London Borough of Barking and Dagenham

Inspection of children's social care services

Inspection dates: 18 February to 1 March 2019

Lead inspector: Brenda McLaughlin
Her Majesty's Inspector

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

Services for children in Barking and Dagenham require improvement, as was the case at the last inspection in 2014. The recently appointed director of children's services (DCS), together with her senior team, has appropriately prioritised services for children most at risk. Strong and effective senior leadership is resulting in tangible improvements to both the quality and impact of social work practice. Until recently, too many children had experienced delays and ineffective plans as a result of high caseloads and inconsistent management oversight of practice. Decisive action to address these concerns and reconfigure teams, underpinned by rigorous performance management, is now making a discernible difference. The pace of change in the last six months has accelerated, and corporate parenting arrangements are being reinvigorated. Leaders have high aspirations and are determined to do the right thing for children and their families. They have a thorough understanding of the improvements that are required to ensure that children and their families receive consistently effective services.

Strategic partnerships are mostly well established, but timely access to health services when children come into care and for children experiencing emotional and mental health problems is poor, and health provision for care leavers is a significant concern.

What needs to improve

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

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

1. Early help services are insufficiently targeted or coordinated with partners to meet the needs for specific groups of children. For instance, referral pathways for homeless 16- and 17-year-olds are not understood by partners, resulting in an inconsistent response. The recent implementation of daily triage meetings in the early help hub to consider thresholds is a positive development, but the quality assurance of the work is not yet fully embedded. It is difficult for managers to measure whether neglected children and those living with domestic abuse receive preventative services that make a sustainable difference.

2. Contacts and referrals for children in need or at risk are managed promptly in the multi-agency safeguarding hub (MASH). Actions taken by highly visible and appropriately challenging senior managers have resulted in stronger corporate collaboration. For example, joint work with the 'no recourse to public funds team', social housing providers, adults' services and the children's assessment team has resulted in more rapid action to identify and meet children's needs.

3. The large majority of child protection strategy meetings include key agencies involved with the child and are held within 24 hours of the referral. Meetings are recorded well and management decisions are clear. Consent for sharing information is obtained routinely or overridden if required. When children require further help and protection, cases are passed swiftly to the assessment service.

4. High caseloads in the assessment teams and inconsistent management oversight mean that some children do not receive help and protection quickly

enough. Committed staff strive to provide children with a good service, but social workers are routinely allocated additional work as they are also responsible for providing a duty service. In response to the concerns identified by inspectors, senior leaders carried out an immediate review and took decisive action to increase capacity and strengthen the management oversight of work across all teams.

5. Records of assessment visits vary in depth and quality of detail. Stronger cases include detailed observations of individual children and clearly record their views; others are very brief, and the contribution towards the assessment is more limited. Better assessments capture the lived experience of children and draw on the views of other professionals who have built trusting relationships, if children are reluctant to engage in direct work. Inspectors observed examples of sensitive and assiduous child-centred work that informs plans and makes a real difference to reducing risk. Senior managers have appropriately identified that more work is needed to strengthen the exploration of culture and identity in assessments.

6. In many cases, social workers have strong relationships with children. They see them regularly and alone, according to assessed needs. They understand their lived experiences and take action to make changes that help and protect children and their families. However, some children have been the subject of multiple and ineffective assessments and interventions, sometimes over many years. Insufficiently robust and challenging management oversight in both the assessment and care management teams contributes to delay. While social workers receive regular supervision, actions lack clarity. Managers do not consistently identify drift and delay, and, consequently, some children who have experienced neglect wait too long for a service.

7. Thresholds for instigating the PLO are inconsistent. Until recently, children subject to pre-proceedings letters spent extensive periods of time at this stage without effective review. A lack of robust tracking and delays in commissioning assessments have hampered timely decision-making about applications for family court orders. Recent action by the operational director has changed this process. PLO cases are now allocated to solicitors. The judiciary and Cafcass are positive about the quality of assessment and recommendations to court; nevertheless, there is a legacy of some children remaining in harmful situations for too long.

