London Borough of Barnet

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: 25 April – 18 May 2017

Report published: 7 July 2017

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

[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

There are widespread and serious failures in the services provided to children and their families in Barnet. Inspectors identified a legacy of widespread poor practice and ongoing systemic failures and services that neither adequately ensure the safety, nor promote the welfare of children and young people.

Threshold decisions are inconsistently made and misunderstood at all levels of intervention. Partners in the multi-agency safeguarding hub do not effectively share information or ensure timely decision making. This causes delay for too many children, some of whom remain at risk of significant harm. Strategy discussions and child protection investigations are of poor quality, with insufficient information sharing between partner agencies to ensure rigorous risk analysis. This results in the risks to children not being fully understood or evaluated. Large numbers of poor-quality assessments result in inappropriate planning, and many children subsequently need a reassessment before they can receive more specialised help and support.

Ineffective analysis of risk and assessment of children's needs, including for children looked after, result in poor care planning that is not focused on outcomes and is unresponsive when children's circumstances change or deteriorate. Poor-quality case recording and oversight of casework by managers, child protection chairs and independent reviewing officers lead to ineffective case work direction. This contributes to drift and delay in the provision of appropriate services for children and their families. There is some effective early help to families. However, early help services are not sufficiently well coordinated or focused.

Since the local authority was last inspected in 2012, there has been a significant deterioration in the quality of service provision. The breadth and depth of this decline were recognised by the current director of children's services. He commissioned an independent diagnostic review of children's services in January 2016. This work confirmed widespread systemic weaknesses in practice.

Following the diagnostic review, action was taken to address concerns. Senior leaders have successfully gained corporate support and resources to make improvements, and demonstrate a sound understanding of the areas for development and a commitment to improving services for children and families in Barnet. Most notably, the authority entered into a collegiate partnership with a local authority that is able to share relevant social work knowledge and expertise. From April 2016, changes to the senior leadership team and a social work improvement board have been established to oversee a broad programme of planned activities to address ongoing deficiencies in service provision and to drive improvement. In October 2016, there was further investment in senior practice leadership to enable a focus on quality of practice and children's experiences. There is evidence of some recent improvements that have been made as a result of these strategies. However, to date, these have been ineffective in improving core standards of social work practice for children and their families.

Oversight of practice by heads of service and team managers is weak. The evaluation of practice is often too positive and minimises the risk to children. Managers do not provide sufficient guidance or direction to improve practice for children or keep children's progress at the centre of their practice. Heads of service and operational directors rarely record their involvement in decision making.

The local authority and partners have prioritised the strategic response to child sexual exploitation and multi-agency working for children at the highest risk. This is overseen by the multi-agency sexual exploitation panel and by the newly created multi-agency REACH team for children at risk of gang affiliation and related violence. However, operationally, the response to children, including those looked after, at risk of sexual exploitation and those who go missing is not consistently effective. The action taken to understand and reduce the risk to them is often delayed and insufficient. Recent improvements in the completion of return home interviews are enabling better engagement with children, but this is still inconsistent.

Multi-agency arrangements are stronger for some areas of service that are led by the council's community safety service. The response to radicalisation is effectively coordinated, and there are high levels of awareness and effective systems. Services for children privately fostered do not meet minimum standards, and responses to homeless 16- to 17-year-olds are too variable, with some children's needs not met.

Decisions for children to become looked after are not always timely. Some children who are experiencing significant neglect remain in the pre-proceedings phase of the Public Law Outline for too long before care proceedings commence. Permanence is not considered early enough or achieved swiftly for many children. Social workers see the majority of children looked after regularly, although not always alone. Most children live in stable homes with carers who meet their needs, although some children are living with connected carers in unassessed situations for too long. Children told inspectors that they are listened to and are happy where they are living. Too few children have a record of their life story. Once children are looked after, corporate parenting is stronger, achieving improvements in the housing provision for care leavers and the timeliness of initial health assessments. Children's achievements are recognised and celebrated.

Adoption is achieved without delay for small numbers of children, and adopters are positive about the service that they receive. The quality of adoption reports for adults and children is not consistent. The information and language used in life-story work are not always appropriate for the age of individual children to understand their histories.

