Thurrock 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: 22 February 2016 to 17 March 2016

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

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

Executive summary

Services to children, young people and families in Thurrock require improvement. Children and young people were found to be safe in Thurrock during this inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs.

While there are pockets of good practice across all areas of children's social care, the majority of practice is less than good, specifically much of the core business regarding assessment and planning for children, securing a stable workforce, supervision and management oversight. In the last inspection of safeguarding and looked after children services in 2012, the local authority was judged to be good. Following this inspection, senior officers and leaders did not continue to ensure that children and families received consistently good services.

The local authority has addressed effectively almost all areas for improvement that were identified at its last inspection, including its response to referrers, access to a range of leisure activities for children looked after and implementation of early help assessments. However, the quality of assessments and plans for children in need, including children with a disability, those in need of protection, children looked after and care leavers, requires improvement.

The local authority appointed a new permanent head of children's social care in October 2014, a new chief executive in September 2015 and an interim director of children's services (DCS) in late January 2016, pending the swift appointment of their new DCS who is due to start in May this year. These appointments have been of highly skilled professionals who have demonstrated their positive impact on services in a relatively short time.

Most children benefit from early help provided by a range of strong commissioned services. Children who have more complex needs and require a coordinated response do not always receive such effective early help and support. The local authority does not ensure that all children who have been missing from home or care benefit from a return home interview after they have been missing. Children in need of protection receive a swift and appropriate service, but children in need often experience delay in seeing their social worker for an assessment of their needs. Children are not effectively supported to attend and participate in their formal review meetings. When these meetings take place, reports and minutes from previous meetings are often shared too late to be fully considered.

Children looked after do not receive a consistently good service, and too many become looked after in an emergency. The recruitment of foster carers is not resulting in an appropriate range of local placement options, and too many children live outside the borough, away from their communities, families and friends. Children looked after achieve well relative to their peers in the early years. Outcomes for children looked after at the end of key stage 2 have improved significantly, but are still below outcomes for all children. However, educational outcomes for children looked after who are taking GCSE examinations are poor. Personal education plans are not sufficiently detailed. The virtual school does not effectively monitor the educational progress and outcomes for the majority of children looked after who live outside the borough.

Waiting times for children with a plan for adoption are reducing. However, workers within mainstream social work teams do not consistently consider adoption for all children who cannot return home. Post-adoption support is insufficient for children and families who are entitled to this service. Care leavers receive good day-to-day support, but not enough young people are benefiting from staying put arrangements after they turn 18 years, and they do not all receive effective support to transition into adulthood. Pathway reviews are not being undertaken within timescales.

The local authority's use of performance management and quality assurance information across all areas of the service is poor, and impedes any improvement needed. Use of feedback from children and families to inform service development is underutilised. Accurate data regarding performance is collated, but managers do not analyse this data in order to inform service developments. There are weaknesses in the analysis of social workers' activity in relation to timeliness (for example, of multi-agency safeguarding hub (MASH) processes and assessments), the consideration of trends from return home interviews and 'children missing education' information, the overview and analysis of findings from audit, and the full analysis of key factors affecting services for children in need of protection and children looked after.

The instability of the workforce leaves services vulnerable. The local authority is fully aware of the workforce challenges and has a range of creative initiatives in place to address this in the longer term. Management oversight of frontline practice is inconsistent, with too many areas of weakness, and results in a lack of effective challenge to progress children's plans and effect change for children. Currently, the local authority does not systematically ensure that the workforce receives supervision of sufficient quality and frequency.

Some elements of services to children and their families have improved. The local

authority's Multi-Agency Safeguarding Hub (MASH), for example, is securing strong information sharing between professionals and robust decision making regarding appropriate services for children and their families. Management oversight within the MASH is very strong. Other improvements include the response for children who are at risk of child sexual exploitation, which reduces their risks. The authority has also substantially improved its offer to teenagers, the vast majority of whom receive a good service from the adolescents team.

Despite changes of key personnel, the local authority has greatly improved its corporate and cross-party political support for children's services. The local authority had a recent peer review of its corporate arrangements by the Local Government Association, which endorsed the strong working relationships seen during this inspection. Effective support from the political leadership is evident through the challenging overview and scrutiny function, and in the proactive Health and Wellbeing Board.

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The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection of the local authority's safeguarding arrangements was in June 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in June 2012. The local authority was judged to be good.

Local leadership

- The interim director of children's services has been in post since January 2016.
- The chair of the Local Safeguarding Children Board has been in post since August 2012.

Children living in this area

- Approximately 40,093 children and young people under the age of 18 years live in Thurrock. This is 25% of the total population in the area.
- Approximately 21% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14% (the national average is 16%)
  - in secondary schools is 14% (the national average is 14%).
- Children and young people from minority ethnic groups account for 22% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is Black or Black British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 17% (the national average is 19%)
  - in secondary schools is 10% (the national average is 15%).

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

- Thurrock has the highest rate of unaccompanied asylum-seeking children (UASC) in the eastern region: 20.7 children per 10,000 population. The number of UASC has doubled in the last 12 months. In December 2015, one in four children looked after was a UASC.

Child protection in this area

- At 22 February 2016, 1,609 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,563 at 31 March 2015.
- At 22 February 2016, 263 children and young people were the subject of a child protection plan. This is an increase from 201 at 31 March 2015.
- At 22 February 2016, two children live in a privately arranged fostering placement. This is a reduction from seven at 31 March 2015.
- Since the last inspection, four serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 22 February 2016, 336 children are being looked after by the local authority (a rate of 87.2 per 10,000 children). This is an increase from 280 (70 per 10,000 children) at 31 March 2015.
  - of this number, 245 (or 72.9%) live outside the local authority area
  - 31 live in residential children's homes, all of whom live outside the authority area
  - one lives in a residential special school[3] outside the authority area
  - 238 live with foster families, of whom 65.1% live outside the authority area
  - five live with parents, of whom two live outside the authority area
  - 77 children are UASC.
- In the last 12 months:
  - there have been 18 adoptions
  - 25 children became subjects of special guardianship orders

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

- 114 children ceased to be looked after, of whom 5.3% subsequently returned to be looked after
- 21 children and young people ceased to be looked after and moved on to independent living
- no children or young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that accurate performance data is analysed and that this leads to specific actions for improvement.

2. Strengthen oversight, coordination and quality assurance of early help services to ensure that children and families are receiving the right support at the right time.

3. Ensure that assessments and plans for children are of a consistently high quality.

4. Improve the offer of return home interviews to children and young people who have been missing from home or care to increase take-up of these interviews.

5. Ensure that more children are supported to participate in, and contribute to, their meetings, conferences and reviews, that they and their parents have access to reports beforehand, and that meeting minutes are circulated promptly.

6. Ensure that robust arrangements are in place to reduce the need for children and young people to become looked after in an emergency.

7. Ensure that the recruitment of foster carers is appropriately targeted, better to meet the current and future demand for foster placements, and to reduce the number of children looked after who have to be placed out of the borough.

8. Ensure that personal education plans are of a consistently high standard and that the virtual school monitors and analyses effectively the progress of all children looked after, including those who attend schools outside of Thurrock.

9. Ensure that managers oversee and drive forward permanence plans for children effectively.

10. Develop post-adoption support arrangements to ensure that all children and families who are eligible have access to an appropriate service.

11. Ensure that an effective 'staying put' policy makes it possible for more young people to live with their former foster carers beyond the age of 18 years.

12. Ensure that pathway assessments and plans are developed to engage care leavers effectively, and that care leavers benefit from regular reviews.

13. Ensure that care leavers are supported to gain independence skills effectively, including through the setting of aspirational targets to help them to achieve educational and employment goals.

14. Secure a more stable workforce to ensure that children are able to build enduring relationships with social workers and to enable the local authority to drive through improvement to services, such as increasing early planning for permanence for children that starts at the front door.

15. Ensure and demonstrate that children's and families' views and feedback are used well to shape service developments.

16. Regularly audit supervision files to ensure that frequency and quality of supervision are resulting in improved practice.

Summary for children and young people

- Services to children and families in Thurrock require improvement. This means that the local authority has not maintained the quality of services since its last inspection in 2012, when services were judged to be good.
- Managers do not effectively use the information that they have about the performance of children's social care to understand what is going well or less well, or to help them to plan relevant improvements to services.
- Early help to children and their families is often helpful when only one service is involved. However, when children's needs are more complex and several services need to be involved to help them, these services do not always work well together to provide effective help to children.
- Most children who need a social worker are properly referred for this service. However, there are a small number of children who experience increasing levels of need and risk, and are not referred for a social work service quickly enough.
- The council set up a new team in 2014 to manage referrals for children: the multi-agency safeguarding hub (MASH). This team is doing some very good work. There is a range of professionals from different agencies within this team and they work closely together to share information and make good decisions about who should be working with children and families to meet their needs.
- Children who need immediate protection are seen quickly, and professionals work well together to make sure that any immediate risk is reduced. For those children who are in need, there is often a delay in seeing their social worker.
- The quality of assessments and plans for children, including those in need of protection, those who are looked after and care leavers, are not good enough. Managers do not monitor social workers and the progress of plans well enough, which means that there is sometimes a delay in things changing for the better for children and their families.
- The vast majority of teenagers receive a good service from the adolescents team. They have detailed assessments of need and effective plans.
- Younger children looked after are doing better at school, but most teenagers looked after are not supported to achieve good grades in their GCSEs.
- Although improving, there is still some delay for children who are being adopted.
- Managers have worked well to make sure that children who are at risk of child sexual exploitation receive a good service that reduces their risk.
- When children have been missing, return home interviews help them to talk through any issues. However, not all children receive an interview.
- There is a Children in Care Council, but managers and politicians need to do more to make sure they listen to the children and care leavers of this council.