8. Initial child protection conferences are timely and are well attended by relevant professionals. Records are comprehensive and clear, and identify appropriate actions for the professional network. However, child protection plans vary in quality. More effective plans include specific actions, with updates by multi-agency core groups that demonstrate progress. Strong professional networks support parents to change entrenched patterns of behaviour as well as providing individual help for children.

9. Children and their families benefit from bespoke and skilled work undertaken by the access to resources team. Experienced workers diligently deliver intensive direct work to children who have experienced neglect, and those living with parental substance misuse, poor mental health and domestic abuse. These workers are making a real difference to vulnerable children, helping some children on the edge of care to remain safely at home, and providing substantial support to children returning home from care.

10. Many children in Barking and Dagenham live in families where there are high levels of domestic abuse, but specific domestic abuse perpetrator programmes are not available. This means that risks posed by perpetrators are not fully understood or addressed quickly enough. Targeted parenting support classes are available, for example a 17-week programme called 'Caring dads', that helps fathers to care safely for their children. However, this is insufficient in addressing persistent domestic abuse. Access to family group conference services is helping some children to remain within the wider family or to receive additional support to live safely with their parents.

11. Vulnerable adolescents and children at risk of exploitation and radicalisation receive a timely and well-coordinated response when risks are first identified and when they escalate. Social workers are knowledgeable and confident in recognising the signs of exploitation and the impact of neglect, domestic abuse and absent fathers, which increase vulnerability to exploitation. Skilful child-focused practice ensures that social workers build strong relationships with children. For that reason, children feel safe enough to share sensitive information about the harm and risks that they experience outside the family. As a result, children benefit from carefully tailored interventions which reduce risks and identify how relationships can be strengthened and environments made safer. Strong partnership work with schools, health and police services, including cross-borough information-sharing, supports the effectiveness of the response to contextual safeguarding. The recent appointment of two dedicated missing children coordinators is positive and is intended to improve the response to children missing from home and care.

12. Good awareness of the heightened risks of radicalisation among vulnerable children and direct work are effective in helping to protect children. An external evaluation commissioned in 2017 to assess the critical success factors, challenges and barriers to effectiveness identified several key learning points. These have been taken forward into continuing engagement with local communities and faith groups, as well as work in schools.

13. The co-location of adults' and children's disability services since May 2018 has improved communication and joint work to assess the mental capacity of young people who will need lifelong support. Social workers sometimes find it difficult to access CAMHS for these children. Disabled children are well supported by the all-age disability service managed in adults' services, enabling effective transitions into adult services.

14. A well-resourced and experienced emergency duty team ensures that effective arrangements are in place and that protective action is taken to safeguard children out-of-hours. The team operates across four boroughs, with a dedicated social work team. Communication with day services is swift and effective.

15. Allegations made against professionals and the associated risks to children are managed well by the designated officer. Children who are privately fostered are visited regularly and live in suitable and sustainable care arrangements.

16. Managers maintain an up-to-date database of children missing education and those electively home educated. Managers are actively involved in multi-agency groups that consider missing and vulnerable children. They receive good information on children at nursery who do not start school and they check if children missing education are in households where domestic abuse has occurred. In most cases sampled, staff undertake routine checks and take appropriate action to safeguard children if required.

The experiences and progress of children in care and care leavers: Requires improvement

17. Appropriate and planned decisions are made for most children who come into care. This is an improvement since the previous inspection in 2014, when too many children came into care as a result of emergency police protection. Most decisions are informed by timely and comprehensive assessments, with risks clearly identified and suitable plans in place. Nonetheless, inspectors identified some children now in care who had been left in neglectful circumstances for too long.

18. The timeliness of initial health assessments is extremely poor. Many of these children have experienced abuse and neglect. The poor timeliness of assessments means that children's immediate health needs are not understood quickly enough. The DCS has escalated this matter via the Local Safeguarding Children Board to the local clinical commissioning group, but effective action is still awaited. Children in care do not have sufficient access to CAMHS. Inspectors saw examples of the pupil premium being used to compensate for the lack of therapeutic services available from health providers. Social workers and their managers described situations where children who have suffered serious childhood trauma wait too long for services. This is unacceptable.