The care-leaving service is in touch with almost all care leavers, and knows and supports them well. Almost all care leavers have suitable accommodation, but although the majority of care leavers are engaged in learning or employment, too many are not. Not enough care leavers know what the local authority pledges to do for them or what their entitlements are, or have ownership of their pathway plans.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates two children's homes. Both were judged to be good in their most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements for the protection of children was in January 2012. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in January 2012. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since May 2015.
- The DCS is also responsible for culture and libraries.
- The chief executive has been in post since January 2017.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since October 2013.
- The function that the local authority has delegated to a third-party provider is the emergency duty service.
- The local authority uses a 'resilience' model of social work.

Children living in this area

- Approximately 93,590 children and young people under the age of 18 years live in Barnet. This is 25% of the total population in the area.
- Approximately 17.4% of the local authority's children aged under 16 years are living in low-income families (HMRC 2014).
- The proportion of children entitled to free school meals:
  - in primary schools is 16.7% (the national average is 14.5%)
  - in secondary schools is 13.1% (the national average is 13.2%).
- Children and young people from minority ethnic groups account for 67.6% of all children living in the area, compared with 30% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Indian and Black African.

[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.

- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 48.7% (the national average is 20.1%)
  - in secondary schools is 38.8% (the national average is 15.7%).

Child protection in this area

- At 31 March 2017, 2,849 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,338 at 31 March 2016.
- At 31 March 2017, 196 children and young people were the subject of a child protection plan (a rate of 25.4 per 10,000 children). This is a reduction from 263 (29.6 per 10,000 children) at 31 March 2016.
- At 31 March 2017, 16 children lived in a privately arranged fostering placement. This is an increase from 14 at 31 March 2016.
- In the two years before this inspection, eight serious incident notifications were submitted to Ofsted and one serious case review was completed.
- There are two serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 31 March 2017, 345 children were being looked after by the local authority (a rate of 38.3 per 10,000 children). This is an increase from 318 (35.8 per 10,000 children) at 31 March 2016. Of this number:
  - 214 (or 62%) live outside the local authority area
  - 40 live in residential children's homes, of whom 70% live out of the authority area
  - 10 live in residential special schools,[3] all of whom live out of the authority area
  - 206 live with foster families, of whom 52% live out of the authority area
  - eight live with parents, of whom 75% live out of the authority area
  - 54 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been eight adoptions
  - 28 children became subject of special guardianship orders
  - 168 children ceased to be looked after, of whom 4.7% subsequently returned to be looked after

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

- 50 young people ceased to be looked after and moved on to independent living
- no children or young people are living in houses in multiple occupation.

Recommendations

1. Ensure a continued and sustained focus on improving core social work practice, strategically and operationally, to equip practitioners and managers to deliver good-quality services to children and their families.

2. Ensure that partners work together in the multi-agency safeguarding hub to ensure timely and accurate information sharing and a consistent application of thresholds for all children referred to children's services.

3. Ensure that social work practice and decision making for children focus on understanding their lived experiences and incorporate their wishes and feelings.

4. Ensure that all children identified as being at risk of harm benefit from effective child protection enquiries.

5. Ensure that strategy discussions include information gathered from all partners, and result in clear planning and recording of actions and the rationale for decisions.

6. Ensure that all written records are clear and up to date, and accurately reflect the circumstances of children and their families.

7. Ensure that the quality of assessments is sufficient to enable an accurate evaluation of the risks posed to children, and that this is regularly updated.

8. Ensure that management decision making is effective and leads to clear, timely and effective care planning that safeguards children and focuses on improving outcomes for them.

9. Ensure that children who are victims of chronic long-term neglect and emotional abuse, and who are subject to long periods of child protection planning, have appropriate risk assessments and plans made for them.

10. Ensure that timely action is taken to understand and reduce risk to children who go missing from home or care and who are vulnerable to child sexual exploitation. When risk does not reduce, or increases, ensure that effective additional safeguarding action is taken.

11. Improve the standard of social work to families under the pre-proceedings phase of the Public Law Outline and ensure that, when there is no improvement within a timescale that is right for children, the local authority issues timely court proceedings to protect them and avoid drift and delay in achieving permanence.

12. Ensure that connected carers are thoroughly assessed within regulatory timescales.

13. Ensure that all children who are privately fostered and their carers are regularly visited, that all work is compliant with minimum standards of good practice, and that the awareness of private fostering is raised in the workforce.

14. Ensure that homeless 16- to 17-year-olds are thoroughly assessed and that appropriate ongoing support is offered to them to meet their needs.

15. Ensure that the oversight of practice by all operational directors, heads of service, team managers, child protection chairs and independent reviewing officers is child focused and effective in achieving positive change for children.