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

Summary

Early help commissioned services are effective and underpinned by a comprehensive early help commissioning strategy. However, oversight and monitoring of early help is not fully developed, so not all children and families receive early intervention and coordinated services at the time that they need it. Thresholds across early help and children's social care are not always applied appropriately, leading to delays in a small number of children and families receiving timely support.

Strong multi-agency partnership working ensures that urgent responses to protect children are established through the multi-agency safeguarding hub (MASH). Contacts are progressed quickly and receive effective management oversight, and appropriate consent is obtained from families.

The majority of social work intervention for children in need requires improvement. There are some examples of more positive practice, but this is inconsistent across the service. Weaker practice is particularly evident in assessments, planning and driving change for children. High caseloads and frequent changes in staff in some teams have had an impact upon relationships with children and families. For a minority of children, this means that change to meet their needs or reduce risk is not always timely or sustained.

A few children experience delays in being seen for an assessment of their needs. Feedback and advocacy for children and young people are not routinely used, and not enough children are supported to attend meetings. Plans are neither proactively driven forward to improve outcomes nor specific enough for families to know how to improve their circumstances.

Risks relating to child sexual exploitation are responded to well, and risk assessments tools are used effectively to reduce risks to children. Responses to children missing are inconsistent. Not all children receive a return home interview, and records from these are not always uploaded into children's records. When completed, return home interviews are of good quality.

While there is detailed oversight of individual children missing education and children electively home educated, the local authority does not routinely analyse and evaluate the data on them to respond to trends or to inform service development.

Inspection findings

17. A comprehensive early help commissioning strategy is in place, and appropriate early support is available for most children and families. This includes an effective range of commissioned services which are leading to improved outcomes for children and their families. Although all universal services are signed up to the offer of early help across the local authority area, children's centres and health visitors currently underuse early help assessments to inform their work with children and families. This means that they are not effectively coordinating early support for children and their families with other agencies.

18. When children and families with more complex needs require a coordinated early help response by more than one agency, there is some variability in practice. For most children, the local authority's early help team oversees these cases effectively, providing support to lead professionals, and makes good use of the multi-agency group (MAG) panels in the locality to clarify additional support needs for children and their families, and to signpost relevant services. For a small minority of children, there is insufficient monitoring and quality assurance of the early help offer, which results in a lack of assessment and a lack of a successful offer of help. The local authority recognises that coordination and oversight of early help are an area for improvement. It is currently exploring relevant options to achieve this (Recommendation).

19. Thresholds are understood, and are being appropriately applied in the large majority of cases, which means that children's and young people's needs are effectively risk assessed and their cases stepped up to children's social care when required. However, a small number of children do not receive the right help at the right time, or help that is proportionate to their needs and risks. During this inspection, a small number of cases were raised where children would have benefited from receiving a social work service rather than early help. The local authority responded swiftly and robustly to ensure that these children's needs and risks were being appropriately recognised and addressed. Parents spoken to by inspectors shared their frustration at not receiving support in a timely way. Conversely, some children who could have received appropriate support though provision of early help have received a statutory service.

20. Effective step-down arrangements between children's social care and early help are not consistently in place. A lack of continuing oversight of children's cases that have been stepped down means that the local authority cannot be assured that all children continue to receive services that promote their welfare via early help after closure to children's social care. During this inspection, no children

were identified to be at immediate risk of significant harm without services in place to reduce risk and meet their needs.

21. The MASH provides a strong response to referrals for early help, troubled families and children's social care. Contacts made using early help assessments are variable in quality, with a minority lacking basic information that is needed to inform decisions fully regarding the most appropriate response. For children in need of protection, strategy meetings are identified swiftly and prioritised for urgent action.

22. The troubled families programme in Thurrock is successful. All 360 families in phase one were helped to turn around much earlier than the target deadline. Managers have set a target to build upon existing success, with a further 1,160 families being helped by 2020. Recently, a frontline troubled families worker has been based in the MASH to identify eligible families actively and to make sure that they receive a timely response. The proactive way in which the local programme is prioritising children with child protection and child in need plans is providing additional practical support to these most complex families.

23. Strong multi-agency performance and information sharing has enabled the MASH to respond to 96% of contacts within 24 hours over the past six months. Good use is made of risk assessment tools and children's family history, alongside clear management oversight and direction in all cases. Professionals obtain appropriate consent from families and, where the need for consent is overruled for the protection of children, the reasons for this are clearly recorded. Appropriate feedback following contact is provided to referrers in order to share the actions taken to promote children's welfare. An experienced and stable emergency duty team ensures that immediate responses to safeguard children out of office hours are effective. The MASH has a good reputation with professionals, who praise the holistic approach taken in responding to children's needs, the advice available to professionals and the range of information collated to help inform decisions to safeguard children.

24. When children need protecting, strategy meetings are timely and include professionals from an appropriate range of agencies. Development of the MASH has helped to secure routine engagement from health and police professionals in strategy meetings. This means that intelligence about risks to children is shared effectively, and demonstrates a real shared ownership of decisions to keep children safe. In a small number of cases, not all key professionals participated in strategy discussion to inform decision making, although minimal impact on decision making for individual children was seen during this inspection. However, the large majority of children in need experience a delay

in being seen after allocation by children's social care, including after a step up from early help. Additionally, some teams have high caseloads and have had many changes of staff, which means that not all children and families were able to develop trusting relationships with workers.

25. The large majority of child protection investigations are thorough, timely and informed by information gathered from relevant professionals and children's histories. Children are seen, and parental involvement and views are appropriately obtained. Responses to safeguard children are proportionate to risks identified, and effective actions are taken to ensure their safety and welfare.

26. Developments to safeguard children at risk of female genital mutilation, as part of a Department for Education-funded innovation project, are beginning to improve awareness of this safeguarding issue across agencies. Referrals to the MASH have increased since December 2015, but further awareness raising is needed to ensure that all children who may be at risk of female genital mutilation in the local authority area are identified and appropriately supported.

27. Assessments of children's needs, risks, strengths and wishes vary in content and quality. Most assessments do not identify the impact of risks or family history for children well, and only a minority fully explore the child's experience. Consideration of identity, diversity and cultural needs, or how these can increase children's vulnerability, is inconsistent, and these needs are identified only in a small minority of assessments. These include assessments completed for children with disabilities, where evidence that social workers know the children well is not always clear and the impact of disability on children's identity is not fully addressed. Too few assessments contain the views of children. Their experiences do not routinely inform decisions made for them. Although there are systems in place to review the progress of assessments, these are not robust. A lack of management oversight contributes to drift in achieving change for a minority of children (Recommendation).

28. Child protection conferences are well attended by relevant agencies and include positive multi-agency engagement. Families do not always receive child protection reports in time to be able to prepare adequately for meetings, and advocacy is not routinely accessed for those families that would benefit from additional support. Children's assessments are used for initial and review conference reports, but do not always clearly record what changes and actions have been taken or progressed to safeguard children. The local authority is reviewing this, but a new process is not yet in place (Recommendation).

29. Child in need and child protection plans do not consistently address children's needs and are variable in detail. Half the plans seen require improvement to ensure that clear outcomes are identified and specific outcome targets set for individual children. In a small minority of cases, poor management oversight has led to drift in plans being progressed, and they are not updated following reviews. Few plans seen by inspectors showed evidence of strong management oversight and direction. However, core groups are held regularly, and are appropriately attended by parents and the relevant professionals in order to review and progress plans. When cases transfer between teams, risk assessment tools are appropriately used to identify actions, and appropriate challenge by managers is evident (Recommendation).

30. Positive and focused work with most teenagers and their families is completed by the adolescents team. This includes effective use of the child sexual exploitation risk assessment and adolescent neglect tool, when relevant, to support young people in need, including those in need of protection. Clear, directive and creative plans help professionals to prevent family breakdown and provide effective direct work with young people.

31. At the time of inspection, 263 children were subject to child protection plans, which is a substantial increase from the 201 who were subject to a plan at 31 March 2015. Managers have explored the reasons for this increase and appropriately identify that it is in response to stepping-up cases where no meaningful change or reduction of risk for children was being achieved at the child in need level. During this inspection, no children were found to be subject to child protection plans who did not require this level of statutory intervention.

