area
    - no children looked after live with their parents
    - 15 children are unaccompanied asylum-seeking children.
- In the past 12 months:
    - there have been 10 adoptions
    - 12 children became subject of special guardianship orders
    - 138 children ceased to be looked after, of whom 8 (5.8%) subsequently returned to be looked after

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

- no children and young people ceased to be looked after and moved on to independent living (although there were 14 in semi-independent transitional accommodation).

- No children and young people ceased to be looked after and are now living in houses in multiple occupation.

Recommendations

1. Strengthen the quality and impact of the role of the child protection chair/independent reviewing officer so that there is more effective monitoring and challenge on the progress of plans, ensuring that all plans that they review contain specific actions, achievable timescales and clear, measurable outcomes.

2. Ensure that cultural characteristics that affect the lived experience of children are fully explored in all assessments and plans, particularly the risks associated with honour-based violence. Ensure also that health professionals are directly involved in considering safeguarding risks at the earliest opportunity in all cases of female genital mutilation.

3. Prioritise the recruitment of independent visitors and increase the capacity of the advocacy service so that all children who would benefit from these services are able to do so. Ensure that children's voices are heard in child protection conferences if an advocate is not involved.

4. Ensure that there is no delay in the completion of assessments of temporarily approved family and friends/connected persons carers, and that progress of children in such placements is robustly tracked and scrutinised.

5. Ensure that life-story books of high quality are provided to children in a timely way.

6. Strengthen service and action plans to ensure that they drive and support the progress and planning of individual service areas.

7. Ensure that performance management information is captured, analysed, presented and used in a way which enables the local authority to achieve greater consistency in the quality and effectiveness of the support and services provided.

8. Ensure that data on missing children provides real-time information about 'missing' episodes and the offer and completion of return home interviews.

9. Ensure that the care leavers' service has an up-to-date overview of the educational progress and attainment of every care leaver, and that care leavers feel that their achievements are fully celebrated.

Summary for children and young people

- Children in Redbridge are kept safe and any risks to them are understood well and acted on quickly. Senior and frontline managers are highly committed and keep a close eye on what happens for all children who need help.
- There are many ways in which the local authority ensures that it listens to children and works in partnership with them to improve the experience for all children. Children in Redbridge have positively influenced services, and their views are valued and well respected.
- Good decisions are made for children and their families when first considering what they will need to support them, including giving careful thought to the individual needs of brothers and sisters. Social workers visit frequently and see children alone.
- Plenty of support is available to help children to stay within their own families, and children only come into the care of the local authority when it is absolutely necessary.
- If a child is in care, they are secure and settled where they live. They live with carers who are, or in a residential home that is, well matched to their needs. This includes placing and supporting children within their wider family. When in care, children are supported to do well in school.
- Some children have had too many changes of social worker or personal adviser, and this makes it harder for them to build up trusting relationships.
- The needs of individual children are well understood and their views are sought and listened to. Social workers know what to do to support children, although sometimes their written plans don't include their actions and the reasons for the action being taken. As a result, managers find it hard to keep track of what is being done.
- The local authority keeps in touch with nearly all care leavers and works hard to ensure that they are well supported, kept safe and are in work or education. Not all services for all care leavers are consistently good and a very small number of care leavers do not feel that their successes are celebrated or that they have a personal adviser whom they know well.
- A very small number of care leavers have not been happy with where they are living. Managers have taken this seriously and acted quickly to sort things out for them.

The experiences and progress of children who need help and protection	Good

Help and protection services overall are good, with a 'front door' service that is outstanding. Rigorous management oversight and decision making results in services that are of a high quality. This leads to good outcomes for nearly all children. Management imprint is evident across the whole service.

There is a broad range of high-quality early help services that are effective, being appropriately managed, well developed and well resourced. When families are referred to social workers for help, 'front door' services are especially robust. Partners fully understand thresholds and routinely provide social workers with referral forms, with the reason for referral clearly identified. The multi-agency safeguarding hub (MASH) is responsive and effective for every child, particularly in its work to secure the safety of unborn children. Referrals to duty social workers are dealt with appropriately and promptly.

Good partnership working, especially with the police, means that child protection enquiries are undertaken swiftly and effectively. Manageable workloads result in case recording on children's files that is generally up to date and completed to a high standard. Case summaries are particularly helpful. However, services could be further enhanced if the analysis sections of assessments become sharper and include more concise conclusions in relation to risk and protective factors in children's lives.

Risk to children of living within families with multiple needs such as domestic violence, substance misuse and parental mental ill health is generally well understood and risk-managed well in multi-agency forums such as the multi-agency risk assessment conferences (MARACs). Understanding of domestic abuse and the impact it has on children is a particular strength. Progress towards outcomes could be better understood if written child protection plans included achievable and realistic timescales. Better use could be made by child protection conference chairs of planning templates, to give core group members, particularly parents, a clearer understanding of who is going to do what, by when, and what difference it will make to children's lives.

Parents are routinely engaged in plans to improve their children's lives even when to do so is challenging. Children are supported effectively to participate in conferences by child protection advocates. Child protection chairs need to do more to ensure that children's voices are consistently heard.

Information on children's cultural, linguistic and religious heritage is well recorded and dealt with sensitively by social workers. This could be used more constructively within assessments and plans to understand and improve their lived experience. Specifically, the risk of honour-based violence could be better

recognised and responded to, and the response to female genital mutilation could be more consistent and involve health partners directly at the earliest stage.

Inspection findings

10. The generally high quality of help and protection services to children is characterised by secure management grip. Operational managers know their service well, and demonstrate a firm grasp of what is happening on a day-to-day basis regarding individual children's lives. A robust system of case transfer panels ensures senior management oversight of every case. Considered allocation of work helps moderate turnover in staffing while supporting the influx of newly qualified social workers, following investment in services.

11. Early help services are well developed, well resourced and well managed. The early intervention and family support service (EIFSS) provides a wide range of services, including targeted family support, parenting courses, a common assessment framework (CAF) team, and a small team undertaking return home interviews for children missing from home or care. EIFSS also benefits from embedded specialist workers from other services, such as the children with disabilities team, women's refuge and a mental health nurse from the child and adolescent mental health service (CAMHS). Approximately 1,200 children, young people and families are currently benefiting from the far-reaching support services that EIFSS provides.

12. The multi-agency early intervention panel (EIP) manages referrals for early help effectively. EIP helps to ensure children, young people and their families receive the right help at the right time by sharing information, agreeing packages of support and tracking agreed actions. Parents spoken to by inspectors were very positive about the help they received from early help services and the positive impact it had on their families' lives. One parent spoken to by inspectors said they were 'not easily pleased' but would give their family support worker 'five stars for service'. When, for cultural reasons, a parent felt unable to join a course, the worker went to the family home to deliver parenting training.

13. 'Families Together' works with families in profound need across the full range of interventions in families' lives, and it is reported by the local authority that it is making suitable progress towards its payment by results target by turning families around. The outcomes records used by the team have been noted as good practice by central government, which also recognised the strength of the programme in using its funding constructively to target important local issues, such as domestic abuse.

14. A well-staffed CAF team is led effectively by an enthusiastic manager who uses a range of performance information to monitor CAF activity, the quality of assessment and the impact of intervention through use of family outcomes scales. These identified that most CAF cases closed during 2015–16 showed some progress, with those identified with higher levels of need at the

commencement of CAF making greatest progress in all areas. Members of staff and partner agencies spoken to were positive about the support provided by the CAF team and the benefits to children, young people and families of being at the centre of assessments and able to access a wide range of support services.

15. A straightforward process for stepping cases up from early help to social care services works well and shows a shared understanding of threshold. The majority of CAFs are completed by staff in the early intervention team and children's centres and these are generally of a high quality. The latest figures available to inspectors showed that all CAFs were completed on time. There is further work to do with partner agencies in improving the quality of CAFs they complete, and for some agencies such as schools to increase the number of CAFs completed by them.

16. 'Front door' services are exceptionally strong. The multi-agency safeguarding hub (MASH) is an effective single point for all referrals for children, young people and families. Referrers receive good quality verbal advice and assistance, supported well by clear written guidance contained in the Local Safeguarding Children Board's (LSCB) threshold document and by routine use of the multi-agency referral form (MARF). Referrers customarily receive confirmation that their referral has been received, and feedback is routinely provided to them on what happened as a result. Practice and process for managing workflow in the MASH is effective. Sufficient and capable management capacity, combined with swift multi-agency input and good use of information systems, means that all children's cases are dealt with in a timely an appropriate manner. This is a very high level of performance.