16. Improve children's participation in all decisions and planning that affect them and in future service developments, including their stronger involvement in corporate parenting.

17. Ensure that all children receive help to understand their histories, and that social workers write life-story books and later-life letters sensitively, in a child-focused way.

18. Ensure that children's diversity and identity needs are met and that they are supported to retain their birth language. Ensure that interpreters are used to communicate with them and their families, when needed.

19. Improve care leavers' ownership of pathway plans and the quality and timeliness of targets, to improve their lives. Ensure that care leavers have the tools, such as money management, to cope with life's challenges and are fully aware of the 'Pledge' and their entitlements.

Summary for children and young people

- Too many services for children and young people in Barnet are poor. Senior leaders know this and have started to do something about it by making changes and focusing on recruiting good-quality staff to work with children and young people, but it is taking too long. This means that some children and young people in Barnet are not kept safe from harm.
- Senior leaders, all managers and social workers do not find out enough about what it is like to be a child or young person living in Barnet who needs help or protection. Social workers do not always respond at the right time to help children.
- When professionals tell social workers that children and young people need help, social workers do not always act quickly enough to help them.
- In almost all cases, social workers do not make enough effort to find out what children and young people want or need. This means that plans to help children and young people in need are not very good. It is not clear what is going to happen, or by when, to improve children's and young people's lives.
- Not all social workers are good at working out the risk of dangers to children and young people. They do not always make sure that children and young people are receiving the right services from the right people.
- Social workers' managers do not guide them to make sure that they are getting things right. When they do, they do not always write this down so that they can check that it has happened.
- The majority of children and young people in care live with someone who knows them well, listens to them, looks after them well and keeps them safe. Children and young people told inspectors that they are happy where they are living and that their achievements are celebrated.
- Social workers do not always bring children into care soon enough.
- Young people who go missing from care receive a poor service, because social workers do not find out enough about the risks to them. This means that young people who go missing are not always kept safe enough from dangers, such as gangs or adults sexually exploiting them.
- Once it is agreed that children in care are to be adopted, they receive a good service.
- Young people leaving care receive a better service from members of staff who know them well, find out what their basic needs are and put clear plans in place to meet their needs.

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

Summary

Since the last inspection in 2012, the quality of the service provided to children in need of help and protection has deteriorated. A lack of focus on listening to children in order to understand their experiences is at the core of the widespread and serious failings seen across the service. Risks are not always recognised, and many children live in neglectful or abusive situations for too long.

Threshold decisions are inconsistent at every stage. Partners in the multi-agency safeguarding hub do not work together effectively to ensure timely or effective decision making that is informed by good-quality information. This causes delay in receiving a service, for many children, and some remain at risk of harm because of this.

For many children, when they are identified as being at immediate risk of harm, the strategy discussions and child protection enquiries are of poor quality, with insufficient information sharing and lack of risk analysis. This results in risks to the children not being fully understood or evaluated, poor management decision making, and thresholds not being understood and consistently applied.

Large numbers of poor-quality assessments do not effectively analyse risk, so lead to reassessment and poor planning, therefore delays in the provision of services and poor outcomes for children. Poor oversight of casework by managers and child protection chairs leads to drift and delay for many children, particularly those identified as at risk of harm from neglect and emotional abuse. This means that those children do not have prompt and effective responses when things are not improving. Some children remain in the pre-proceedings phase of the Public Law Outline for too long before appropriate decisions are made about the next steps. Oversight in this area has recently been strengthened, but it is yet to have an impact on frontline practice.

Although the local authority has taken action to improve services for children with disabilities and homeless 16- and 17-year-olds, similar weaknesses in assessment and care planning, and poor management oversight are apparent.

The response to children at risk of sexual exploitation and those who go missing is not consistently effective. Despite some recent improvements, services for children privately fostered do not meet minimum standards, and the response to homeless 16- to 17-year-olds is too variable, with some children's needs not met.

Multi-agency arrangements are stronger for some areas of service led by the council's community safety service. The response to radicalisation is effectively coordinated, and there are both high levels of awareness and effective systems.