32. At the time of this inspection, there were 125 children subject to child protection plans due to risk of emotional abuse, 120 due to neglect, six due to risk of physical abuse and 12 due to risk of sexual abuse. The local authority removed the category of multiple abuse by the end of January 2016 after a review revealed that the category was masking information regarding the risk of sexual abuse. This led to an increase in children who were subject to child protection plans for risk of sexual abuse, from 1% to 5%, since March 2015. There has also been an increase in the use of the category of emotional abuse, from 26% to 48% in the same period. The local authority is appropriately reviewing this in order to gain a fuller understanding of the issues leading to this increase. Effective child protection surgeries with senior managers are held in order to review progress and to reduce risk for children who have been subject to child protection plans for a nine-month period or longer. The additional oversight provided by these surgeries has helped the local authority

safely to manage down the number of children remaining on child protection plans for over two years.

33. Social workers recognise and respond well when children are at risk of sexual exploitation. Good use is made of the pan-Essex risk assessment tool to identify those who are most at risk. This leads to strategy meetings for those with complex needs to share information and to develop a strong, coordinated, multi-agency response for individual children. The child sexual exploitation coordinator provides social workers and managers with effective challenge, advice and guidance. Although the local authority currently keeps separate data in respect of children missing from home, school or care, and those at risk of child sexual exploitation, the operational risk assessment group rigorously cross-checks data against the most recent list of children reported as missing to the police to ensure that individual children are safeguarded and protected. However, the group is not using data collected from return home interviews to inform planning for these vulnerable children.

34. Appropriate referrals are made to a commissioned service to deliver return home interviews, but the large majority of children decline the offer of a return home interview after they have been missing. When they are completed, the return home interviews are rich in information about the child's life, home circumstances, who their friends are and places where they like to go. However, these records are not reliably uploaded to children's local authority records. This limits the potential use of this information to plan actively to reduce risk for children and young people (Recommendation).

35. The local authority has developed a range of good initiatives to help children and young people, including children looked after, to keep themselves and others safe from issues such as from bullying and online grooming. Successful projects such as 'Show racism the red card' are used in schools to deliver key messages about hate crime and 'Prevent'. An e-safety project has reached a number of troubled families, helping to make parents aware of potential dangers online.

36. A consultant practitioner provides expert advice to social workers in supporting children and families where parental substance misuse or mental health issues are a feature. This includes advice on hair strand tests and reports for court processes, to ensure that all risks to children are appropriately identified.

37. Children and young people aged five to 16 years who are experiencing domestic abuse within their families have access to domestic abuse support groups that are innovative, fun and creative. These groups support children to understand their rights, protect themselves and learn new skills. Appropriate

referrals are made to the multi-agency risk assessment conference (MARAC), where positive attendance, engagement from a range of agencies and clearly recorded safety plans ensure that effective actions are in place to protect children and adults.

38. Homeless 16 and 17 year olds who are identified as vulnerable or living in unsuitable accommodation are effectively assessed, and provided with accommodation if they are found to be in need. Those young people who do not wish to become looked after are appropriately supported through a joint protocol between housing and children's social care for homeless young people. They are provided with expert mediation from the homeless intervention project to assist them to return home, or they are provided with hostel accommodation with additional support from a commissioned provider. Bed and breakfast accommodation has not been used for the past two years.

39. There are 79 children missing education, including those who are in alternative education but not receiving their full 25 hours per week offer, with the number being reduced each month. A rigorous system is in place to monitor children missing education, and effective monthly strategic meetings on children missing education involve key professionals and their managers to focus on all children missing education. The local authority assures itself that children have a suitable school place and are confirmed as attending before it ceases its monitoring. Vulnerable children, including unaccompanied asylum-seeking children and those in Years 10 and 11, are discussed at detailed monthly inclusion panels. Here, the headteachers of secondary schools explore who can provide the best place for each individual child.

40. There are currently 173 Thurrock children who are electively home educated. The local authority actively reviews all children who are electively home educated at the monthly strategic meetings on children missing education. This includes checking the information that they hold to ensure that children are not at risk and that they have been seen, and to identify when a conflict with school can be resolved. A 'traffic light' system is used to flag families on this list that may need additional support. The local authority does not sufficiently analyse and evaluate the data about children missing from education and those who are electively home educated to find out if there are particular trends, for example if numbers are increasing or decreasing, or to consider fully why this may be (Recommendation).

41. Notifications about private fostering arrangements are responded to within statutory timescales and, in the large majority of cases, are subject to robust scrutiny to ensure that children are safe. Children are seen and visited

frequently, with their views and wishes recorded in private fostering assessments. Neither proactive engagement with community faith groups nor awareness raising with professionals and the public have increased notifications. These are very low, and only two children are currently being supported as privately fostered children.

42. The local authority's response to allegations against professionals working with children are effective and timely. Referrals and management planning meeting minutes clearly record risks to children and the actions to be taken. All planning meetings are well attended by appropriate agencies in order to share relevant intelligence and information, and to ensure that children are protected. Officers efficiently track the progress of investigations and plans.

43. The 'Prevent' duty has a high profile in Thurrock as a result of cooperative working relationships through the community safety partnership. Multi-agency working is supported by a clear 'Prevent' strategy and a thorough action plan that has recently been refreshed. A helpful practitioner guide for direct work with young people was used well with 14 young people in the past year. An excellent equality impact assessment underpins the 'Prevent' agenda. There is strong collaboration between agencies, including the Local Safeguarding Children Board (LSCB).

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

Summary

Greater persistence is required to translate senior managers' goals into improved outcomes for all children looked after. Most become looked after in an emergency, including unaccompanied asylum-seeking children (UASC). The recruitment of foster carers needs to be better targeted. The fact that most children looked after live outside of the borough is having a significant impact on social work time, energy and resources. This is contributing to the generally poor quality of assessments and plans. Children's electronic case files are often incomplete. Family group conferences are not used fully, and the use of the public law outline is not consistently well recorded. The quality of pre-proceedings letters is variable. Assessments completed in support of care or adoption proceedings are generally of a good standard. The length of care proceedings has been reduced, and most are completed within 26 weeks. Good use of special guardianship is providing long-term stability for children and young people.

Most children live in settled and stable placements, but the staying put policy is not yet successful in achieving stability for young people post-18. Good attention is paid to children's health and emotional well-being. Reviews are regular, but children and families do not routinely see social workers' reports beforehand, and there are significant delays in distributing review meeting minutes. Not enough is done to support children to contribute to and participate in their reviews. Children looked after who are at risk of sexual exploitation receive effective help. The response for children who have been missing is inconsistent, and one in five are not offered an interview to explore their issues. The virtual school is not effectively evaluating the educational progress of children looked after. While the gap in attainment between younger children looked after and their peers is narrowing, very few young people looked after achieve five good GCSEs.

Adoption is not routinely considered at the earliest opportunity for all children who cannot safely return home. Once children have a plan for adoption, timely progress is made in recruiting and matching them with adoptive families. Further work is required to improve the volume and range of post-adoption support.
Assessments of care leavers' needs and subsequent plans are not sufficiently detailed and their style does not engage young people. Not all care leavers are supported to gain relevant independence skills. Care leavers do benefit from good day-to-day support, live in safe and suitable accommodation and the number of care leavers engaged in education, employment or training has increased.

Inspection findings

44. Children become looked after when risks increase and they need to be safeguarded and protected. The local authority responds positively to the needs of unaccompanied asylum-seeking children (UASC), who currently account for 23% of the children looked after population. However, too many children come into care in an emergency. These include UASC, for whom it is often not possible to forward plan. However, emergency placements are potentially traumatic for children and undermine the local authority's ability to match them with suitable placements (Recommendation).

45. The number of children looked after has increased from 280 at 31 March 2015 to 336 at the time of this inspection. In a small number of cases, inspectors saw evidence of the local authority having missed the opportunity to prevent family breakdown because it had been slow to intervene. However, when the vast majority of children return home, robust arrangements are put in place to ensure that they are appropriately safeguarded and protected.

46. The local authority is making extensive use of the public law outline, but this is not always well recorded, and the quality of pre-proceedings letters is variable. Some letters identify issues and concerns clearly and concisely, and explain in plain and simple language what needs to change. Others are over-complicated and include jargon and acronyms, which makes them less easy for parents to understand.

47. The creative potential of family group conferences (FGCs) to explore and develop family-based solutions is not being fully realised. FGCs are only used in cases where the public law outline has commenced, and there is a waiting list for this service. As a result, when cases come to court the local authority frequently finds itself under pressure to complete multiple viability assessments.

48. In the last nine months, the weekly threshold panel has become increasingly influential in overseeing potential placement decisions for children looked after. However, it does not retrospectively review all emergency placements, and this limits the local authority's ability to learn from these cases in order to reduce the number of children who become looked after in an unplanned way (Recommendation).

49. The majority of assessments require improvement. Inspectors observed delays in starting assessments, particularly in the case of UASC and older assessments that had not been updated. Assessments completed in support of care or adoption proceedings are generally of a much better standard. Almost all are

timely, take good account of historical issues and concerns, and are strong on analysis (Recommendation).

50. In the majority of cases, children are seen alone by their social worker, the views and experiences of the child are well recorded, and there is good observation and analysis of children's behaviour and interactions, and purposeful direct work. In a minority of cases, there is evidence of poor recording, lack of focus, historic gaps in the pattern of regular statutory visits and, in the case of UASC, delays between children becoming looked after and being seen by a social worker. In 2015, high staff turnover made it difficult for children and young people to build and maintain meaningful relationships with their social workers, and this contributed to drift and delay. According to foster carers, since then the appointment of a number of newly qualified social workers with protected caseloads has made a significant difference. Improved stability of social workers within the children looked after social care teams now means that frequent changes of social workers are now the exception rather than the norm.