17. The responsive MASH swiftly gathers together both historical and multi-agency information, prioritises it and passes it to the duty social work team in a timely manner. Duty social workers immediately address the presenting problem with the benefit of checks already in place. Effective training by the Local Safeguarding Children Board (LSCB) means that thresholds for intervention are well understood by partner agencies and referrals are frequently accompanied by MARFS that clearly identify issues. Arrangements for the out of hours service to hand over to daytime services are secure. Information received by the MASH on emergency responses that were required out of office hours is responded to swiftly and robustly.

18. Consent to a social work assessment of need is routinely obtained by MASH, ensuring that parental engagement is secured at the earliest possible stage. Children are seen and seen alone by duty social workers to gather their views at the earliest possible opportunity.

19. In all cases seen, this level of efficiency was a precursor to good quality social work assessment of children's needs. Assessments were generally timely and comprehensive, presenting a full picture of children's circumstances and

needs. Time taken for an assessment to be completed is appropriate and proportionate to the needs of each child. In the best, assessment, including risk assessment, was clear and precise and this aided swift and effective decision making. Some social workers effectively used research to support their findings, particularly research on domestic violence or the partnership's 'Prevent' duty. An understanding of relationships within large and complex families was assisted by the use of helpful genograms. These were particularly in evidence where legal proceedings were under consideration. The service would benefit from their wider use. The analysis section of assessments could in most cases seen be sharper, with a clearer expression of risk and protective factors, although no cases were seen where children were placed at risk by a lack of analytical succinctness.

20. Robust duty social work processes mean that child protection enquiries are undertaken quickly and effectively. Strategy discussions with the police child abuse investigation unit are swiftly and routinely undertaken by duty social workers to identify any immediate concerns for a child's safety. This is frequently followed up when necessary by a strategy meeting involving key professionals in a child's life, such as school teachers and health visitors. The outcome of these discussions and meetings is clearly recorded and forms the basis of suitably thorough child protection enquiries, which appropriately lead to child protection conferences where the threshold of significant harm, or the likelihood of such, is met.

21. Initial child protection conferences are timely and well attended by partner agencies. Parental engagement is strong and advocacy or translation services are consistently provided when appropriate. Social workers' reports to conference are clear and result in considered decision making on whether a child protection plan is necessary and under which category of abuse. The council's most recent figures show a reduction from 8% in 2014–15 to 5% this year in children made the subject of a child protection plan for a second or subsequent time. This level of performance is well above that of comparators.

22. Initial child protection plans are not effectively prioritised and can be hampered by timescales that are unachievable. The written plans do not accurately reflect the good work undertaken by social workers in child protection work. Core groups modify the child protection plan and reset timescales to more realistic targets at their first meeting. This means that parents who attend conferences and core groups see the key professionals in their lives disregarding child protection plans to which they as parents are held accountable. Core group minutes do not consistently offer a clear progress update against specific and measurable child protection plans. One parent interviewed by inspectors commented that 'the plan just wasn't realistic and ran the risk of being detrimental to my mental health, which they said was [a] risk factor'. (Recommendation)

23. Regular visits, core group meetings and review conferences take place as a routine part of delivering child protection plans. The council's most recent figures show that 97% of plans were reviewed regularly, this is improved performance locally and better than that of comparator authorities. All children had an allocated social worker who saw them regularly, saw them alone and undertook direct work with them.

24. Parents are frequently engaged well in meetings and reviews. Evidence was seen of advocacy or interpreter services being used to ensure the effectiveness of parental and child involvement. Better child protection plans were supported by detailed minutes from well attended core groups, demonstrating that a very high level of resources are available to support children. This is particularly the situation with domestic abuse cases, where planning is aided by the use of assessment tools that clearly identify expected outcomes. Better plans also identified children's cultural needs well and made good use of additional resources available in their community to support the plan. Notwithstanding some deficits in written planning, keyworkers, core groups and review conferences were generally vigilant in ensuring that children's need for safety are met.

25. Case recording is generally comprehensive. Manageable caseloads of an average of 14 in the assessment teams and 22 in the community teams mean that social workers are able to record their casework thoroughly, with few exceptions. Children's comments are recorded when they see their social workers but, outside of formal advocacy services available at child protection conferences, the child's voice does not demonstrably influence planning. (Recommendation)

26. The majority of children in need (CiN) plans seen appropriately comprised an ongoing set of practical measures to help the family, in which social workers co-ordinated the provision of a wide range of support services. CIN plans are particularly detailed when the case has been stepped down from a child protection plan or when the plan's primary purpose is to prevent a deterioration in improving home circumstances.

27. Arrangements for the protection of homeless 16- and 17-year-olds are robust. All young people presenting as homeless are offered an assessment of need and the opportunity of reconciliation with their family. Where accommodation under Section 20 of the Children Act proves necessary, placements are made with short-term foster carers with an emphasis on retaining stability in the young peoples' lives, such as their college placements. The local authority has good networks with other London authorities to enable considered decision making on where gang-affiliated young people can be safely placed. A very small number progress through the housing department's allocation processes to tenancies, but this is limited by the availability of suitable accommodation in the local area. Following mediation, most young people are eventually re-unified with their family.

28. Child protection services for unborn children are strong, and this is particularly the case when the service is provided by the ante-natal specialist practitioner embedded in the MASH. When multiple risks are known or identified that are likely to cause harm to an unborn child, which customarily means parental substance misuse, mental health issues or the presence of domestic abuse in the home, robust arrangements are in place to monitor the pregnancy and ensure the safety of the child. Examples were seen by inspectors of excellent casework, with a clear focus on the needs of the child and robust child protection measures in place as part of the birth plan, including removal at birth where necessary. The standard of all pre-birth planning was undertaken well but not at the same high quality of the antenatal specialist practitioner service.

29. Well established multi-agency risk assessment conferences (MARACs) are consistently well attended by the police, children's services and the independent gender violence advocate/ independent domestic violence advocate service. Risks to children living in homes where domestic abuse is a feature are therefore well recognised and responded to. Children's services' attendees provide reliable and effective representation at MARAC, and act as a direct line of communication to the social work teams. They are therefore able to share up-to-date information and this aids sound risk management. MARAC is central to the partnership's approach to managing families who have multiple needs, and would benefit from more regular attendance by adult mental health service partners.

30. When children go missing from home, the dedicated missing children's team is diligent and persistent in ensuring that every child or young person is offered a return home interview. Records of these interviews are full and detailed. The local authority and its partners demonstrate a high level of awareness and understanding of child sexual exploitation, as evidenced in contacts, referrals, return home interviews and assessments. Robust strategic and operational governance arrangements ensure that, when risks are identified, cases are escalated appropriately including to the child sexual exploitation panel or the multi-agency sexual exploitation meeting, where information is shared well. Inspectors saw good and effective use made of strategy meetings, which were well attended and resulted in appropriate decision making, including the mobilisation both of support services to the young person and disruptive action where necessary. Children and young people who are considered to be at greatest risk are appropriately made the subject of monthly child sexual exploitation strategy meetings.

31. The partnership's approach to children missing education is robust and thorough. The authority has recently revised its protocol with schools, providing training and briefings to support its implementation. This ensures that schools are proactively providing information about families moving in and out of the borough. As a result, the central register now provides an

accurate picture of children known to the local authority who are not attending school, either having recently arrived or left the borough. At the time of the inspection, the local authority had 160 open cases of children missing education. Of those, 18 involved children coming into the borough and 142 of children leaving with some of those leaving the borough believed to have moved abroad. Wherever possible, the local authority pursues its enquiries to any overseas addresses or contacts it has been given and this is good practice.

32. Multi-agency public protection arrangements (MAPPA) meetings are well attended by partner agencies. Scrutiny of MAPPA minutes demonstrates that partner agencies share all relevant information to ensure that where adults being released from prison pose a known risk to children, effective safeguarding arrangements are put in place. Risk management plans and the actions associated with high risk individuals are appropriately tracked by the meeting chair. The children's services' representative consistently attends meetings and provides links to social work teams. This allows social workers to undertake any necessary risk assessment on cases when an offender has links to children, prior to the individual being released from custody.