Inspection findings

20. Work with children in need of help and protection is inadequate in Barnet, because practice is not child focused. At all stages of children's journeys, the work undertaken with children does not demonstrate enough professional curiosity to find out what is happening to them to ensure a sound understanding of their lived experiences. Social work practice too often describes and documents events and situations without any consideration or analysis of the impact on children or any clear plan of what needs to change to improve outcomes. This inhibits timely and effective intervention and means that some children remain at risk of significant harm. (Recommendation)

21. Not all children receive the right help at the right time. Referrals and concerns to children's services via the multi-agency safeguarding hub (MASH) do not lead to the consistent or effective application of thresholds. This results in delay for many children. For children at the highest level of risk, action is taken quickly to ensure that they are safeguarded. However, for some children, risk remains unassessed for too long. For children who are not at immediate risk, there is delay as multi-agency information gathering takes too long or is incomplete. Children may not receive the appropriate help at the right time and then need more specialised help and support at a later stage, or be repeatedly reassessed before receiving an appropriate service. (Recommendation)

22. Many children identified as at risk of harm do not benefit from effective child protection enquiries. Strategy discussions do not routinely consider sufficient information from partner agencies, and the decisions to proceed to an initial child protection conference are not informed by thorough enquiries. The application of thresholds is inconsistent, resulting in low numbers of children being discussed at multi-agency conferences and some children not being offered intervention at the appropriate level of need. (Recommendation)

23. While some very recent assessments are of better quality, the overall quality of social work assessment is weak. There needs to be more consideration of historical information and analysis of parenting capacity, better consideration of diversity and a focus on the lived experience of children. The impact on children living with the risk posed by parental behaviours is poor, in the majority of cases considered. Decision making is often flawed, as it is based on a poor-quality evaluation of children's circumstances, and this leads to the help not being provided at the right time. (Recommendation)

24. The vast majority of care planning is ineffective. There is a lack of focus on measuring progress for children or their outcomes. When there is no progress, this is not re-evaluated or escalated effectively. This leads to drift and delay. This is particularly stark for a significant number of children who are victims of chronic long-term neglect and emotional abuse, who do not have the impact

of this risk recognised, responded to or reduced, despite spending long periods subject to child protection planning. Examples include children whose chronic neglect is 'missed' due to a focus on a child's disability, and whose parental mental health and learning difficulties lead to drift and delay in instigating the Public Law Outline (PLO) processes. (Recommendation)

25. Some children remain in the pre-proceedings phase of the PLO for too long before appropriate decisions are made about the next steps. The local authority has recently strengthened its oversight of practice within the PLO through a review of all children's circumstances by heads of service. However, decisions to take legal action have not been progressed swiftly for a small number of children, resulting in further drift and delay. This has meant that a small number of children have remained living in circumstances of high levels of neglect for unacceptable lengths of time. (Recommendation)

26. There has been some improvement in the participation of partners at regular core groups and reviews, but meetings are not sufficiently focused on the experiences of children. They do not offer a robust scrutiny of the progress of plans. This means that too many children live with neglect and abuse for long periods without effective intervention from multi-agency practitioners.

27. Poor-quality practice has gone unchallenged until recently. The ineffective management oversight is compounded by the lack of purposeful challenge from independent child protection chairs, who fail to act to address drift and delay for many children. Since January 2017, the local authority has begun to address this lack of effective oversight and is starting to implement change and improvements by strengthening practice leadership. This is not yet evident in the work undertaken with the majority of children.

28. Work with other specific cohorts of vulnerable children reflects similar issues. Services for children with disabilities demonstrate some skilled and sensitive direct work and some good-quality support, but also some examples of poor care planning, and drift and delay for those in need of protection.

29. The response to children at risk of child sexual exploitation and those who go missing has been the focus of recent improvement, but it is not yet consistently effective. Those children identified as being at high risk and regularly discussed at multi-agency sexual exploitation meetings receive a more coordinated response. However, the weaknesses seen throughout the service also result in some children at risk of sexual exploitation being responded to using incorrect thresholds. Consequently, assessment and care planning do not effectively address the underlying issues that place them at risk. Some children continue to be vulnerable to further exploitation, and others are responded to only when the risk has escalated to such a high level that it results in their becoming looked after and being moved to out-of-area placements to ensure that they are safeguarded.

30. Children who go missing from home are now receiving a more consistent response from the new service that undertakes return home interviews, but it is too early for the service to evidence real impact. Information is not evaluated so the reasons and patterns of 'missing' episodes may be understood for some children who are living with their families. The individual interviews undertaken were not used to inform future care plans.

31. The local authority has well-established arrangements, such as the pupil placement panel, to monitor those children missing education. The pupil placement panel has clear records and reasons why children are currently missing from education. The most recent local authority records at this inspection show that 57 children are not in full-time education. The attendance rate from data supplied by the local authority for all children in 2015—16 was around the level of the national rate.