51. Until very recently, social workers have not been sufficiently proactive in identifying children, particularly those who are estranged from their families, including UASC, who would benefit from having an independent visitor to befriend, advise and support them during their time in care. Between April and December last year there were 106 requests for advocacy support, all of which were met. Currently, however, nearly half of children looked after who are old enough to do so do not participate in or contribute to their reviews. The local authority has also recognised that further work is required to ensure that children and young people know how, and feel confident to, provide feedback on the services that they receive (Recommendation).

52. While good understanding and awareness of child sexual exploitation, and the need to safeguard and protect children who go missing from care, ensure that risks are identified and assessed, one in five children looked after who go missing are not offered a return interview. The local authority recognises that this is not good enough and is appropriately planning to address the problem (Recommendation).

53. Progress has been made in promoting the health and well-being of children looked after, as evidenced by improved performance figures. For example, dental checks are up from 84% in 2013–14 to 93% in 2014–15, and in 2014–15 86% of children looked after were to up to date with their immunisations compared to only 57.8% the year before. However, confusion about referral pathways and delays in completing the necessary paperwork mean that the

timeliness of initial health assessments (IHA) is still a cause for concern. While the issue is being actively addressed, as of 1 March 2016 approximately 20% of children looked after who were eligible for an IHA assessment were waiting for an appointment and a further 20% were waiting for the necessary paperwork to be completed. This is not acceptable, particularly given the high number of UASC who may not have had their health needs assessed for some time.

54. The local authority and its health partners are developing a more responsive approach to the emotional well-being and mental health of children and young people, including children looked after. Since 1 November 2015, children and families are able to self-refer to a single point of contact. Here, they are offered an effective weekday triage service resulting, for the most vulnerable, in an immediate response from the crisis team, or, in the case of those whose needs are less urgent, in timely clinic-based appointments. Six-weekly looked after children surgeries, chaired by the head of service, make sure that, after initial health assessments have been completed, the education and health needs of children looked after are met.

55. Although 87% of children looked after attend a good school, the virtual school does not consistently analyse and evaluate the information that it collects on the educational progress of children looked after, particularly the 73% of children looked after who attend schools outside of Thurrock (Recommendation).

56. In 2014/15, 80% of children looked after reached a good level of development at the end of the early years foundation stage (EYFS) and performed better than their peers overall. During the same period, the number of children looked after who attained a level 2B+ at key stage 1 in reading dropped to 70% and in writing to 50%. However, the most recent, unvalidated data suggests an improving picture at the end of key stage 2 with 89% of children looked after making the expected two levels of progress between key stage 1 and key stage 2. Although slightly below the average for all Thurrock children, the gap in attainment in reading, writing and mathematics at the end of key stage 2 is closing. The corporate parenting committee has identified the attainment of young people looked after at the end of key stage 4 as a cause for concern. Very few young people achieve five A* to C grades, including maths and English, at GCSE. The prediction that 15% of Thurrock young people looked after would achieve five A* to C grades in 2015/16 has been reduced to a prediction of 10%.

57. The quality of personal education plans (PEPs) is not good enough. The better ones include clear targets with measurable success criteria, and capture the

child's voice and foster carers' views well. The minority that are less good lack key information, include targets that are general rather than specific, and are not always sufficiently individualised for brothers and sisters. While 90% of compulsory school-aged children have a PEP, only 76% of those in Year 12, and 69% in Year 13, have one (Recommendation).

58. When children looked after are missing education, prompt action is taken to find a suitable school place for them. Currently, four school-aged children looked after are missing education. Two of these are not in receipt of full-time education and are accessing suitable alternative part-time provision or tutoring, as part of agreed plans to support them back into full-time education as soon as possible. For the remaining two children, the local authority is working proactively to identify an appropriate education place.

59. Most children looked after live with families. Only 31 (9%) live in residential care. A service level agreement with Essex County Council increases access to foster placements within a reasonable distance of Thurrock. The local authority is aware that it needs to improve long-term stability for children looked after, but inspectors found that most children are living in settled placements.

60. The large majority of placements are of a good standard and are meeting children's needs. Good communication and liaison between carers, placements, schools and social workers ensure that packages of support, sometimes involving a range of different agencies, are well coordinated. Children looked after are encouraged and supported to maintain contact with their birth families, where applicable. In most cases, contact arrangements are clear, appropriate and well recorded. Children looked after are encouraged and supported to participate in social and leisure activities. However, while the local authority has a formal scheme of delegation, it is not being used. In practice, foster carers contact social workers for permission for children to participate in everyday activities. This is wasteful of social workers' time, unhelpful for carers and potentially intrusive for children.

61. The quality of care plans varies considerably. Although most focus on outcomes, the majority are over-lengthy and are neither sufficiently specific nor measurable. This makes it difficult for children looked after to understand or own their plans and, in some cases, contributes to drift (Recommendation).

62. The majority of reviews are timely, purposeful, well attended and well recorded. Independent reviewing officers (IROs) are knowledgeable and experienced, and know the children well. They are concerned by and continue to challenge the fact that children and families do not routinely have the opportunity to read social workers' reports or view proposed changes to their

care plans before their looked after reviews. This is disempowering as well as disrespectful for children. Delays in circulating review meeting minutes are contributing to drift and delay. They also mean that children looked after, and those who are caring for them, do not have ready access to the decisions taken and actions agreed at their reviews. The backlog, which is substantial, is due to a combination of relatively high IRO caseloads and a lack of administrative support, exacerbated by the number of children who are living out of borough (Recommendation).

63. With refreshed marketing and publicity materials, the fostering team has recently renewed its efforts to attract potential foster carers. In the absence of any specific recruitment targets, the general focus is on increasing the number of in-house foster carers who are able to foster older children, and brothers and sisters together. It is too early to evaluate the full impact of the recruitment campaign, but there is evidence of some success in recruiting new carers. The number of expressions of interest in fostering have increased and, in October 2015, Thurrock had 96 fostering households, up from 85 in March 2015 (Recommendation).

64. Prospective foster carers are assessed thoroughly. In-house foster carers are well supported, have good access to training and are subject to rigorous annual household reviews. With training accredited by the University of Essex and support from a clinical psychologist, a skilled group of therapeutic foster carers provide high-quality placements for children who might otherwise need residential care.

65. The quality of evidence and legal applications is generally good. Positive working relationships with the Child and Family Court Advisory and Support Service (Cafcass) and the judiciary are helping to drive down the average length of care proceedings, which has fallen significantly. The large majority are now completed within 26 weeks. This means that children do not have to wait longer than necessary for key decisions to be made about their futures.

66. Achieving permanency is not always clear or straightforward for children, with evidence of delays in some cases and plans being changed significantly in others. In the absence of full engagement from the frontline teams to achieve earlier permanence, the drive and ambition evidenced by middle and senior managers is not yet consistently evident. Inspectors observed a lack of urgency in some cases. The local authority continues to make good and effective use of special guardianship orders (SGOs) to make it possible for children to live with extended family members when it is not safe for them to return to live with

their birth parents. In the last 12 months, 25 children became the subject of an SGO.

67. Staying put arrangements, which enable care leavers aged 18 and over to continue to live with their former foster carers, are not yet fully developed. Only seven young people are living with their former foster carers as part of a staying put arrangement. Lack of certainty about their future is a potential source of anxiety for young people and their carers (Recommendation).

68. The generally poor quality of chronologies makes it difficult for children and young people to understand their life stories. The quality of case records is variable. Key documents including, for example, threshold panel minutes, return home interviews and pre-proceedings letters are not consistently being uploaded to the electronic case record system. This has significant implications for children, if and when they choose to access their records.

69. A small but active Children in Care Council is having an impact. For example, members of the council have been involved in the recruitment of social workers, and in reviewing and refreshing the pledge. They are particularly proud of having managed to secure a commitment from senior managers to include passports, savings accounts and life story work within the new pledge. However, disillusion has led to some young people leaving the Children in Care Council. Currently, the council has very little contact with the many children looked after who are living more than 20 miles outside the borough.

70. In the majority of cases, the service that children and young people receive is sensitive to their individual needs and unique identities. However, social workers are not always sufficiently creative or imaginative in overcoming barriers to communicating with children with disabilities.

The graded judgement for adoption performance is that it requires improvement

71. Adoption is not always considered for all children looked after who are unable to return home. There are initial delays in progressing plans, and early opportunities to secure the child's permanency arrangements have been missed. Consequently, some children have lived with uncertainty for too long. However, it is evident that permanency arrangements for children, either through adoption or SGO, are progressed with a greater degree of urgency once the case is transferred to the permanency team (Recommendation).

72. There has been an increase in the number of children being adopted in Thurrock, from 13 in 2014–15 to 18 in the year to date. Managers are actively working to raise the profile and consideration of adoption and permanence in frontline teams through training, inter-team seminars and case tracking. However, it is too early to see the impact. An adoption and permanency case-tracking tool is also used to improve timely progression through children's social care to adoption. Its effectiveness is limited, as dates and details are not included or updated for all children on the tracker to enable them to benefit from this extra scrutiny.