19. Early permanence planning is underdeveloped. Insufficient management oversight of the planning process to track children means that all options for permanence are not considered simultaneously. This leads to sequential assessments and prolongs uncertainty for some children. Family finding for children who cannot live safely with their birth parents is not considered at an

early stage. The pace of progress in this area since the last inspection in 2014 has been slow. Senior leaders acknowledge that more work is required to change the culture. A recently implemented system to track progress, led by the senior independent reviewing officer (IRO), is a positive initiative, but it is insufficient by itself.

20. The quality of viability and special guardianship assessments of family members to care for children who cannot live with their birth parents is highly variable. The assessments lack rigour and are overly optimistic in considering the capacity of carers to meet the range of children's long-term needs. Most assessments are descriptive and lack critical analysis.

21. Long-term placement stability is beginning to improve. Most children in care live with long-term approved foster carers who meet their needs. Many are making good progress. Children told inspectors that their foster carers were fun and took them on holiday, and that they can tell their carers about their worries. Children spoke positively about their IROs, but some said that they had had too many changes in social worker. Care plans are comprehensive, and most are well matched to children's individual assessed needs.

22. Social workers know children well, and most children are able to build trusting relationships with the same worker. Inspectors found good examples of effective, sensitive and imaginative direct work to help children to understand their experiences. Children are also visited at home by their IROs between reviews. They are helped and encouraged to participate in their statutory reviews via an electronic platform, which is used well by children in care to help to inform their care planning. The voice of the child is consistently evident in children's records and reviews. Children are encouraged to pursue their talents and interests, and their achievements are celebrated regularly.

23. Children benefit from well-planned and supported contact with family members. These arrangements are regularly reviewed with children to ensure that their experiences of spending time with family and friends are positive and feel safe.

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

25. Unaccompanied asylum-seeking children are promptly safeguarded and placed in independent accommodation or foster care according to their assessed needs. Clear planning ensures that these children make progress in all areas of their lives.

26. Strong and motivated fostering and adoption practice managers know their service well and are working hard on the areas that they need to improve.

Detailed assessments by a specialist therapist of whether a child can live safely with their brothers or sisters are informing good decision-making. Approaches such as restorative intervention work with brothers and sisters are helping to support the stability of children's long-term placements. The Mockingbird model of intervention is well established and supports the long-term stability of children with more complex needs. This excellent work provides children with a wider support network, allowing them to remain or be reunited with their brothers and sisters. Four further hubs are planned to become operational over the next few months.

27. Prospective adopters say that they felt welcomed at their first enquiry and overall gave very positive feedback about the recruitment process. The preparation and assessment process is consistently thorough and helps adopters to feel well prepared for the task of adoptive parenting. High priority is given to family finding and to seeking suitable matches for children. As a result, in the past year, more children have been adopted more quickly. The timeliness of matching is variable. However, positive matches for brothers and sisters to stay together, and for children with complex needs, are evident. Adoption support is a strength and has promoted placement stability, with no placement breakdowns recorded over several years.

28. Most children in care achieve well and make good educational progress relative to their starting points. The timeliness and quality of personal education plans have improved, although there is still inconsistency in assessing older children's progress. Children in care achieve better at each key stage when compared to both statistical neighbours and nationally. Progress between Key Stage 2 and Key Stage 4 is strong. A relatively high proportion are in education, training and employment in years 12 and 13. Most children in care attend school regularly. Insufficient focus by the virtual school to target young care leavers with more complex needs means that some do not access employment or training. Leaders have not yet evaluated the effectiveness and impact of the virtual school.

29. Strong relationships formed between staff and care leavers mean that most care leavers are in touch with the service, but contact is not always recorded. Care leavers told inspectors that they benefit from the support and independent training provided by personal advisers. They spoke warmly about the children's rights officer, saying that she was like a 'Nan'. Pathway plans are comprehensive but repetitive. They are perceived by young people to be overly long and boring. A revised aspirational version, 'It's All About You!', has been introduced, which allows young people to write about themselves, including their aspirations for the future. However, some pathway plans are not thorough enough or updated after significant changes in young people's circumstances, and actions are not progressed in a timely way. Some young people have not received a copy of their plan.