32. Schools receive up to two visits a year from the local authority to support them to understand their safeguarding responsibilities. When children are absent, schools swiftly assess the reasons for absence and, when the head teacher has concerns, they make a referral to the MASH. Managers at the local authority rate schools for risk, for example where there may be clusters or higher volumes of children at risk of child sexual exploitation. Managers at the local authority attend the 'Channel' panel.

33. The local authority keeps accurate records on the number of those children who are being home educated. From May 2016 to May 2017, the number increased by 12 to 155. The manager responsible has a clear oversight of this, and the local authority keeps in touch with all home-educated children and makes visits to most. All children receive 25 hours of learning a week, unless the child can only cope with less, due to specific medical or behavioural needs. There are currently six children looked after in alternative provision. One of these is outside London.

34. The service for 16- and 17-year-olds who present as homeless was identified by the local authority as an area for development, and it is currently being remodelled. Current practice does not yet ensure robust assessment of the needs of this group of vulnerable young people or that suitable plans or accommodation are in place to give them appropriate levels of support. This results in some young people left in situations that place them at continuing risk. (Recommendation)

35. Arrangements for assessing and monitoring children in private fostering arrangements are showing improvement in more recent cases, following the creation in October 2016 of a dedicated social worker position. However, work with children does not currently meet minimum standards. Case records are of poor quality. Records are unable to demonstrate the required checks of carers and there are gaps in the records of initial visits. A small number of children are living in arrangements in which the carers are resistant to social work visits and state their dissatisfaction at the delay and drift on the part of the

local authority. There has been no ongoing work to maintain and raise awareness, and the number of private fostering notifications received by the local authority in the last 12 months have decreased significantly from previous years. The local authority has recently acknowledged this, and work is planned to address this. (Recommendation)

36. There is a range of early help provision that is offering some good-quality support to children. However, the services operate independently and do not offer an integrated early help service that provides seamless support to families. This is recognised and work is underway to develop more integrated, locality-based services.

37. The quality of assessments and plans is variable across the partnership, with stronger-quality work undertaken by social workers in the common assessment framework team. However, the limitations of this resource mean that the model currently requires partners to take lead responsibility for complex situations in families that have recently been at the threshold for social work intervention or straight from the MASH. This often results in children being stepped back up to social work teams when progress is not maintained or further concerns arise. In too many cases, the decision to pass work to early help is not informed by a social work assessment, despite long-standing concerns and lack of progress.

38. Children at risk of domestic abuse in their homes are referred to the multi-agency risk assessment conference, at which an established group of partners regularly share information to provide effective risk analysis. The outcome of meetings is clear and communication is effective, resulting in a good range of services and interventions being offered to families to respond to and reduce risk. However, for a small number of children, the risks of domestic abuse are not assessed or evaluated appropriately, or are minimised, and this leads to ineffective planning to protect them.

39. There is an effective service to respond to allegations against professionals. In addition to raising awareness of the service effectively, the designated officer ensures a rigorous response to concerns from the initial contact through to the strategy meetings to follow up and review. This is effective in dealing with allegations and protecting children from further risk.

40. Systems to recognise and access support for children at risk of radicalisation work well in Barnet, and there is good partnership engagement and information sharing through the 'Channel' panel to ensure that risks are known and children's circumstances are appropriately reviewed. There is good awareness of the risk of female genital mutilation among professionals, with examples of robust action taken to protect children when this is required.

41. An effective out-of-hours emergency duty service operates in partnership with Harrow children's services, employing a range of appropriately experienced

staff. This provides full coverage out of hours to deal with crises such as family breakdown, child protection enquiries and requests for accommodation.

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

Summary

Recent decisions for children to become looked after are appropriate, although not always timely. Some children experiencing significant neglect remain in the pre-proceedings phase of the Public Law Outline for too long before care proceedings commence. When children looked after go missing and are vulnerable to criminal or sexual exploitation, the action taken to understand and reduce the risk to them is often delayed and insufficiently robust.

Permanence is not achieved swiftly for many children. A lack of urgency in completing assessments of parents and connected carers means that a minority of children experience avoidable delay in returning to their families or live in unassessed situations for too long.

Independent reviewing officers' quality assurance of practice is not sufficiently focused on children's experiences, and escalation processes to challenge practice are rarely used. Team managers' oversight of work is irregular and lacks challenge. Consequently, staff do not receive enough guidance to improve the quality and timeliness of the services provided to children.