33. In cases seen where children were at risk of female genital mutilation, the partnership's immediate response is prompt and proportionate to risk. However, risk assessments are not routinely informed by research into specific religious or cultural practices that may be influencing parental behaviour, and this is a missed opportunity. Female genital mutilation referrals are low although some awareness raising has taken place. A clear pathway around female genital mutilation is in place and all social workers benefit from a clear understanding of the pathway. Health visitors play an active role in female genital mutilation work in terms of parental education and monitoring and provide information to consider risk. However, health professionals do not routinely directly take part in initial strategy discussions when female genital mutilation is suspected, although they do provide written information. (Recommendation)

34. In the well-resourced children with a disability service, social work caseloads average 15 and this enables effective work with children and families. CiN care packages are reviewed regularly and the service benefits from consistent management oversight and supervision. Social work practice is sensitive to the needs of children with disabilities, with good awareness demonstrated of child protection issues when they affect this service user group. The service has strong working relationships with partner agencies, such as health and education services and with other social work teams, and this means that the safety of children who have disabilities is assured.

35. Children living under private fostering arrangements (PFA) are offered a far-reaching service, including allocation to social workers within the long-term social work teams. Their carers are offered the services of a support worker

embedded in the fostering team. Children are visited and their circumstances reviewed regularly. Most arrangements are settled and longstanding. Notwithstanding the high level of service provided, only a small number of children are identified as living under PFA given the demographics of the local area. Improving the reach of this service was a recommendation of the last inspection of child protection services. Information and awareness raising activities have taken place, although this has not yet had a significant impact and needs to continue.

36. A suitable service is provided by the designated officer when allegations of abuse are made against professionals or carers. Observation of designated officer strategy meetings by inspectors demonstrated that all relevant information is shared and appropriate plans for investigation are made by partners. The current temporary arrangements precede the appointment of a designated officer who is not a qualified social worker and this is contrary to guidance within 'Working Together to Safeguard Children 2015'. The local authority has been able to provide a robust reasoning for the decision making in the recent designated officer appointment.

37. Detailed information gathering in the MASH ensures that children's ethnicity and heritage is nearly always entered onto the recording system at an early stage. The council's own performance reports indicate very high levels of completion. For instance, the child's ethnicity is known in almost all CiN plans. Inspectors saw good practice examples of social workers making constructive use of information about children's unique identity for the purposes of assessment and planning. Social workers' handling of diversity issues is sympathetic and sensitive, and work to secure children's immigration status is particularly strong. However, written assessments and plans reviewed during the inspection did not invariably make full use of diversity information, by drawing it together and expressing its impact on children's lives precisely and clearly. A small number of cases were seen when this shortfall had resulted in a failure to accurately identify and plan for the risk of honour-based violence. Audits by senior managers of cases chosen by inspectors for tracking identified that the consideration of a child's diversity was a shortfall in a number of instances. This represents a missed opportunity to understand the possible impact on risk and protective factors of children's complex cultural heritages and the highly diverse area in which they live. (Recommendation)

The experiences and progress of children looked after and achieving permanence	Good

The majority of Redbridge's children looked after are settled where they are living and are progressing well, assisted by good support from a range of services, including children's social care, health professionals and the virtual school. The vast majority of children looked after are reaching the expected levels of progress in their education and, in some cases, exceeding those expectations.

Decisions that children should become looked after are evidence-based, appropriate and implemented promptly. Effective practice prior to and during care proceedings reduces the risk of delay for children. Plans for children to return home are based on good assessment of need and appropriate support is put in place to help children remain safe and make good progress.

A relatively high proportion of children looked after are in foster care, despite the ongoing challenges that the local authority face in recruiting sufficient locally based foster carers. Good arrangements are in place to ensure that children, including the small number who live at a considerable distance from Redbridge, are not disadvantaged by living outside of the borough.

Social workers' visits to children are purposeful and well-recorded. The support children receive is sensitive to their diverse and individual needs. Children's contact with family and friends is actively promoted and they are supported well to understand their life experiences. Risks to children are clearly identified and managed effectively and there is a robust approach to children who go missing from care. However, the quality of written care plans does not always match the standard of support actually provided and the level of challenge by independent reviewing officers (IROs) to any drift and delay should be stronger.

The reducing number of complaints from children looked after are handled well, aided by strong independent advocacy support. Not all children who would benefit from seeing an independent visitor are able to do so and there is a small waiting list.

Adoption services are strong overall, with adoption being considered for a wide range of children at an early stage. More consistently robust management oversight is required to ensure that all cases are awarded the same degree of urgency. Family finding and matching processes for children who require adoption are persistent and thorough. Assessments of prospective adopters are comprehensive and parents and children are well-prepared for adoption.

There are areas of strong practice in services for care leavers but they are not yet good. Not all their education and training outcomes are tracked effectively and their successes are not fully celebrated. Not all young people have been able to

maintain or develop trusting relationships with their personal advisers. Care leavers understand their rights and entitlements well and are receiving good support with their physical health needs and their emotional well-being. Managers within the service responded promptly to issues raised by care leavers and they have been active and influential through the children in care council for older children, 'Don't Whisper,' in working in partnership with the local authority to make improvements.

Inspection findings

38. The number of children looked after by Redbridge has remained relatively stable in recent years, although an increasing number of older children and unaccompanied asylum-seeking children requiring care has contributed to a slight rise in the last 12 months. The thresholds for care are appropriate and consistently applied, with appropriate management oversight and direction. Children do not come into care unnecessarily and decisive action is taken when children need to become looked after.

39. The Public Law Outline is used effectively. Letters before care proceedings set out clearly to parents what action is required by them to protect and care for their children and the likely course of action if the necessary changes do not occur. In nearly all cases seen by inspectors, legal planning meetings and reviews led to prompt and appropriate action on behalf of children. In a very small number of cases when there was delay in taking the required actions, the local authority took swift and urgent measures to safeguard children when it was brought to their attention by inspectors.

40. The quality of court assessments and evidence are of consistently good quality. There is only limited use of independent social worker assessments. Family group conferences are used routinely and regularly to ensure that all suitable options for children are explored. In most cases, target timescales are met and it is appropriate for some to have taken longer. Recent data shows an average completion time for care proceedings that is reducing and close to the national average figure despite an increase in the number of care applications made by local authority in the last 12 months.

41. When there are plans for children to return home from a period of care, there are specific and proportionate measures in place to ensure that it is safe for children to return. Plans are suitably specific, with explicit contingencies and appropriate statutory safeguards in place when required. Assessments of special guardians are of generally good quality and the support packages that are in place after the order has been granted are appropriate to children's needs.

42. The number of complaints from children has decreased steadily in recent years and the vast majority of complaints are resolved informally. There is effective support from the valued, but stretched, advocacy service, including

help for children living outside Redbridge. The consistently robust responses from senior managers to children's concerns and complaints regularly lead to positive and appropriate outcomes for children. The local authority's analysis of complaints contributes to an increased understanding of service effectiveness and to plans for improvement.

43. Only a very few children see an independent visitor regularly. Too many children who would welcome and benefit from a match with an independent visitor wait too long for this service, with four children currently waiting. (Recommendation)

44. In the majority of cases seen, risks to children were clearly identified and managed effectively. Risk assessments and management plans are suitably specific and updated regularly. The detail is understood and implemented as necessary by all key parties, including a range of agencies as appropriate, carers, young people themselves, their carers, and family members. In a small number of cases seen, information was not shared sufficiently with carers and the agreed actions to reduce identified risks were not sufficiently clear and lacked the necessary urgency.

45. Practice to protect children who go missing from care is strong and embedded. Most children who go missing take up the routine offer of an independent return interview. These interviews are well recorded and lead to purposeful follow-up action. Joint work with the police to address issues relating to young people going missing from residential care and specific training for foster carers are further examples of a robust response to children going missing from care. The impact of this joint work has been particularly strong, with a significant reduction (46%) in the number of incidents of the young people involved going missing, which, in turn, has reduced the likelihood of their exposure to associated risks.

46. The local authority has not met its own target to increase the number of local in-house foster carers and has not approved a new foster carer since September 2015. However, the local authority helpfully commissions independent foster agency placements, ensuring that they are able to meet Redbridge children's overall and diverse placement needs. The local authority reports that 82% of children who are looked after were in foster care at the time of the inspection (above the national percentage of 74% for 2015–16). Overall placement stability is in line with the national average and similar local authorities. The vast majority of Redbridge's children looked after are settled where they are living and progressing well.

47. Visits by social workers to children have a clear purpose and direction. However, due to high staff turnover, not all children have been able to develop lasting relationships with their social workers, although this has improved in recent months. Children are actively encouraged to see and keep in touch with their families and friends, including those who live far from their

home area. When it is in their best interests, they are able to live with their brothers and sisters. When children have been living and settled with their foster carers for some time, their views about the continuing frequency of social work visits and statutory reviews are sought and, in some cases, these have been appropriately reduced so that children can experience family life without unnecessary involvement of professionals. They are actively encouraged to develop and pursue their own hobbies and interests.