73. The local authority is committed to pursuing adoption as an option for children with complex needs, and has successfully secured adoptive placements for children with disabilities or who have special needs, brother and sister placements, and a young person in their teens. In the last year, the local authority appropriately rescinded the decision of placement for adoption for one child.

74. There has been an improvement in the length of time that children wait from the date at which they enter care to when they are placed for adoption. For the 2012–15 three-year average this was 625 days, which is 85 days shorter than the 2011–14 period (710 days). However, this figure, while showing a speedier process, is greater than both the national average of 593 days and the government target of 487 days. Similarly, after the court makes an order for a child to be placed for adoption, the local authority now takes less time to place the child in an adoptive family. For 2012–15, this was 186 days, which was 58 days shorter than the 2011–14 period. This is shorter than the national average of 223 days, but longer than the government target of 121 days.

75. The positioning of the adoption family-finding social worker in the permanency team has strengthened parallel planning. A greater sense of urgency is now

being applied to reduce the time that children have to wait before being matched with a suitable family. The local authority has been proactive, and currently 10 children are subject to placement orders and waiting for adoption. One is still in the family-finding stage, six have already moved in with families and three children are linked to prospective adopters, awaiting panel decisions regarding the match.

76. Children are prepared well for adoption. A complete picture of the child, their views and needs are captured well in child placement reports in order to facilitate a positive match with prospective adopters. Detailed introduction plans, although intense for carers, maintain a clear focus on the child. Well-managed arrangements achieve a seamless transition for children into their adoptive families. However, the lack of timeliness in completion of children's life story work in 2015 limited the effectiveness of this work.

77. The recruitment and assessment of potential adopters is thorough and rigorous, and adheres to national regulations. All assessments, including prospective adopter reports, are of a good standard, sufficiently detailed and informative. Adopters spoken to described their experiences as 'stressful', 'rewarding' and 'challenging'. However, prospective adopters waited between seven and 10 months for approval. There has been a lack of clear feedback to adopters across all stages of the recruitment and assessment process, and adopters said that this caused them unnecessary anxiety and stress.

78. The adoption panel is made up of representatives with relevant personal and professional experience of adoption. The panel has appropriately identified areas for improvement in relation to the quality of the medical contribution, quality assurance and support. Improvements in these areas would help to ensure that cases were better prepared for panel and avoid unnecessary delay. The head of service, in his role as agency decision maker, provides oversight and examination of panel information, and his decision-making is clear, concise and timely.

79. The local authority completed a comprehensive appraisal of its adoption services for children and has established a detailed action plan to address the challenges for the service. For example, weaknesses include a lack of 'foster to adopt' and concurrent placements, and the requirement of placements for brothers and sisters and older children who do not match many of the prospective adopters' profiles. As a result, the recruitment, assessment and approval of prospective adopters moved to a commissioned service in October 2015. Thurrock's new and prospective adopters (eight approved, four at stage two, three at stage one and 27 enquiries) have moved to the commissioned

provider, and this transition has been well managed. There is emerging evidence of these new arrangements making a difference, with two children and their prospective carers soon to be presented to panel for matching.

80. Potential adoptive families are provided with effective support when children are first placed. However, once an adoption order has been secured, support is less developed and the range of services are limited. Adoptive parents are not clear about their future entitlements or what support could be available. Over the past year, only 11 families have received post-adoption support, with eight to 10 adults (total 20) attending bi-monthly group support sessions. Support offered includes bereavement support, direct work with children, life story and therapeutic play/work. The quality of this work is valued by the children and adults, but the number receiving support is too low. Thurrock is not meeting its responsibility to ensure that adoption support is available to all adoptive children and their parents living in their area. Inspectors were informed of seven adoption breakdowns for children who were previously adopted through other local authorities but who now live in the borough and are the responsibility of Thurrock. Workers with these young people failed to recognise the need to refer them to the adoption support service or to offer specialist adoption support, which they are entitled to (Recommendation).

81. The local authority provides an impressive support group for adoptive children. This gives them the opportunity to meet regularly, share experiences, gain confidence and learn from each other. Letterbox arrangements for 152 children are in place and effective; birth parents and adoptive parents are supported to maintain agreed levels of contact. Specialist support is also beginning to be secured through good use of the adoption support fund. Since November 2015, 17 applications have been made, nine of which have been successful, primarily for therapeutic counselling support. Five further requests are awaiting an outcome. Adoption support for new carers will be provided by the new commissioned provider. It is too early to evidence the impact of this new offer.

82. The local authority supports families with SGOs well and provides financial support to 133 children's special guardians at the same level as its foster carers. Following the commissioned provider taking over the support of adoptive carers, the adoption support service now has some capacity and has extended its support offer to special guardianship carers and their families. While it is still an emerging offer, the local authority successfully engaged 28 special guardians in a three-day workshop in March 2015, and it has a plan in place to provide regular support groups for adult carers, children and young people.

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

83. At the time of the inspection, the local authority was responsible for supporting 157 care leavers. Of these, 61 were aged 16 to 18, 92 were aged 19 to 21 and four were over 21. Of these, 68 (43%) are unaccompanied young asylum-seekers (UASC), which is a greater proportion than in previous years.

84. There has been a creative decision to place two after-care workers within the targeted youth service, where their line manager and colleagues have great experience of engaging young people in purposeful activities. This has led to a significant improvement in the number of care leavers staying in education, or entering employment or training. Currently, 62% of care leavers aged 19 to 21 are in employment, education or training, compared to 41% in March 2015 (which was lower than statistical neighbours at 51% and the England average of 48%). Effective links have also been established with the local careers centre. Care leavers state that the drop-in sessions at the local careers office give them an insight into writing CVs and getting a job, which is very helpful. However, the take-up and impact of this service is not monitored to evaluate benefit and outcomes.

85. The local authority has appropriate plans in place to increase further the number of care leavers engaged in education, employment and training, through work with the Duke of Edinburgh's Award scheme and Prince's Trust. To date, 10 care leavers have participated in a Duke of Edinburgh's Award scheme programme and just one in the Prince's Trust, so this is still at an early stage of development.

86. After-care workers have a tangible and clear commitment to the care leavers whom they support. They frequently go beyond what they need to do in order to support them. As a result, the local authority is regularly in touch with 89 (97%) of its current care leavers aged 19 to 21, a significant improvement from 2014–15 when the reported figure was 79%. Five care leavers were in custody at the time of inspection. The local authority maintains regular contact with these young people to ensure that appropriate plans can be made for their release.

87. Regular contact with workers who know them well means that young people know where and how to get help if they need it. They feel safe, and any concerns or issues about their safety or well-being are taken seriously. All care leavers who were spoken with as part of this inspection were aware of the risks

associated with sexual exploitation. Their workers know about their situations and act promptly when required, such as in helping their care leaver when faced with a situation of domestic violence or abuse.

88. Assessment records are too formulaic and are not presented in a user-friendly format. The majority of pathway plans do not use the views of care leavers in planning targeted next steps or to suggest how improvements can be made. Young people told inspectors that they lose interest when developing and reviewing their plans, saying that they stay involved in meetings because they like, and do not want to offend, their workers (Recommendation).

89. Plans are not reviewed with sufficient regularity, due to capacity issues within the after-care team. Crucially, plans and reviews neither record longer-term aspirations nor adequately capture educational achievements and next steps that might encourage or motivate young people to attain qualifications or to broaden their horizons. For example, reviews are not suggesting possibilities for apprenticeships at different levels and where these can lead. Information about staying-on rates in school sixth forms and the numbers of those who enter further education or training are not systematically collected. This limits further planning and improvement to help young people make effective transitions through adulthood (Recommendation).

90. Care leavers receive prompt and helpful support for their health and well-being needs, and they know how to access medical help. They receive effective help from a range of services such as counselling, and mental health and sexual health services. They receive good personal support at times of need, and their workers encourage and coax them to persevere. The local authority has invested in a health app to give care leavers access to their health histories. Although this is a promising development, it is not known how many care leavers are using this new technology.

91. Support is limited for care leavers to develop skills for their transition to greater levels of independence. There are currently no groups for care leavers to support them in developing their independent living skills, although work is undertaken on an individual basis. Care leavers are provided with appropriate information, for example when applying for driving licences or passports. The progress in implementing the 'staying put' policy to maintain stability of accommodation and care has been too slow (Recommendation).

92. The large majority of care leavers (92%), including all those who have special educational needs or a disability, live in suitable accommodation. Full checks are made to ensure that accommodation is safe and that young people feel secure. Additionally, managers carry out spot checks effectively to be assured

that agreed measures are being followed by accommodation providers. Close attention is paid to making sure that UASC are housed where they are safe and can access services to help them, such as proximity to colleges to learn English.

93. The local authority gives priority and appropriate help to care leavers when they seek their own accommodation. However, further work is required to ensure that the process for securing local authority tenancies becomes more young person friendly. If issues arise over tenancies, such as rent arrears or unsocial behaviour, workers promptly intervene to minimise disruption, and to make sure that the care leaver learns from the error or misbehaviour and can be rehoused promptly.