Social workers visit the majority of children regularly, but do not always see them alone. The quality of assessments is variable and care planning is often delayed or insufficiently clear or specific. The quality of case recording is often poor. Children's identity needs are often not met well and interpreters are not always used when needed. Few children have a record of their life stories.

Most children live in stable homes with carers who meet their needs. Children told inspectors that they are happy where they are living and are confident that they are listened to. The local authority is good at recognising and celebrating their achievements. While almost all children looked after attend good or better schools, too many personal education plans identify the targets insufficiently to evaluate children's progress and achievements.

Small numbers of children are placed without delay to achieve permanency through adoption. Generally, the quality of adoption reports for adults and children is not consistent. The information and language used in life-story work are not always appropriate to the age of individual children to enable them to understand their histories.

The care-leaving service is in touch with almost all its care leavers and knows them well. The local authority provides suitable accommodation for almost all care leavers. Although the majority of care leavers are engaged in learning or employment, too many are not.

42. While recent decisions for children to become looked after are appropriate, they are not always timely. Some children remain in the pre-proceedings phase of the Public Law Outline (PLO) for too long before appropriate decisions are made about the next steps. The local authority has recently strengthened its oversight of practice within the PLO, through a review of all children's circumstances by senior managers, and has established a permanency planning panel to scrutinise children's plans. However, the decisions to take legal action have not been progressed swiftly, for some children, resulting in further drift and delay. When children become subject to court proceedings, the quality and timeliness of assessments and planning for them are stronger. While not quite meeting the national target of 26 weeks, Barnet's performance in September 2016 was 29.6 weeks, in line with the London average of 29.4 weeks.

43. Social workers visit children looked after regularly. Not all workers meet minimum requirements for statutory visits, as some do not take place at the child's home and some visits to children are always made by arrangement. Some children are always seen with brothers or sisters, and not alone. These practices limit social workers' assessments of the children's home environments and mean that some children do not have the opportunity to speak confidentially to their social workers to influence the planning for their futures.

44. Children who go missing from care often receive a poor service. They are not always offered return home interviews to determine any underlying causes and to inform planning to reduce risk. The local authority strengthened and improved arrangements in November 2016, and since then children have been offered return interviews more often, rising, for example, from 23% as at April 2016 to 58% at the time of the inspection in May 2017. However, this service is not routinely extended to the majority (62%) of children looked after who do not live in Barnet. Return home interviews for children placed out of area are completed by a commissioned service that has struggled to meet demand. Outcomes of return home interviews are often not included on children's records. This makes it difficult to use the information gathered from the interviews in safety planning or even to know whether the interviews have taken place.

45. Overall, the local authority is far too tolerant of the risks that children face when they go missing and the risks that they present to others. Inspectors saw examples of children being threatened with violence or being physically attacked, and a small number of children going missing, sometimes for extended periods, without appropriate action being taken to find or protect them. This risks children believing that their experiences are acceptable or that professionals do not care what happens to them. While the local authority provides children with services to reduce specific risks, such as gang affiliation and child sexual exploitation, safety planning is not always timely or sufficient. Provision of services is sometimes delayed and, when children do not engage, the alternatives are not swiftly considered. Consequently, children sometimes

remain in circumstances that are unsafe for too long before it is recognised that the risk is not being reduced and additional action is taken. Inspectors saw examples of the risk of sexual exploitation to children being effectively reduced through placing children at a distance from Barnet. However, such examples were in a minority, and transition planning was not robust for those children when they were due to leave care.

46. Most children (68%) live in foster families and benefit from the experience of family life that this affords. Inspectors saw evidence of carers who know their children well, support them and meet their needs effectively. Carers have delegated responsibility, and this helps to normalise children's experiences. Carers reported that they are generally well supported by supervising social workers, although communication with children's social workers is more variable. Some carers reported delays when unaccompanied asylum-seeking children need age assessments, causing uncertainty about the suitability of arrangements and concerns that adults may be placed with children.