30. There is a range of suitable accommodation available for young people, including 'staying put'. Young people told inspectors that they feel safe in their accommodation but would welcome more help and support when they move from care to their new homes. Care leavers have participated in the recently refreshed Pledge. They told inspectors that staff are not consistently ambitious on their behalf. Senior leaders agree that they need to do more improve the local offer and to increase opportunities for employment and training.

31. Health arrangements for care leavers are weak. Health histories for young people are not available. Care leavers are not provided with a health passport or with specific targeted support to address mental health or emotional concerns.

The impact of leaders on social work practice with children and families: Requires improvement

32. More recent strong and effective senior leadership is leading to tangible improvements in both the quality and impact of social work practice. The new DCS, together with her senior team, has taken well-considered and essential action to address key weaknesses in the quality and impact of services for vulnerable children. They have worked extremely hard, in one of the most deprived boroughs in London, to implement changes quickly.

33. Leaders know their communities well. They have high aspirations and are determined to do the right thing for children and their families. An extensive and accurate self-evaluation and external analysis of frontline social work practice found many strengths, as well as significant areas for improvement. They found that, despite highly committed staff, basic safeguarding practice was too variable across children's services. They accurately identified serious safeguarding deficits and appropriately prioritised children most at risk, including services for safeguarding vulnerable adolescents, neglected children living in harmful situations and pre-birth risk assessments and plans for babies. Decisive action to address concerns, reconfigure teams, and rigorous performance management are making a discernible difference. The pace of change has accelerated dramatically in the last six months.

34. Leaders have aligned and strengthened services effectively to address the broad range of risks experienced by vulnerable adolescents and exploited children. The recently redesigned vulnerable adolescent and youth offending service, which is co-located alongside the MASH, is improving communication and responses to these children at the 'front door'. Effective relationships with key partners have resulted in the location in Barking of the three-borough police-led integrated gangs' unit and have helped to retain a strong health resource within the youth offending service. Extended funding from the Mayor's Office for Policing and Crime (MOPAC) for the youth at risk matrix and the successful bid to develop contextual safeguarding are evidence of the

impact of thoughtful and influential leadership responding to the needs of the children in Barking and Dagenham.

35. Performance management has been significantly strengthened and is helping to drive improvement. Managers now use weekly performance scorecard information, which has led to improvements in the timeliness of visits to children and of initial child protection conferences. Senior managers recognise that they have more work to do to move to a culture of measuring impact and outcomes, rather than processes. A revised quality assurance framework and findings from enhanced and rigorous audit activity have informed the redesign of services. These include the development of a multi-agency hub to assess risks pre-birth, and targeted recruitment of staff to work specifically with trafficked children. A comprehensive action plan and a tracker help to ensure that recommendations and learning from audits are disseminated.

36. Sound governance arrangements ensure that members of the senior leadership team communicate regularly and effectively. A formal cycle of weekly and monthly meetings between the chief executive officer, the DCS, elected members and corporate directors, supported by 'real time' performance information, makes sure that they are well informed on matters for which they hold strategic responsibility. Elected members work purposefully to prioritise resources to meet the widespread and complex needs of their constantly changing community. Services for children are protected and have increased in times of austerity, with ongoing political financial commitment.

37. Elected leaders listen carefully to children and young people and are passionately committed to improving their futures. Corporate parenting work is being re-invigorated, as leaders recognise that it is not as effective as it needs to be. Some key issues have not been addressed quickly enough, for example the limited range of opportunities for accessing education, training and employment for care leavers. In addition, effective action has not been taken to ensure timely initial health assessments when children come into care and the provision of health passports for care leavers.

38. Senior leaders recognise that competent managers are vital to continuous improvement. Successful action to tackle poor performance and the creation of additional posts are beginning to make a difference to the quality of practice. The operational director of children's services is creating a culture of mutual esteem and respectful challenge, holding heads of service and managers to account for the quality of practice in their teams. The senior management team, including the DCS, interacts well with frontline services. They know individual children and social workers well. Morale is good and a persistent focus on and an investment in training and development are increasing the number of permanent managers and frontline staff. Social workers told inspectors that they enjoy working in Barking and Dagenham, and that they feel listened to and supported.

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