94. Care and support for the 18 care leavers with disabilities are effective. They have clear pathway assessments and plans, and benefit from much stability. All are in suitable accommodation, with nine in residential accommodation and nine in foster care. The majority have high needs and attend two local special schools graded as outstanding by Ofsted.

95. Care leavers understand their rights and entitlements, and know what support they can expect from their workers. They told inspectors that this is achieved more successfully through personal contact with their workers than through the written information available about their entitlements, which they described as uninteresting and not engaging. Care leavers, including those with special educational needs or who have a disability, receive a care-leaving grant which helps them to settle into living more independently. The local authority celebrates the achievements of care leavers positively at an annual awards ceremony.

Leadership, management and governance	Requires improvement

Summary

Leadership, management and governance require improvement in Thurrock, because many elements of core business do not deliver consistently good services to children, young people and families. Performance management is unsophisticated. Key data is not sufficiently analysed to provide leaders and managers with a narrative to understand the underlying issues or trends over time, and thereby develop relevant action plans. Of note is the absence of regular case audit analysis. This gap means that an accurate understanding of the quality of practice and any differences between teams or particular aspects of work is missed, and improvements over time cannot be monitored.

The effectiveness of management oversight varies between teams, and this is an area for improvement recognised by the local authority. Steps are being taken to address this, with a number of panels and surgeries set up to ensure that cases are kept on track, alongside the development of management training and initiatives. However, the quality of supervision is not routinely scrutinised.

Strong partnership working is evident, alongside effective corporate and cross-party support for the maintenance and development of services. Swift action has taken place when improvements were identified. This is evident in the response to issues raised during this inspection and the recent appointment of a new DCS.

Commissioning arrangements are robust, and based on a comprehensive analysis and understanding of local needs. This has led to joint commissioning of new services, and detailed scrutiny and evaluation of the effectiveness of services already commissioned. Further work is needed by the local authority to ensure that there is a sufficient range and choice of placements for children and young people, and that specific targets are in place for the recruitment and retention of foster carers.

The local authority uses learning from a range of sources to develop practice, but it does not gather feedback from children and families sufficiently or demonstrate how it has been used to improve services.

The high number of agency staff and vacancy rates within the workforce have prompted the local authority to set up a retention and recruitment board to give this issue continued attention. The local authority is appropriately working with neighbouring authorities to develop joint strategies to reduce instability in the workforce, and has achieved some success in the longer-term teams.

Inspection findings

96. Performance management and quality assurance in Thurrock are underdeveloped. As a result, the local authority lacks a full understanding of the effectiveness of its services to children and families. A range of performance data is available, including a daily snapshot providing basic information such as numbers of children subject to plans and a corporate scorecard, which provides more detailed recording of monthly activity. However, while some documents offer a narrative and analysis, there are too many key areas, such as return home interviews for children who have been missing, in which data is not analysed to consider the key themes behind the figures. The newly appointed interim DCS quickly identified performance reporting and analysis as an area of weakness, and is working with colleagues to develop a strategic model to strengthen this critical area. Despite a regular programme of case auditing within the local authority, the information from these audits has not been evaluated and does not form the backdrop for an action plan. This means that there is an overall lack of clarity about the quality of practice, or improvement and trends over time (Recommendation).

97. Management oversight is not effective across all teams, contributing to inconsistent service delivery. The local authority found that management oversight was less than good in 85% of its own case audits for this inspection. The majority of case supervision records are poor, where actions agreed are not specific enough and workers are not challenged. This contributes to poor quality assessments and delays in progressing plans for children. In the minority of cases that were better, clear decision making is seen, which leads to decisive actions to protect and promote the welfare of children and young people, and to progress plans. When cases were referred by inspectors to the local authority for a review of decision making and actions, these were dealt with thoroughly and swiftly, and detailed action plans were immediately put in place to meet children's needs.

98. The local authority is aware of the variability of management oversight and is taking steps to address this. Senior managers are chairing a number of panels and surgeries to regain management grip, and to ensure that casework is progressed. The local authority also provides specific management training courses for new managers, and during 2015 three new managers received mentoring. A managers' forum is in place, and a new aspiring managers' scheme is being developed to provide training and support for those moving into management roles. This scheme is under development and its impact cannot yet be seen. Staff spoken with during the inspection stated that their

managers are supportive, know about the work they do, and are available to offer advice and guidance when needed.

99. Senior local authority managers, leaders and elected members work effectively together to promote services for children and families in Thurrock. Very clear governance arrangements are established between the key committees and groups, and there is active communication between board chairs, leaders and officers of the council. There is full corporate support for the work of children's services, and this critical function is receiving appropriate focus and prioritisation across the council. For example, through budget setting, leaders have maintained funding for children's services, and the local authority's planning department plays an active part in the Health and Wellbeing Board, helping to promote healthy lifestyles for children.

100. Children's social care receives strong cross-party support from elected members. This engagement is enhanced through monthly meetings between the chief executive and the lead for each political group to ensure that they are informed of current issues. Senior leaders and officers engage in regular discussions and meetings to ensure that key issues are communicated in a timely manner. For example, the head of care and targeted outcomes meets fortnightly with the lead member for children's services to provide an overview of key issues and progress of work undertaken. These meetings are supplemented by more informal discussions when critical incidents occur regarding the welfare of children or staff.

101. The chief executive and lead member have not held formal meetings over the past six months to hold the chair of the Local Safeguarding Children Board (LSCB) directly to account. However, this gap in meetings has had limited impact during what has been a busy time for the LSCB, as there have been numerous discussions between the LSCB chair, council leaders and officers regarding the publication of the recent serious case review, and the DCS and lead member regularly attends the LSCB. These activities have ensured effective scrutiny and oversight of the work of the LSCB and the chair.

102. The successful Health and Wellbeing Board is at the centre of the local authority's work with children, with its strategy providing the overarching framework for the children and young people plan (CYPP). This plan sets out four clear aims, priorities and actions, and gives direction to the Children Partnership Board in promoting and securing children's welfare. Although the Children Partnership Board could evidence its activity in a number of areas, it was not able to show readily the impact of its work or how this linked to the CYPP.

103. The vast majority of commissioning arrangements are robust and based on a joint strategic needs assessment (JSNA), which provides a detailed analysis of local needs. This has led to a clear commissioning strategy with seven priorities linked to the CYPP. Joint commissioning between Thurrock, Southend and Essex, alongside the seven Essex Clinical Commissioning Groups (CCGs), has been effective, for example with the recent commissioning of a children's and young people's emotional well-being and mental health service. In addition, examples of commissioned services within the early offer of help show these services to be making a real difference to the lives of children and families. Services such as those for alcohol and substance misuse, a domestic violence perpetrator programme and a sexual violence service are well evaluated, and contracts are regularly and robustly monitored. Monitoring arrangements consider how far services are meeting performance indicators and improving outcomes, whether they are achieving value for money and whether their work is preventing statutory involvement for children. Service user feedback about these services gives clear indications that individuals feel safer as a result of the help that they have received, and that they better understand the impact that their behaviours have on their children and young people.

104. While there is a good understanding of local needs, there is mismatch between the needs of the children looked after population and the availability of suitable placements to meet these needs. The sufficiency statement does not adequately address this gap and does not contain an updated action plan. This means that there are no set targets for the recruitment and retention of a specific number and type of foster carers to meet the needs of children looked after in Thurrock. Too many children are looked after in placements outside the borough (Recommendation).

105. With strong leadership, the corporate parenting committee is successfully driving improvements on a number of fronts, as evidenced by improved performance figures on immunisations, health assessments, dental checks and return home interviews, and better marketing and recruitment of foster carers. Not afraid to challenge senior managers and leaders, the committee has also listened to the Children in Care Council and is taking action on passports and savings accounts for children looked after. The committee has further work to do to ensure that members of the Children in Care Council feel valued for their contributions, and also to continue to improve timeliness of initial health assessments.

106. Councillors have a good understanding of children's social care and their corporate parenting role. However, this is limited due to the poor quality of strategic analysis of performance information. All 49 councillors in Thurrock

have successfully completed induction training to aid their understanding of children's social care, and 17 have attended corporate training courses. In addition, the lead member meets with the Children in Care Council, and elected members sit on the fostering and adoption panels. However, councillors do not ensure that they regularly engage with children and families to seek their views to inform service development. A recent report to the corporate parenting committee noted that opportunities for senior officers and councillors to attend meetings have not been used, which means that chances to hear children's views have been missed (Recommendation).

107. The overview and scrutiny committee is an effective group, which has increased its workload in order to consider a wide range of issues affecting children and families. The chair ensures that meetings consider a broad spectrum of reports and activities, while maintaining an open slot for the LSCB, Youth Cabinet or health services to bring any matters requiring immediate attention. The group is mindful of local authority spending and has sought evaluations of services and reasons for the development of particular packages of care. It has demonstrated its tenacity by repeatedly raising issues of concern arising from a serious case review.

108. Leaders, managers and elected members have a broad understanding of the service's strengths and weaknesses. Their self-assessment demonstrates a good understanding of the quality of their services to children and families. The local authority shows a willingness to assess its own performance and to bring in external agencies to advise or take on improvement work to augment its work. It has used independent scrutiny, such as a review of the MASH in 2015, and has recently commissioned an external provider to help it to strengthen its edge of care and early help services to seek to reduce the number of children becoming looked after. The local authority demonstrates that it can be swift in responding when change is identified. This was seen during the inspection in the effective response to cases requiring review and the response to a question from an inspector which led to the development of a leaflet for young people to explain the troubled families programme.