48. The majority of children looked after who live outside the local authority area are living in neighbouring local authorities and are relatively close to their home areas. The few children who do live at a distance from Redbridge are appropriately placed. They are visited regularly by the social workers, and contact with family and friends is well supported. In all but a small number of cases seen by inspectors, communication with host authorities and care providers was effective.

49. Case recording is of consistently high quality. Chronologies and regularly updated and case summaries set out clearly the key events and issues in children's lives. The voice of children, including those who have language barriers, is conveyed strongly. There is clear and regular evidence of management oversight and direction. Children's ethnicity, religion and culture are consistently recorded in case records and, in most cases, this knowledge is used well to inform assessments and plans. Inspectors saw several examples of good direct work with children and families to help to promote children's understanding of their life histories. The support was sensitively timed and tailored to take account of children's wishes and individual needs.

50. Long-term fostering is considered appropriately as a permanent option for older teenagers as well as for younger children. When it is not possible to find a direct ethnic match for children, effective action is taken to meet their diverse needs in the agreed placement. A small number of matching reports for panel seen lacked full clarity about how carers will meet the individual and specific needs of children but, generally, the reports are of good quality; in particular, they coherently represent and take into account children's wishes and feelings.

51. Effective and tenacious support from co-located health professionals, including the children looked after nurse and the child and adolescent mental health services (CAMHS) psychotherapist for children looked after, are part of an embedded multi-agency approach to supporting children looked after. Children's physical health needs are given careful early consideration when they enter care and are addressed routinely in case planning. The local authority acknowledges, however, that the overall timeliness of initial health assessments can be improved, and tracks compliance and quality closely, within current capacity constraints. The percentage of children who have had an annual health assessment in 2014–15 was broadly in line with the national average at 89%.

52. Some children experience difficulties in gaining access to support for their emotional well-being and mental health. In particular, there is often a long wait for children following assessment to receive treatment from wider CAMHS. However, carers, professionals and families valued highly the support that children had received from the CAMHS psychotherapist for children looked after, who provides a range of services, including consultation, training and direct work with children. This flexible support helps to build the capacity of professionals and carers to understand and respond sensitively to children's emotional needs. This is assisted further by the local authority's long-standing and productive use of strength and difficulties questionnaires to inform assessments and plans for children.

53. The virtual head is providing effective leadership for the 133 pupils on roll at the virtual school and tracks progress closely. A small virtual school team includes four high-level teaching assistants (HLTAs) who see every looked after child individually on a regular basis. There is good continuity of support and the virtual school staff come to know the children very well.

54. Governance arrangements for the virtual school are in place and currently meet requirements, but they would benefit from being strengthened. The virtual head has identified this need and plans to strengthen the current twice-yearly reporting to the corporate parenting board by developing a wider governing body to provide more effective support and challenge.

55. Over 90% of pupils benefit from attending schools judged as good or better through inspection, and the very small number of pupils currently placed in schools that require improvement are remaining in these schools to ensure stability. While most children attend schools outside the borough (49%), the vast majority are attending schools within a 20-mile radius. Attendance is carefully monitored and current average attendance rates, at 93%, are just below the national average and in line with London figures.

56. The vast majority of children looked after are making expected levels of progress and, in some cases, are exceeding expectations. Attainment levels and progress for children looked after are generally above the national averages for children looked after. At the end of the summer term in 2016, schools reported that 68% of the cohort was making expected, or better than expected, progress, representing an increase of 12% from December 2015. This positive progress trend is further reflected in key stages 1 and 4, where the improvement is better than the national trend.

57. When children are not making expected levels of progress, the HLTAs identify and agree support strategies with the school, foster parents and carers to help children to get back on track.

58. The vast majority of the personal education plans (PEPs) evaluated by inspectors were good. All were timely. The best PEPs were characterised by well-defined targets, clear timescales and effective analysis of children's individual progress. The use of the pupil premium is thoughtful and effective. Schools work well with social workers and carers to counter bullying and tackle discrimination.

59. Particularly good work is done to support pupils at key stage 5. The virtual school is currently supporting 76 young people between the ages of 16 and 18 by working individually with pupils, helping foster carers to provide support to young people attending sixth form college and other further education provision, providing one-to-one support and offering bespoke independent advice and guidance to help young people to make appropriate choices for their next steps. Only six young people within this cohort are not in education, training or employment.

60. No child looked after has been permanently excluded for the past six years, but there were fixed-term exclusions for 11% of children in 2015/16 and these disproportionately involved children living outside the borough. Interventions to schools from the virtual head are beginning to have an impact and, overall, the number of fixed-term exclusions of children looked after are now reducing.

61. Good arrangements are in place to support children who are known to be electively home educated. The authority is vigilant in registering those families who are educating their children at home so that they can offer to visit families and provide appropriate support.

62. Only five children looked after are currently accessing alternative provision. The type of provision varies from special needs provision and the Redbridge pupil referral unit to secure provision out of the borough. The authority contracts a small number of alternative education providers. A recent contract has been awarded to a local academy that will provide 40 Year 11 places. The Redbridge inclusion panel sits regularly, and whenever possible young people are reintegrated into mainstream provision or found alternative local provision if necessary.

63. Foster carers receive good support from their supervising social workers, who visit them regularly and know them well, offering appropriate challenge when required. Annual reviews are held in a timely manner. Foster carers are happy with the overall level and quality of support that they receive, including help outside office hours. Recently approved carers describe the assessment and approval process as intensive but realistic, providing the knowledge and preparation required to provide good care for children looked after. Training for foster carers is varied and accessible and is available to all foster carers, including family and friends carers and, when appropriate, carers from

independent fostering agencies. The range of training meets individual needs well.

64. Most foster carers spoken to by inspectors said they are well prepared and information is shared quickly and effectively when children come to live with them. There is a lack of clarity, however, for some children about their carers' level of delegated authority, although this is routinely discussed at placement planning meetings and later reviews.

65. More than a third of current assessments of temporarily approved family and friends (connected persons) carers have not been completed within the statutory timescales. While persistent and serious delays in Disclosure and Barring Service checks are beyond the control of the local authority, some delays are avoidable, and the progress of the assessment is not always subject to the required scrutiny of the fostering and adoption panel. (Recommendation)

66. In most cases seen, plans for permanence were formulated and pursued rigorously. However, several aspects of planning could be improved to avoid pockets of delay. Permanence tracking panels, while usually effective in tracking and driving progress, at times limit themselves to straightforward description of activity when, instead, they need to be more directive or challenging. (Recommendation)

67. The high quality of practice articulated by professionals involved in supporting children is not always reflected in all written plans. Written plans, including plans for permanence, are too inconsistent, and some care plans are not sufficiently specific and lack detail. In a small number of cases seen, timescales for planned actions were unrealistic. (Recommendation)

68. The statutory reviews chaired by independent reviewing officers (IROs) do not consistently provide a sufficiently strong vehicle for driving forward plans for children's futures. Reviews are generally timely, well attended and ensure that children's views are heard, but the records of discussions during reviews are not always clear and, too often, reviews lead to vague recommendations. Weaker practice, including when there is delay in progressing children's plans, is not robustly challenged. IROs need to be more specific and decisive when monitoring and reviewing children's progress so that plans for children are clearer and any delays can be challenged more strongly, when necessary. Alert processes for IROs to raise concerns about practice or delay are not routinely used. (Recommendation)

69. The Children in Care Council comprises two groups of children and young people, split by age, that represent the views of children looked after and care leavers in Redbridge. These small but vibrant groups work closely with senior managers to influence positive change for their peers, including the development of a pledge for children looked after, a health passport for care

leavers and more equitable guidelines on pocket money. Newsletters are impressively engaging and professional.

The graded judgement for adoption performance is that it is good

70. Adoption in Redbridge is appropriately considered for all children who are thought to be unable to return to their birth parents. The local authority has recognised the importance of ensuring that consideration of adoption happens at the earliest possible opportunity and ensures that it does so in a timely way for the majority of children. The local authority has provided training to ensure that social workers keep this option in mind during early planning. The adoption team manager now attends legal planning meetings. These measures are leading to a gradual increase in very young children being placed with foster carers with a view to adopt, or being placed in concurrent placements.

71. Managers understand the adoption data well and know where they need to target their improvements. Adoption practice is understood in the context of overall safeguarding and managers are targeting training at frontline workers to encourage them to think more consistently about adoption for children who can no longer live with their birth families. Recent placements of babies with foster carers who hope to become adopters show thorough early consideration of the needs of the child.