47. The legacy of delay is a major contributory factor in the effectiveness of care planning for children, and contingency planning is not always clear or rigorous. Although some more recent plans contain timescales, this is not yet consistent or embedded. This makes it difficult to hold workers, agencies and sometimes parents to account. Children experience delay in planning for permanence. For some children in stable foster homes, the impact is minimised. However, inspectors saw significant, avoidable delay in reuniting some children with their families, due to a lack of urgency in completing assessments. Some children live with connected carers for extended periods without a full assessment of the suitability of the arrangement, causing uncertainty for all concerned. (Recommendation)

48. Independent reviewing officers' (IROs') oversight of casework is regular and children have timely reviews. IROs visit children between reviews and sometimes are stable figures in children's lives. Children are encouraged to participate in their reviews, and many do so. Reviews for children looked after routinely consider children's contact with the people who are important to them, including previous foster carers. While not always timely, inspectors saw examples of clear efforts made to re-engage family members, when necessary, to the benefit of children. When children's contact requires supervision, support workers provide an effective service that ensures that children's contact with their families is safe. However, IROs' quality assurance of practice is overly focused on process rather than children's experiences. They have not used escalation processes sufficiently when positive change for children is not achieved within acceptable timescales. While the local authority has taken recent action since January 2017 by reshaping the service and refreshing escalation procedures to ensure that IROs have the capacity and skills to be more effective in their oversight of practice, this is not yet resulting in improved outcomes for children.

49. Staff report good informal support by frontline managers. However, in written records, team managers' oversight of practice is variable in frequency and is rarely challenging or effective in improving the quality of practice. This ineffective oversight by managers and IROs is not sufficiently focused on children's experiences. This means that staff are not provided with enough guidance to improve practice standards. (Recommendation)

50. While there is evidence on some case files of very recent activity to ensure that case recording is up to date, too many files overall do not give a complete picture of a child's experience. The quality of case recording is often poor, and it is sometimes not possible to tell from children's records what has happened in their lives or even where they are currently living. Discussions with heads of service are not recorded, so there is no evidence of their oversight of casework, including when children are at significant risk. This risks the out-of-hours services making decisions on casework without access to all relevant information and children not having coherent records of their histories if they choose to access their records in later life. (Recommendation)

51. The completion of life-story work and life-story books for children who do not have a plan of adoption has not been prioritised, and very few children have received the help that they need to understand and have a record of their story in the past 12 months. (Recommendation)

52. The virtual school has a clear oversight of the improvement in learning required for the children looked after for whom they are responsible, both in and out of the borough. It has established strong partnerships with schools and purposeful governance arrangements to improve the scrutiny of its progress and achievement and to raise its aspirations. It has identified salient priorities and ambitious targets for improvement and is taking steps to achieve these targets. For example, there has been an increase in the regular attendance of children looked after at school, although this remains too low, and a reduction in their authorised and unauthorised absence.

53. A high proportion of children looked after go to a good or better school. Arrangements for the few children who require alternative learning provision at the two specialist schools in the borough ensure a range of individualised curricula to meet their diverse educational and emotional needs. There are also some carefully planned initiatives in which children looked after mentor younger children, which helps to improve their behaviour and confidence. The majority of children looked after achieve well in their reading, writing and mathematics by the end of primary school. However, too few achieve sufficient qualifications and high grades or make sufficient progress by age 16 in secondary school. At age 16 to 18, although the large majority are in education and training, too many are not. Managers recognise the need to improve advice and guidance for children looked after to help them to understand all the learning options for them post-16. They are developing apprenticeships and traineeships with partners to increase the insufficient

number of children looked after who follow this employment-focused learning pathway.

54. The proportion of children looked after who are removed from school for a short period is too high, as is that of the small number of these children who are persistently absent. Managers are fully aware of this and it forms part of their improvement plan. The local authority allocates additional funding (the pupil premium) appropriately for children looked after, to provide a range of targeted support to help them to keep up with their learning. Education planning for children looked after has historically been poor. However, teachers and the local authority are now taking full ownership of a recently introduced electronic system, and the quality of personal education plans is improving. Despite this, too many plans articulate the targets insufficiently to enable managers to measure the progress and achievement of children. In addition, a few children do not yet have a plan on the new system.

55. The local authority has recently successfully prioritised improving the timeliness of initial health assessments when children first become looked after. Investment in training for local general practitioners and awareness raising is improving the quality of these assessments. Children receive review health assessments that are timely and provided by dedicated nurses for children looked after, including those children placed out of area. Few children refuse this service, which means that any emerging health needs are identified and addressed. The local authority recognises that children can experience unacceptable delay when they need additional support for their emotional or mental health needs through child and adolescent mental health services. For this reason, the local authority is in the process of recommissioning the service.