109. The local authority actively disseminates learning from serious case reviews, information about practice developments and national research through easy-to-read monthly blogs by the principal social worker. The local authority evidences learning from complaints, with clearly recorded learning logs which set out lessons learned and recommended actions. These have been effective and led to changes in practice, such as better arrangements for transporting children with disabilities, and identification of managers' actions to ensure that work is completed when staff are off sick. Children's and families' views and

feedback are not routinely sought, limiting opportunities for them to inform service development (Recommendation).

110. Despite a workforce development strategy, and a regular retention and recruitment board, the high number of agency staff in Thurrock leaves the local authority vulnerable to staff churn. Currently, half of the social workers employed in Thurrock are agency staff (49 of 98 registered social workers). Some children have experienced delay in progressing their assessments and plans as a result of changes in their social worker. The vacancy rate at the time of the inspection was 21%, which is a slight improvement from 25% at December 2015. Some teams such as the MASH and Children Family and Assessment Teams are predominantly staffed by agency workers, and the past nine appointments have been agency staff. Staff changes mean that teams lack cohesion, identity and resilience when challenges occur. Although this leaves the local authority potentially vulnerable, 22% of agency staff have been in post for over two years, and 51% between six months and one year, which does provide some stability. Conversely, staffing stability has improved within the longer-term teams, with the successful recruitment of a number of newly qualified social workers. Thurrock is taking action and working collaboratively with the 10 other local authorities in the eastern region in an attempt to limit the number of agency staff by managing pay rates, and terms and conditions. The impact of this measure is yet to be seen.

111. Caseloads for workers are increasing and are currently above comparators. They have risen from an average of 16 cases for a full-time worker in 2014 to 18 in 2015, and some social workers currently have caseloads of up to 28, which is too high. This will need further monitoring by the local authority, as it will not assist the recruitment of permanent staff.

112. The continued professional development of staff is actively encouraged, with clear pathways established from the assessed and supported year in employment (ASYE) social workers through to management level. This focus on staff development is a strength of the local authority. The ASYE academy is reported by staff as attractive to newly qualified social workers and, to date, is showing signs of success. An increasing number of newly qualified social workers are joining the local authority (19 this year and 12 last year). They receive relevant training through an increasingly effective academy, and they receive valued individual and group support. Successful use is being made of additional agency social work staff to ensure that caseloads for ASYEs remain low during their first year. Succession planning is being well considered, with the development of mentoring, senior practitioners as practice educators and the current development of an aspiring managers' scheme.

113. A comprehensive training programme is available to staff, and over the past 12 months 390 days' training have been presented across a range of relevant subjects. Figures are collated for the number of staff attending, but the impact of the training is not fully evaluated over time. Specific management training courses are available, such as a management essentials course with a focus on leadership style and priority setting. However, this area of training provision requires additional focus, as management oversight and supervision of staff remains too variable. Of 14 supervision files audited by inspectors, none were judged good, only four demonstrated reflective supervision and only one demonstrated follow up on previous actions. Despite the local authority's awareness of the variability of management oversight and the poor quality of supervision, it is not completing a regular audit of the frequency and quality of supervision. This leaves the local authority unclear about the performance of individual managers and the impact of management training (Recommendation).

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The Local Safeguarding Children Board (LSCB) in Thurrock is effective and innovative, and has a clear understanding of the key safeguarding priorities across partner agencies. A renewal of governance and terms of reference in 2015 has brought helpful clarity and demonstrates continued progress, following a review of the board in 2013. There is a clear collective ownership of safeguarding across all partners, who are positively engaged in action and reflection to support children, young people and their families. The board is chaired well by an influential chair who both supports and challenges partners, and accountability is high. Strong and efficient support is offered by a committed business team. Partners report clear and collective responsibility, and a high degree of challenge, scrutiny and accountability. This was described by one board member as 'good transparency and honesty'.

Child sexual exploitation, female genital mutilation and 'Prevent' duty have a high profile, with key leads from relevant agencies working effectively with the LSCB. Elements of the work of the LSCB, such as the 'Walk on line' roadshows, are outstanding, ensuring that over 10,000 schoolchildren will have received interactive safeguarding workshops of a high quality. The children most at risk of going missing, sexual exploitation, gang involvement and online exploitation are given comprehensive multi-agency consideration. The effective risk assessment group (RAG) demonstrates added safeguarding value. Capitalising on the high degree of multi-agency commitment, it leads case discussion using live access to a range of databases and expertise.

The board considers the range of experiences for children, young people and their families. It has influenced the development of the MASH, the use of appropriate categories for child protection plans and deep-dive audits. These have evaluated the experiences of the most vulnerable, including those who have been on a child protection plan for more than 12 months and children looked after. The chair has challenged MARAC about the lack of a MARAC report to the LSCB for the past two years. This limits the board's ability to monitor the work of this critical multi-agency safeguarding group effectively. The quality of the audits undertaken individually is high, but they lack overarching analysis. The take-up of multi-agency training offered is good, and participants and partners speak positively about the benefits. More analysis is required to enable full understanding of the impact of the training offer.

Recommendations

114. To improve further the strategic learning available from the multi-agency audits through overarching evaluation and analysis of outcomes and impact.

115. To undertake a comprehensive evaluation of the training provided in order to demonstrate the impact on frontline practice.

Inspection findings – the Local Safeguarding Children Board

116. The LSCB in Thurrock meets its statutory requirements well. Governance arrangements were refreshed in 2015, leading to new terms of reference which provide a strong framework for the work of the board. This is also supported by a helpful protocol between the Health and Wellbeing Board, and both the children and adult safeguarding boards.

117. The LSCB works closely with other relevant boards and panels, and has ensured that it has access, either as a member or through an open offer of attendance, at the appropriate groups in order to influence planning. This includes either the LSCB chair or business manager sitting on the Health and Wellbeing Board and the separate health and well-being strategic group, and the community safety partnership group where the 'Prevent' duty is considered, the Children Partnership Board and the early offer of help, MASH and troubled families groups. The LSCB business team apprentice sits on the Youth Cabinet. This enables fully integrated planning and detailed links back to the LSCB executive group and the LSCB full board. A positive action that came from the Children Partnership Board ensured that each school was provided with a height and weight profile to address childhood obesity.

118. The board is able to prioritise and challenge effectively, according to local need, and in the last 12 months has shown impact through increasing the police attendance at child protection conferences. Between April and November 2015, police attended 18 out of 87 initial case conferences. At the time of this inspection, this had increased to attendance at 96% from April 2015 for all conferences. Other recent challenging conversations have focused on the need for equity of funding and an overall increase in funding to manage the increase in serious case reviews (SCRs), oversight of the development of the child sexual exploitation local strategy and action plan, and ensuring the board's proactive involvement in the development and analysis of the MASH. There is a clear business plan for the work of the board, and an action plan appropriately

reflects key local priorities, including missing children, protection from abuse and exploitation, and the early offer of help.

119. Challenge within the board is strong, with agencies held to account through the main board, and the chair demonstrating a strong and assertive style. Partners are challenged collectively through themed discussions at the full board, for example each agency's performance relating to listening to the voice of the child, and the impact of funding constraints and restructuring in individual organisations. This was particularly helpful in enabling probation to explain the transformation of their agency. The police identified a gap in following up with comprehensive victim support in the discussion about the voice of the child.

120. There is a clear challenge to make improvements, if needed, in individual agencies, and the chair demonstrates a strong challenge to the performance of partners. One partner agency described this as 'open, honest. We can fight, disagree and still be okay with each other'. There have been recent challenges to the police, for example, on the speed of their response to actions required by agency-specific inspections. The chair has also challenged when there has been poor attendance at subgroups and the lack of a report from MARAC for the past two years. This has still not been produced. The board challenged children's social care on the low use of sexual abuse as a category in child protection plans and on whether this fitted the anecdotal knowledge of risks to adolescents. This has resulted in an increase in the age profile of child protection plans to safeguard those at risk of child sexual exploitation. The number of 10 to 15 year olds on a child protection plan has risen from 24% to 31%. At the time of the inspection, 12 children (5%) had an open plan for sexual abuse. Numbers were previously suppressed, due to the low figure.

121. The work of the board is supported by the work of the management executive group, where the detail of operational issues and concerns is appropriately considered. As an example, the November 2015 meeting considered the decrease in private fostering figures, the multi-agency review of child sexual exploitation, a report from the youth offending service, risks of legal highs and the planning for feedback from the new child protection level 3 pilot training programme.

122. The performance board subgroup started in March 2015, enabling each partner agency to attend and present data on the safeguarding work of their agency. This is scrutinised by other board members, including the LSCB chair. This has provided in-depth information on the broad range of functions of each agency. This has led to peer challenge and an opportunity for detailed questioning, including, for example the caseloads of midwives, and training on child sexual

exploitation and female genital mutilation for fire, rescue and ambulance services. Board members spoke highly of the learning afforded by the performance board, the impact on understanding partner functions and the rigour of challenge.