72. Timescales for adoption in Redbridge are largely in line with the national average and statistical neighbours. The most recently published adoption scorecard shows that the average number of days between a child becoming looked after and moving in with their adoptive parents was 551. This is slightly better than the England average of 593, and 64 days slower than the Department for Education (DfE) target of 487 days. Similarly, the average number of days between the placement order and a match with prospective adopters was 144. This is considerably better than the England average of 223, and only 23 days longer than the DfE target of 121 days. Recent in-year figures in Redbridge show a dip in performance on both measures. However, the data is affected by the complex circumstances of a small number of children, and the reasons for these are well understood by the authority.

73. Fewer children are leaving care through adoption in Redbridge than in other areas, and managers have a clear understanding of the reasons underlying this. Numbers of children in care who are under 10 years old in Redbridge are low, with a higher percentage of teenagers and unaccompanied asylum-seeking children becoming looked after. Over 33% of children looked after are over 16 years old and therefore the adoption figures are appropriate, within the context of the looked after group of children overall.

74. Decisions that children should be placed for adoption are sound, based on clear reports which demonstrate the impact of parental behaviour on children. The agency decision maker records her rationale for decisions, which means that there is clarity throughout the process. Very few decisions are overturned, which indicates the robustness of the decision-making process and reflects the considerable efforts made to achieve adoption for children. The reversal of decisions to adopt is mostly due to the appropriate consideration of the suitability of viable family members who became known late in the planning and were able to offer appropriate care for children within the wider family.

75. Children looked after reviews and permanency tracking panels are held regularly and offer clear management oversight, and this is effective for the majority of children. However, they need to be more challenging when cases are not progressing as quickly as they could be. In a minority of cases, there have been delays in permanency planning or panel attendance, and managers and IROs need to ensure that there is a sense of urgency within the planning process for all children, to avoid drift or delay. (Recommendation)

76. The partnership arrangement with a voluntary adoption agency (VAA) means that the borough has access to all of the VAA's adopters across the country. Assessments of prospective adopters undertaken by the VAA are thorough and analytical, with a clear exploration of applicants' history and experience, and their ability to meet the needs of children. Applicants are encouraged to think about the needs and experiences of children in care and how, or if, they can manage certain behaviours. This partnership has led to an improvement in the quality of prospective adopter reports (PARs), and the most recent PARs seen were of a high standard. There is an inclusive approach to potential adopters and single adopters, as well as same-sex couples, who described feeling welcomed when they expressed an interest in adopting.

77. Family finding is thorough, detailed and sensitive to the needs of the child. Social workers make use of online national family finding resources, as well as adoption activity days and profile days, to find the right families. The ethnicity of children is considered sensitively when looking for families, but is not a barrier to prospective adopters, who have the skills to meet the needs of children. The local authority demonstrates tenacity and determination to find the right family for children, even when this may take some time. Inspectors were impressed by the 'never give up' attitude and commitment to finding the right family for children, including brother and sister groups and other harder-to-place children. When brother and sister groups are taken into care, a 'together or apart' assessment is undertaken, usually by an independent social worker, which adds objectivity to the process. Assessments seen were of a good quality and showed clear consideration of the needs of children, as well as consideration of their wishes and feelings.

78. Matching is thorough, with a clear focus on how adopters can meet the needs of the child. The recently introduced matching grid clearly sets out how prospective adopters will meet the individual needs of children. Due to the improved early consideration of adoption, the local authority has, in two cases, been able to identify potential adopters for children prior to the placement order being made. This means that children are moved quickly into their adoptive placements, causing less disruption and promoting early attachment.

79. Adopters spoken to were positive about their experiences with the local authority and described good, supportive relationships with their social workers. They appreciated the support that their social workers had offered them, describing them as 'amazing' and 'fantastic'. The assessment process was seen as a challenging but necessary part of the process, which enabled them to think about the family that they wanted. All adopters felt that they were given a realistic understanding of the kind of trauma that children looked after may have experienced and the potential impact of this on children throughout their childhood. Changes in social worker had caused delays in some assessments, although the majority are completed in a timely way.

80. Child permanence records paint a clear picture of the child, detailing family history and giving prospective adopters a good understanding of the issues that their child may face. The medical adviser meets parents to talk through any identified health issues so that parents are able to make decisions with a full understanding of health implications.

81. The adoption panel is chaired by a suitably experienced and independent chair. Panel minutes demonstrate a thorough consideration of prospective adopters' ability to meet the needs of children. Probing questions are asked to understand adopters' suitability. The panel quality assures the information presented to them and an annual report draws out themes. The agency decision maker scrutinises recommendations from the panel and will seek further information if necessary to ensure that decision making is robust.

82. Introductions are well planned and children are well prepared for moving in with their adoptive parents. In some cases, books or DVDs were given to children to help them to familiarise themselves with their new parents. Foster carers assist with the introductions, so that children who are adopted are able to develop secure attachments to their new parents.

83. Adoption disruptions or breakdowns are very rare. When they do occur, an independent review is undertaken to ensure that learning is understood. An example of this has led to more referrals for therapeutic support via the adoption support fund (ASF) to ensure that parents and children are appropriately supported in preparing for, and following, an adoptive placement.

84. Adoption support plans are drawn up prior to a match being agreed. A variety of training opportunities and support groups are offered that enable parents to develop networks, as well as to access support. Families are able to request a post-adoption support assessment and 22 requests for therapeutic support have been made using the ASF, including for families with older children who have approached the authority for support. The local authority needs to make sure that requests are always responded to promptly in order to offer support when it is first needed.

85. Life-story books are, in the vast majority of cases, written in simple language suitable for a small child. However, they are not always provided to families within the local authority timescale of 10 days post-adoption order. In some cases, there have been considerable delays in passing on life-story books, which may have a negative impact on children's ability to understand their lives. (Recommendation)

86. The later-life letters considered by inspectors were of a good quality and written in a friendly tone, inviting young people to access their files when they reach 18 years of age to help their understanding of their early lives. They contained sufficient detail for older children, with an exploration of how the child came to be living with adoptive parents. This will make children's journeys through to adoption easier to understand as they grow older.

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

87. Services for care leavers in Redbridge demonstrate a number of areas of strong practice and a generally improving service, including some very recent additional staffing capacity. However, not all areas are sufficiently or consistently strong and, overall, the service requires improvement.

88. Staff are in touch with the vast majority of the 173 care leavers (98%) in Redbridge. Young people are actively encouraged to remain in care until the age of 18, and the vast majority do so. The five young people who are currently out of touch are awaiting outcomes regarding their asylum-seeker status. While the service continues to make enquiries about these care leavers to last-known addresses, previous contacts and the Home Office, staff believe that these young people are consciously evading any contact while they await the outcome of their asylum applications.

89. Care leavers are positive about the support that they receive from their key workers, particularly those attached to their accommodation providers, and have built trusting, and in many cases long-standing, relationships that have supported them well in gaining increasing independence.

90. The relationship offered to care leavers by their personal advisers (PAs) is more variable. This service is offered through a commissioned partnership, managed and overseen by the local authority. Care leavers spoken to by inspectors reported recent concerns, including lack of communication regarding the changeover of allocated PAs, delays in responding to them and extended periods when PAs were out of contact. Therefore, although the service is in touch with the majority of care leavers, the frequency of contact and quality of support received by care leavers have been inconsistent.

91. A very small number of care leavers felt that the quality of service had declined. As from August 2016, the leaving care team has a full complement of staff, including two new managers, and there are early signs of improvement. All staff are committed and passionate about their work, with care leavers showing a determination to improve the service that they provide.

92. Pathway plans are generally useful and are completed for all care leavers. Mostly, they reflect plans linked to appropriate timeframes, and young people find their engagement in the process of completing the plan helpful. For a very small minority, this was not the case. For some care leavers, including the 39% who are not in education, employment or training and the five care leavers who are currently in custody, outcomes are poor. Some of these young people became known to the local authority at a very late stage and the time available to effect change is limited.

93. Key workers are particularly successful in supporting the majority of care leavers with their health needs, encouraging them to register with local GPs and dentists and complete their health history document. As a result, care leavers have good access to extended health services, including support for their sexual and mental health. Care leavers demonstrate a good understanding about the dangers posed by excessive alcohol and drug use. For the very small number of care leavers who have disabilities, thorough and well-managed transition arrangements ensure that they continue to be effectively supported into adult services.

94. For those young people who are at risk of not achieving their educational potential, the service has recently developed a pre-apprenticeship programme to support young people who need to retake their English and mathematics examinations, offering them a level 1 programme. Although no young people have achieved their functional skills qualification in either English or mathematics, the programme helps them realistically to consider their employment and training options, including progress towards traineeships, apprenticeships and/or employment.

95. A generous package of support, including financial assistance, is available for all care leavers to attend higher education, which, in addition to their fees and living allowance, includes travel allowance, contribution to internet charges,

book allowance and payment of the television licence fee. Care leavers are also supported during holidays. This well-considered package of support is enabling 29 young people to attend university or access higher education programmes.

96. Fifty-five young people have accessed, or are currently accessing, further education courses over the past three years, which is a strong performance. However, it is unclear what progress these young people are making or how many of them have successfully completed their programmes. This is because the service does not have a sufficient strategic overview or accurate, up-to-date data on the progress, including the educational outcomes of its current cohort of care leavers. This means that managers are not able to identify trends or gaps in provision in order to improve the service for young people. (Recommendation)

97. The range of accommodation offered to care leavers generally meets their needs. Long-standing contracts with accommodation and care providers are successfully supporting and providing accommodation for significant numbers of care leavers. In addition, 24 are benefiting from 'staying put' arrangements and are continuing to live with their foster families. Providers offer a suitable range of accommodation from transition units with 24 hour staffing, to shared accommodation with other care leavers, to individual standalone accommodation. Care leavers are given priority for council housing and a small number have successfully secured their own tenancies.

98. A very small number of care leavers have raised concerns about their accommodation. These concerns relate either to the physical condition of the property or feeling safe. The local authority has worked consistently hard to address concerns from care leavers about their accommodation, as evidenced through the 'You Said, We did' document and through taking swift action required during the inspection. This level of oversight needs to continue to ensure that every care leaver feels safe and is living in suitable accommodation.

99. While care leavers are justifiably proud of their achievements, including becoming successful parents, achieving academically or securing employment, a small number of care leavers report that they have not felt that their achievements are widely celebrated. Care leavers reported that they appreciated the positive feedback and encouragement from their key workers. (Recommendation)

100. A small number of care leavers regularly make contributions through the 'Don't Whisper' group to ensure that the views and experiences of care leavers are influential. Contributions are made to the Redbridge children and young people's plan and also by speaking to potential foster carers about their experiences of being in care. Care leavers participated in the 'You Said, We Did' process, resulting in, for example, smart clothes being provided for

interviews. A high number of care leavers (45) participated in peer research through the Children in Care Council in April 2016, giving feedback on the service that they receive.

Leadership, management and governance	Good

Children, young people and families continue to benefit from good-quality services. Governance arrangements are well developed and effective. Engagement by elected members is strong. The level of investment, particularly in early help and in social work staffing establishment, is indicative of the high level of commitment to children and families.

Senior managers and leaders share a good understanding of the diverse, and changing, needs of the local community. Senior leaders are well briefed and provide effective challenge and scrutiny. Senior managers know their services well. They understand what is happening at the frontline and are in touch with the experience and progress of the children, young people and families who use their services. The local authority is a good corporate parent.

The move to a people's directorate, with a single director of people who has overall responsibility for children and adult services, has been carefully considered. Partnerships, at both a strategic and operational level, are well developed. The Health and Wellbeing and community safety partnership boards work well together with the Local Safeguarding Children Board (LSCB). The chief executive is effective in holding the director of children's services and the chair of the LSCB to account.

The local authority and its partners are in the process of developing a more fluid response to the strategic assessment of needs, modernising their commissioning and contract monitoring arrangements, and increasing the influence of children, young people and families in the design, development and delivery of services. The local authority should ensure a careful monitoring of the improving service for care leavers.

The response is robust to children who are missing from home, care or education, who have been, or are at risk of becoming, victims of child sexual exploitation or who are in danger of being radicalised. Information is shared effectively, leading, in most cases, to ensuring appropriate safeguarding and protective action.

Middle and senior managers make good use of performance management information to manage their day-to-day business. However, the local authority's performance scorecard is not yet fully balanced. Written service and action plans do not fully support the monitoring and evaluation of the positive work undertaken. While frontline managers provide effective oversight, the quality of critical challenge provided by independent reviewing officers and child protection chairs is not consistently robust.

Social workers, including newly qualified social workers, talk positively about the progress that the local authority has made in strengthening its approach to the recruitment and retention of staff. Actions taken to improve staff recruitment are starting to have a positive impact.

Inspection findings

101. Senior leaders and managers are proactive and make themselves visible and available to frontline staff. They have a good understanding of the diverse needs of the local community and are responsive to changing circumstances. Governance arrangements are robust. A combination of face-to-face meetings and regular briefings ensures that senior leaders are aware of the challenges faced by frontline services, including individual cases of concern. This means that they are able to provide effective scrutiny and an appropriate level of critical challenge. Senior managers provide effective oversight and control.

102. The level of engagement by elected members is strong. The corporate parenting advisory panel (CPAP), which is chaired by the deputy leader, includes the cabinet leads for housing, skills and development as well as planning and regeneration. Corporate parenting is taken seriously, as evidenced by the high level of investment in frontline services and the extra investment that was used to pay for additional social work posts in order to ensure that caseloads are realistic and manageable.

103. The period of transition between the departure of the previous, long-serving director of children's services (DCS) and the arrival of the new director of people, with overall responsibility for children and adult services, has been managed sensitively and well. This has helped to keep disruption to a minimum. The potential risks associated with the new arrangements have been carefully considered.

104. The Local Safeguarding Children Board (LSCB), the Health and Wellbeing Board and the community safety partnership work well together in the interests of children and families by promoting effective partnerships and ensuring that appropriate action is taken in relation to key strategic objectives, including, for example, countering radicalisation and child sexual exploitation.

105. Public health colleagues are in the process of developing a more nimble approach to the joint strategic needs. The prevalence of neglect and domestic abuse is well recognised. A proactive approach to the challenges faced by children and young people living in families with multiple needs, when parental mental health, substance misuse and domestic violence are present, has led the local authority and its partners to commission an appropriate range of services. Early help services are of a consistently high standard.

106. When children go missing from home or care, the dedicated missing children's team is diligent and persistent in ensuring that every child or young person is offered a return home interview. Return home interviews are well structured, consistently generating a wealth of information which is shared with social workers, uploaded to electronic case records and used to inform subsequent

action. While the 'missing' panel, which is still relatively new, is not yet fully embedded, clear plans are in place to strengthen it.

107. The local authority and its partners have developed robust strategic and operational 'Prevent' arrangements which ensure an effective, and continually evolving, professional response to radicalisation. Actual and potential risks are well understood. Close links with the multi-agency safeguarding hub (MASH), multi-agency risk assessment conferences and the child sexual exploitation panel mean that there is no danger of radicalisation being viewed in isolation. Schools are fully engaged. With over 3,800 people having completed WRAP (workshop to raise awareness about 'Prevent') training, to date, awareness of the risks associated with radicalisation is high. As well as helping to build resilience, the innovative young leaders' project ensures that young people are engaged in, and able to contribute actively to, the 'Prevent' agenda.

108. Awareness of the risks associated with child sexual exploitation is high. Robust strategic and operational governance arrangements ensure that, when risks are identified, cases are escalated appropriately to the multi-agency sexual exploitation panel. Information is well shared. Good and effective use is made of strategy meetings, resulting in appropriate decisions to mobilise support and services to safeguard and protect young people.

109. The sufficiency strategy is currently being rewritten. The local authority has a good understanding of the current and future demand for foster placements, although it has not yet met its internal recruitment target. Successful working with independent fostering agencies ensures that the local authority consistently finds suitable placements for children and young people. Helpful partnership arrangements have been put in place to support a suitable choice of adoptive placements, and out-of-authority residential care is used appropriately.

110. Commissioning arrangements are being modernised. Moving away from an over-reliance on spot purchasing and static service frameworks, the local authority is actively developing dynamic purchasing systems with a number of different external partners in order to provide greater flexibility, while at the same time achieving best value. Contract monitoring is becoming better focused on impact and outcomes.

111. Working closely in collaboration with the children in care council and 'Don't Whisper', the CPAP has been influential in developing a pocket-money policy, publishing a welcome pack for children and young people coming into care and introducing health passports. A high priority is given to involvement, consultation and partnership working with young people, and there are over 30 groups and consultations to seek the views of young people. This includes roles of influence, such as the current chair of the safer neighbourhood board being a 16-year-old member of the youth council.

112. The chief executive has a clear sense of vision and purpose and a good understanding of the local authority's strengths and areas for development. The chief executive is effective in holding both the DCS and the chair of the LSCB to account.