123. Section 11 assessments are undertaken annually, and the board flexibly accepts the different formats used by agencies in acknowledgement that many agencies report to three LSCBs within the pan-Essex arrangements. Compliance is high, with very good progress made at the time of this inspection for the end-of-year submission. The board maximises the potential from the returns, and recently (spring term 2016) added a 'Prevent' audit to the school returns. This has enabled specific data to be extracted and used to inform the 'Prevent' duty action plan. A gap in training for school governors was identified and is now being met, with some training having already taken place and more planned.

124. The board has developed a helpful learning and improvement framework with statutory partners. The LSCB carefully considers whether a SCR is required, and demonstrates a strong commitment to learn and improve practice. Over the past three years, this has resulted in the board completing two SCRs, and it is currently in the process of completing a further three. Correct decisions have been made to explore learning through the rigorous SCR journey, resulting in added value to the understanding of safeguarding practice.

125. The SCR subgroup is an effective group and has appropriately checked with the national panel to reach decisions to proceed when there has been a split decision among the subgroup members. The SCRs are undertaken thoroughly and published on the website, and learning is disseminated widely. All of the SCRs and the one individual management review showed appropriate learning and led to a reconsideration of risk. For example, the adolescent neglect tool came from this learning, as did the reconsideration of child sexual exploitation as an increased area for a child protection plan for adolescents. It is clear from this inspection that support to adolescents from the local authority has improved. The majority of social workers are aware of the key issues from the most recent published SCRs. The board also produces excellent summary booklets to maximise learning, with a well-presented high-quality product.

126. If a decision is made that a SCR is not required, but that there are lessons for a single agency, then the board undertakes a management review. One such review has appropriately been undertaken and published in relation to fabricated illness, showing openness in the learning for health partners. All action plans are thoroughly followed up through an action matrix, and the chair presented one SCR to the local authority's overview and scrutiny committee.

127. The financial position of the board has been stretched, with challenges to ensure an equitable contribution from one pan-Essex partner and, additionally, to meet the need for SCRs. The number of SCRs has put added pressure on time and resources. The majority of partner agencies make a proportionate financial contribution overall, and the chair requested a review with one agency when this was not the case, and a constructive solution was found. All agencies have agreed to add finance to the board to meet the demands of the SCRs.

128. All partner agencies are committed to the board, and contribute time and resources to ensure that it functions effectively. The chair is very clear with partners that board business is part of everyone's work. Suitably senior and influential partner representatives attend the board, and are able to take back lessons and challenges to their individual agencies. This has been challenged by the chair previously to ensure that appropriate membership is now in place. Subgroups are chaired across a range of partner agencies, reflecting the collective ownership of the work of the board.

129. The LSCB in Thurrock benefits from being part of the Southend, Essex and Thurrock (SET) shared arrangements, including shared policies and procedures updated and available on the Thurrock LSCB website. Policies and procedures are clear, accessible and easy to understand. Shared resources offer an economy of scale between the three LSCBs as shown through the recent 'I didn't know' child sexual exploitation awareness campaign and sharing of local expertise, including the strategic SET child sexual exploitation group and a strategic SET child death review overview panel (CDOP) group. Child death overview arrangements are effective, and there are strong rapid response protocols in place. The number of notifications in Thurrock have remained consistent over the last three years (10 in 2013–2014, nine in 2014–2015 and nine in the year to date).

130. The Southend, Essex and Thurrock group enables collective pan-Essex learning to be analysed for appropriately focused awareness-raising campaigns. These have included safer sleeping, furniture safety and water safety. The current pan-Essex focus is on suicide prevention, with relevant planning underway using specialist mental health practitioners. There is a very strong commitment and attention to detail in the work undertaken by CDOP. For example, the safer sleeping campaign is launched every holiday with helpful information sent to holiday parks, where usual sleeping arrangements will be different. This is a highly efficient pan-Essex service with a strong commitment to prevention, understanding and to support for families.

131. Local understanding of child sexual exploitation in Thurrock is considered through the developing multi-agency sexual exploitation group (MASE). This subgroup has equipped itself for its task through exploration of the Ofsted child sexual exploitation thematic study and is ambitious to understand the local landscape more fully. This has included, for example, challenging each agency to identify its 10 most vulnerable children or young people, an exercise which revealed a gap in health data. It has also identified the five boys most at risk of child sexual exploitation.

132. The comprehensive child sexual exploitation strategy and action plan have been developed, and these are rigorously overseen through the work of the LSCB. The strategy has been tested during 2015 through both internal and peer review, which showed good steady progress, and the board has further developed the child sexual exploitation action plan in response. Further work will be undertaken, including the prosecution of perpetrators and increased awareness raising. The 'I didn't know' child sexual exploitation awareness-raising campaign was launched during this inspection, and the board works closely with the police. The MASE group has a good understanding of what more needs to be done and this is informed by the detail of the experiences of children through the risk assessment group (RAG). The plan for data analysis will address the need for a more sophisticated 'heat map' of local risks.

133. The RAG established in March 2015 has brought together a number of separate panels that looked at risk (child sexual exploitation, online exploitation and missing children). This effective group has offered a real-time live multi-agency discussion for the most vulnerable children, with immediate access to the range of different agency databases. This approach has enabled a more sophisticated understanding to emerge of the complex overlap between different types of risk. This has resulted, for example, in coordinated intervention when children are referred as being at risk, and also then found to be a risk to others. It has started to reveal more detail on the prevalence of underlying risk, such as children going missing and then found to be affected by gang involvement. A clear action matrix ensures that all actions for each child are followed up effectively. The RAG is chaired by the local authority and is an operational service, sitting under the auspices of the LSCB. This unusual positioning allows the broadest opportunity for referrals from all partners, and harnesses all knowledge and investment from partner agencies in Thurrock to consider and safeguard children. It is working well, with evidence of reduced risk for children who are particularly vulnerable. However, it does not currently consider information from return home interviews.

134. The quality of the multi-agency audit work undertaken is highly detailed, resulting in clear action plans that are effectively followed up. These audits consider a broad range of relevant safeguarding issues across the partnership. These include audits regarding children and young people who have been on a child protection plan for more than 12 months and attendance at child protection conferences. Issues considered demonstrate that the board is aware of key issues across the local authority, and the findings from the audits regarding areas for development are reflective of some of the findings from this inspection, for example management oversight and life story work. Despite good-quality detailed work, the audit subgroup is without a consistent chair and attendance has not been strong. In its role of overseeing the multi-agency audit programme in Thurrock, it has analysed and disseminated learning from the audit programme through a recent learning and improvement booklet, but requires regular multi-agency attendance to ensure a sustained higher degree of overarching analysis and evaluation (Recommendation).

135. The LSCB values the views and contributions of children, and ensures that their views and experiences influence the work of the board. The board is creative and innovative in how it does this, including holding a 'voice of the child' conference in 2013–14 and ensuring that children actively participated in the board's conference in 2014–15. The board, working jointly with the Community Safety Partnership, has recruited 12 safeguarding ambassadors aged 13 to 16, including a hate crime and a youth crime ambassador through the Youth Cabinet.

136. To gauge understanding and risk to children online, the LSCB started a series of roadshows called 'Walk on line' in 2014. These covered the broadest range of risks to children and young people, including child sexual exploitation, grooming, sexting, going missing, cyber-bullying, female genital mutilation and 'Prevent' from a child's perspective. Initially offered to Years 5 and 6 pupils, they were extended to Years 10 and 11 pupils at the request of the Youth Cabinet. 10,000 children and young people have attended, and impact has been shown through changed behaviours such as amending privacy settings, as measured through anonymous child-friendly questionnaires. 'Walk on line' demonstrates a creative and comprehensive understanding of risks to children and young people. This outstanding piece of practice demonstrates a strong partnership approach between the LSCB, education, parents and the specialist police knowledge by the child exploitation online service.

137. A good range of training is offered, and this is valued by partner agencies, with 117 agencies currently participating in the training programme. The LSCB has engaged well with non-statutory partners, including faith groups, and meets

regularly as a member of Thurrock Faith Forum. It has good relationships with local voluntary organisations that access training through the board and are represented on subgroups of the board. Each course is evaluated by the individual participant, and the learning and development subgroup evaluates the effectiveness of specific training through feedback forms. Training is also observed to evaluate its effectiveness directly. Partners are held to account for both their attendance at multi-agency training and the training that each agency offers on safeguarding, but there is no overall evaluation of the impact of the full training offer. This means that the board cannot assure itself that the training offer is having sufficient impact on frontline practice (Recommendation).

138. The LSCB produces a clear annual report that demonstrates a comprehensive understanding of the strengths and achievements of the board, together with work still to be done. Strengths include improved engagement of all types of educational establishments, close partnership work with the Youth Cabinet and the overall steady progress made since the review of the board in 2013. Evidence of impact includes the monitoring of child protection plans and the challenge to increase consideration of sexual abuse, which had been an area for improvement. All agencies contribute their own end-of-year evaluation, including data, to the annual report so that their voices are heard, and they are held to account for the difference that they have made.

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 whom 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 eight of Her Majesty's Inspectors (HMI) from Ofsted.

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