113. Management oversight of practice is robust. Systems and processes, particularly around the MASH and between the MASH, children's social care services and early help, are well understood and well managed. A simple but effective set of panels, each with its own terms of reference, ensures that there are appropriate checks and balances in place and that, in nearly all cases, drift and delay are avoided. Staff receive regular supervision, and case records consistently and robustly reflect a strong management footprint.

114. Senior leaders and managers have a clear understanding and awareness of the changing profile of the local population and take this into account in their planning. Team and service managers have access to a wealth of performance management data, which they use effectively on a day-to-day basis to scrutinise individual and team performance and ensure compliance, particularly in relation to the timely completion of actions and outputs. Senior managers make intelligent use of, and act on the learning from, case audits, themed audits and deep dives as part of a systematic approach to quality assurance. The way in which services are delivered and developed is continuously improving.

115. However, performance management information is not consistently being used or presented to best effect. For example, the commentary that accompanies the performance scorecard, which senior managers and leaders routinely scrutinise, is descriptive rather than analytical and, while some performance indicators are RAG-rated (red, amber and green colour codes), others are not. The performance scorecard itself currently includes 13 performance indicators relating to care leavers, but only one on adoption and none, for example, on common assessment frameworks (CAFs), early help, the number and percentage of cases that have been stepped up or stepped down, or the use of the escalation policy. The latest vacancy and turnover rates are reported elsewhere. (Recommendation)

116. An up-to-date, well-maintained single 'missing' list ensures that the local authority routinely knows of every child who is missing from education, home or care. While the single 'missing' list makes it possible for senior managers to see at a glance which children, and how many, are missing, the way in which the database has been constructed makes it difficult to aggregate and analyse the information in order to identify trends and patterns. This means that senior managers do not have access to real-time data about the number of 'missing' episodes or the offer and completion of return home interviews. (Recommendation)

117. A clear, well-written, overarching children's and young people's plan covering 2015 to 2018 guides the progress of the local authority, and is supported by a detailed action plan. The quality of service and action planning at the next tier down is not as robust. In their current form, service plans are not sufficiently ambitious, specific or measurable. The quality of audit action plans is also variable and, despite all the activity that is being undertaken to improve recruitment and retention, the local authority does not have a workforce development action plan. The lack of clarity on who needs to do what, by when, in order to achieve overarching objectives makes it difficult to monitor progress and hold people effectively to account. (Recommendation)

118. Independent reviewing officers and child protection conference chairs are not consistently providing the level of critical challenge that children, young people and families require. This represents a missed opportunity and undermines the local authority's commitment to continuous improvement. The quarterly report card that is used to monitor the progress and performance of the quality assurance and safeguarding team is underdeveloped and an annual report for 2015 to 2016 has not yet been produced.

119. The local authority has been creative and imaginative in opening itself up to the voices of children and young people and finding ways of increasing children's and young people's influence, and involvement, in the decisions that affect their lives. Senior managers act decisively on the learning from children's and young people's complaints.

120. Good working relationships with Cafcass and the judiciary have contributed to a reduction in the average length of time that children, young people and families have to wait for critically important legal decisions to be made.

121. The local authority has been making a concerted effort to make itself more attractive to potential employees. Opportunities for continuing professional development and career progression have increased. Social workers, including newly qualified social workers (NQSWs), talk positively about the level of support and supervision that they receive and the training opportunities available. Morale is good and staff are positive about working in Redbridge.

122. Of the 54 social work-qualified staff recruited since March this year, 30 are already in post. Currently, 31 NQSWs are completing their assessed and supported year in employment. The local authority has worked hard to improve staff recruitment and its efforts are starting to have an impact. There is still a necessary reliance on agency staff and turnover rates remain high, although this is partly a product of a significant investment and increase in the social work staffing establishment.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

This is a good Local Safeguarding Children Board (LSCB) that provides effective and robust challenge to partner agencies in order that they provide sound, coordinated services for children, young people and families in Redbridge.

The review took place at a time of interim cover arrangements, with the LSCB chair acting as interim director of children's services (DCS) and the vice-chair of the board acting up temporarily as the chair. Both have worked highly effectively and flexibly to ensure a continuous strengthening of the work of the board. The chair and partners have accurately identified key priorities and successfully harnessed widespread partnership commitment to ensure that they are being addressed through a comprehensive action plan. This includes the refinement of the data set available to the board, which is in progress.

The independent chair of the LSCB provides clear leadership, direction and guidance. He has facilitated a forward-thinking board and created a culture where constructive challenge and scrutiny are welcomed in order to improve service provision effectively.

The board is appropriately constituted and attendance at board meetings is consistently high, with representation from a full range of key statutory agencies at an appropriately senior level, as well as exceptionally good engagement and representation from the voluntary sector. This is evidenced by increased financial contributions from some partner agencies and the effective chairing of sub-groups by others. The diversity of the local communities is appropriately represented through lay members, who are an integral part of the board.

The board has successfully implemented a multi-agency audit programme, demonstrating a clear understanding of the key issues in Redbridge. The audit programme needs to become further embedded for the board to be fully assured that the services provided and work undertaken by agencies to keep children and young people safe are consistently robust and effective.

The board uses both national and local learning reviews and auditing activity effectively to ensure that policies and protocols are regularly updated. Training is comprehensive and of a high quality, but evaluation of training courses is underdeveloped. The LSCB annual report is thorough, evaluative and well written. It outlines the priorities, current context, progress made, areas for improvement and challenges across safeguarding services in Redbridge.

Recommendations

123. Extend the range of the performance data set to include data on child sexual exploitation, children missing and female genital mutilation, in order to better identify patterns and issues to be addressed.

124. Strengthen the evaluation of training to ensure that it is longitudinal, robust and can evidence positive impact on outcomes for children and families.

125. Embed the multi-agency audit programme in order for the board to have greater assurance of the quality of frontline safeguarding practice.

Inspection findings – the Local Safeguarding Children Board

126. The Local Safeguarding Children Board (LSCB) is well established. It holds partners effectively to account to ensure that they safeguard children and young people. This is evidenced through strong joined-up partnership arrangements at both strategic and local level.

127. Strong governance arrangements across partnerships are supported by the inter board governance protocol (2014), which provides clear lines of accountability, engagement and communication between the Health and Wellbeing Board (HWB) children's trust partnership, LSCB, Adult Safeguarding Board and the community safety partnership board (CSP). The regular sharing of annual reports and business plans provides opportunities for scrutiny and challenge, as well as coordinated strategic planning. The governance arrangements between the chief executive officer, the LSCB chair and the director of children's services are appropriate, enabling the chief executive to hold the LSCB chair to account.

128. A joint working protocol between the board and the CSP reflects the shared priority areas, including child sexual exploitation, female genital mutilation, radicalisation, extremism and violence against women and girls. Cross-representation on sub-groups enables effective information sharing, the shared use of resources, and the development of strategies and services. An example of this working well is the CSP and LSCB, which worked together to produce a child sexual exploitation 'problem profile' for Redbridge.

129. The LSCB chair provides strong, effective and analytical leadership. He has focused and driven the work of the board since taking up the post in August 2014. Partners are encouraged and enabled by the chair to provide constructive challenge. This is well evidenced in board and sub-group minutes and has shown an impact on, for example, improved health attendance at child protection conferences and a reduction in social work vacancy rates. Board partners acknowledge and appreciate the progress made and express strong confidence in the leadership and management of the board by the chair.

130. The board demonstrates a culture of effective and respectful challenge to partners and agencies, and scrutiny from the chair is serving to improve service provision. A comprehensive challenge log is kept, reviewed and updated, measuring the progress and outcomes achieved. For example, following scrutiny of workforce sufficiency across a number of agencies, a very serious shortfall in the number of health visitors in Redbridge was identified. A joint letter from LSCB, HWB public health and the health scrutiny committee was sent to the Secretary of State. This successfully resulted in additional funding to address the identified deficit.

131. Engagement and commitment of partners to the work of the board are very strong. This is shown through good attendance and considerable effort and energy in evaluation, action and monitoring by all partners, with a shared analysisdedicated focus on the jointly agreed priorities of the board. The board's multi-agency threshold document and the outstanding multi-agency practice seen in 'front door' services reflect the widespread understanding and engagement of the partnership in safeguarding practice. The chair's successful challenge and partners' commitment resulted in an increase in contribution from partners, and the chair has ensured proportionate financial commitment by partner agencies.

132. An impressive range of partner representation helpfully includes a broad span of voluntary agencies, including Redbridge Faith Forum, and three lay members. Membership appropriately reflects the diversity of the communities in the area and the breadth of partnership working. Lay members confirm that they are an integral part of the board, and that their expertise and knowledge are used to good effect. They regularly observe the training offered, and feedback to the board and provide consultation on leaflets. For example, the three lay members provided feedback on a leaflet for parents and professionals on consanguinity, which was identified as a local learning need. The expertise and knowledge within the membership reflect the priorities in the business plan, enabling an opportunity for robust challenge and scrutiny, as well as a contribution to learning and development.

133. Involvement, inclusion and partnership working to capture children's voices are clear strengths within the board, and the chair is creative in seeking ways to engage young people. This includes working closely with the lead for the LSCB youth forum through regular meetings. Youth theatre has been used widely to raise awareness, particularly around child sexual exploitation and mental health. A 'Voice of the Child' conference, facilitated by the board, ensured that the youth forum had a wide-reaching platform from which to share concerns of young people with professionals and organisations that provide services to children in Redbridge.

134. The board is both influential and strategic in shaping and driving improvements in key areas, including the offer of early help services. The impact of early help has been evaluated through a children's trust partnership

report in 2015, which identified strengths and areas of development. The board monitors uptake of early help through the multi-agency monitoring data set and it is reflected in a clear overview in the LSCB annual report. Good links between learning, reviews and auditing activity result in policies and protocols being regularly updated, for example the development of the multi-agency neglect strategy and tool kit which was seen used well in practice, the child sexual exploitation strategy, the female genital mutilation strategy and the children who have a disability protocol.

135. The refreshed 2016 multi-agency threshold document, 'Are you worried about a child', provides comprehensive guidance to assist practitioners and managers in every agency to assess and identify a child's level of need. This was described as providing a 'common language' for professionals, and the work seen by inspectors strongly demonstrated the usefulness and clarity provided by the threshold document.

136. The business plan for 2016 to 2017 is clear and focused on key priorities, and demonstrates the board's accurate understanding of current local need. The action plan for the key areas – child sexual exploitation, female genital mutilation, domestic violence, mental health, substance misuse, violent extremism, children who have disabilities, neglect and coordinating the effectiveness of multiagency safeguarding – is outcomes-based, providing specific and timed actions and measurable impact.

137. The board operates four sub-groups (training, learning and improvement, child sexual exploitation and child death overview panel (CDOP)), and these are effective forums for furthering the work of the board, with each chaired and managed effectively. The sub-groups feed in to an executive group that brings these elements together to drive the work of the board efficiently. An example is the analyses offered by the child sexual exploitation sub-group of data on the incidence, scale, scope, type and sites of child sexual exploitation, which resulted in the police using the information to set up surveillance operations in identified areas.

138. The board is committed to ensuring that safeguarding is a priority for all partner agencies and that the board has a way of measuring this. Section 11 audits were last completed in 2014, predating the appointment of the current chair. The feedback report was not sufficiently comprehensive and the chair requested a further report on the response to actions of each agency in 2015. The expectation of what will now be provided has been considerably strengthened and a further S11 audit will be completed this year, alongside the implementation of a much sharper and challenging peer review process, including a self-assessment, and peer and lay challenge via panel interviews. It is too early to comment on the effectiveness of this, but a clear and robust programme is being finalised.

139. Multi-agency audits were re-established by the chair when he took up post in 2014 and board members regard them as critical to improving practice within and between agencies. The current multi-agency audit programme outlines the themed audits, which are linked to the priorities in the board's business plan. The themed audits completed so far demonstrate a clear understanding and focus on the key issues in Redbridge and have included children missing from education, teenage relationship abuse, child sexual exploitation and neglect. Impact is shown, for example through the report and the action plan on teenage relationships that resulted in the identification of local hotspots for potential perpetrators, which were then targeted by the police. The multi-agency audit programme needs to be further embedded for the board to have greater assurance of frontline safeguarding practice. The chair is aware of this and acknowledges that they are on a journey to make this more effective.

140. The board is committed to fostering a learning culture. The learning and improvement framework is clear, succinct and covers all matters expected by statutory guidance. Frontline practitioners have a good awareness of the work and role of the board. It has a good focus on local priorities and identifies how learning is disseminated. Half-day training and e-learning modules are used to maximise opportunities for attendance. The training programme and policy for 2016 to 2017 provide a comprehensive range of training courses for practitioners and managers across partner agencies. The training sub-group has representation from key statutory and voluntary partners. It monitors, plans and has oversight of all training activity. However, the evaluation of training courses is underdeveloped and the chair acknowledges that 'more work is required to enable both the LSCB and partner agencies to be confident about the impact of training in terms of quality of practice and improved outcomes for children'. The board is developing strategies for evaluating the impact of training, and the appointment of a training coordinator will strengthen this area of work.

141. The LSCB job-shadowing scheme provides an opportunity for professionals from partner agencies to gain experience and understanding of the role, functions and procedures of another agency. This is an innovative and positive way to develop multi-agency partnership working further and contribute to improving the safeguarding of children and young people in Redbridge.

142. Child sexual exploitation and 'missing' continue to be a major focus for the LSCB, and the board is determined to seek to improve services to children at risk of child sexual exploitation and those who go missing. It has set out a well-structured and comprehensive child sexual exploitation strategy. Work to counter child sexual exploitation is driven by the dedicated sub-group through a comprehensive multi-agency action plan that covers awareness raising, training and prevention, disruption and prosecution. 'Chelsea's Choice', a theatre production on child sexual exploitation, has been made available to all secondary schools. Child sexual exploitation was the subject of a multi-agency audit, and this enabled the board to monitor and evaluate the progress and

the effectiveness of services for young people at risk of both child sexual exploitation and going missing. Operation 'Makesafe' is working to raise awareness with the business community in Redbridge. Impact of the role of the LSCB has seen increased police involvement with local children's homes, and includes children placed by other local authorities.

143. Countering female genital mutilation is another key priority of the board. A multi-agency female genital mutilation strategy was agreed in April 2015, providing clear pathways for the referral for children's social care and health services. Awareness raising and training is ongoing with health, including GPs, education and social care via training courses, information leaflets, updates on the LSCB website and e-learning modules. The evaluation of the impact of training needs to be developed further.

144. The board routinely considers data from partners via a quarterly data set, but the current data set has some gaps in information across the partnership in relation to information on child sexual exploitation, female genital mutilation and missing children. The chair identified early the limitations of the current performance information, and met with all the performance leads from partner agencies. Consequently, a more detailed multi-agency scorecard has been agreed and will be made available to the October board meeting.

145. Serious incident notifications are thoroughly reviewed by the chair, who has reviewed three cases to determine whether a serious case review (SCR) needed to be convened. Ofsted appropriately received notification of all the cases and the national panel endorsed the chair's decisions not to initiate SCRs. The board does not have a SCR sub-group. This work is driven by the chair and the learning and improvement sub-group. The board is focused on learning and initiates a review when the criteria are not met for a SCR yet lessons can be learned. This demonstrates commitment to improving practice and services and maximising learning. National learning from SCRs is disseminated via newsletter, briefings and the LSCB website.

146. reference. Reviews of cases are thorough, and there is evidence of challenge analyses to agencies, and effective and appropriate information sharing. Learning from reviews is shared to raise awareness among professionals, parents and members of the public. An example is the publication of information leaflets on parents' genetically related and genetic disorders.

147. CDOP produces an annual report which appropriately provides a breakdown by age, ethnicity and analysis of the issues. During 2014 to 2015, CDOP completed 16 reviews of child deaths. Four had modifiable factors related to the death and 12 had no modifiable factors. There is considered use of the data, with clear analysis and findings leading to actions for improvement. All child deaths are reviewed thoroughly, subject to multi-agency and professional challenge, and actions for improvement are identified, when necessary, and tracked in terms of completion.

148. The LSCB annual report 2014 to 2015 is comprehensive and well structured. It addresses the priorities, the current context, progress made, areas for improvement and challenges across safeguarding services in Redbridge. The board's excellent website is interactive and informative, with up-to-date information for professionals, children and young people and parents. The front page provides the latest updates on local and national issues. There are links to the comprehensive training programme, which can be booked online, helpful links to policies and procedures, and learning from local and national reviews. Information for children is particularly well presented in a range of age-specific categories, providing information in visual and audio format. The LSCB also helpfully uses Facebook and Twitter to share information and updates.

Information about this inspection

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

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people 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 nine of Her Majesty's Inspectors (HMI) from Ofsted.

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