56. Children's diversity and identity needs are generally not met well. The local authority struggles to find a sufficiency of placements either within or outside its own resources to match children's linguistic and cultural needs. While this would be a struggle for any local authority, given the richly diverse children looked after population, inspectors saw examples of some basic needs not being met, such as ensuring that a child retains the ability to speak their birth language or that they are always provided with interpreters, if required. However, inspectors saw a few examples of stronger practice with sensitive attention to children's identity needs. (Recommendation)

57. The local authority is home to increasing numbers of unaccompanied asylum-seeking children. At the time of the inspection, 17% of all children looked after were unaccompanied asylum-seeking children. The quality of support and services provided to them demonstrates the same deficits in practice as are seen in services provided to other children. While inspectors saw some examples of children's additional needs being met in a timely fashion, such as support to make asylum claims, this was due to the tenacity of individual carers and social workers, and other children experienced delay. When unaccompanied asylum-seeking children go missing, there is little recognition

of their additional vulnerabilities and, when this is recognised, action agreed is not always taken.

58. The newly reformed Children in Care Council has undertaken some useful and helpful work, such as a recent survey of children looked after, which echoes some of the findings in this inspection. Children spoken to by inspectors are happy where they are living and confident that they are listened to. The local authority is good at recognising and celebrating their achievements.

59. While the local authority has taken action to address drift in care planning, to strengthen quality assurance of practice and to improve responses to children who go missing, this is too recent to improve the quality of service that children receive.

The graded judgement for adoption performance is that it requires improvement

60. Low numbers of children leave care through adoption. Since April 2016, eight children have benefited from permanence arrangements through adoption, including children over five years old, children with complex disabilities, and brother and sister groups. At the time of the inspection, Barnet has a very small number of children in 'foster to adopt' arrangements and 12 children who are placed for adoption.

61. The local authority has identified that permanency planning requires improvement to ensure the earlier identification of plans for children who need adoption. Since October 2016, a permanency-planning panel and a permanency-planning tracker have been introduced to provide more focus and scrutiny. An adoption worker is identified to attend legal planning meetings to improve the timeliness of permanency planning. It is too early to see evidence of positive impact on children's timescales.

62. Once the agency decision maker (ADM) makes the appropriate decisions to proceed to a plan of adoption, the timeliness of adoption work is good, evidenced by a strong adoption performance scorecard. Published figures for 2012—15 show that the average time between a child entering care and moving in with their adoptive family was 472 days, compared to the national average of 593 days and below the national scorecard threshold of 487 days. This performance is continuing in 2016—17.

63. The prospective adopter reports (PARs) seen by inspectors vary in quality. This is acknowledged by the ADM, independent panel chair and adoption team manager. While the large majority of reports seen are detailed and contain all required checks and references, the documents are neither consistently completed in a timely manner nor adequately quality assured before they are submitted to the adoption panel. The large majority contain grammatical and

recording errors, while others lack sufficient analysis of the information presented. The ADM and recently appointed independent adoption panel adviser are robustly addressing the quality of written submissions with the adoption team manager. Joint training with the foster panel is planned in June 2017 to develop workers' skills and knowledge in writing reports.

64. Adopters who spoke to inspectors, including second-time adopters, were positive regarding the preparation, assessment and support received from the agency. Joint recruitment and preparation of prospective adopters, in partnership with the North London Fostering and Adoption Consortium, is supported by a wide range of good information, guides and an easy-to-use website. The joint preparation course is comprehensive and provides adopters with a good, basic understanding of the needs of adopted children. Adopters spoke positively of the learning and insight that they had gained from attending the foundation day and preparation course, and from the assessment process.

65. However, adopters and the service acknowledge some delays in moving between adoption stage one and stage two assessments, preventing some PARs from being progressed in a timely manner. Adoption recruitment has recently been brought back into the adoption service from the recruitment and assessment team to ensure the prompt assessment of prospective adopters.

66. The quality of child permanence reports is too variable. Reports seen contain recording errors and are not routinely updated by social workers. A minority of reports include irrelevant information from brother and sister assessments, and information such as medical adviser comments is missing. Senior leaders are aware that the lack of pre-adoption medicals to inform planning for children requires improvement. A recent paper presented to the clinical commissioning group has very recently led to a decision for resources to be allocated to address this issue.

67. The local authority works well with the North London fostering and adoption consortium to ensure the timely exchange of information and secure appropriate links for children and waiting adopters, resulting in the majority of children living at the earliest opportunity with an adoptive family that meets their needs. Local authority year-to-date figures show that children who wait less than 16 months between entering care and moving in with their adoptive family is 58% (11 children out of a total of 19), continuing the strong performance of 2012–15.

68. Timely family finding and robust matching are effectively scrutinised by the adoption panel, members of which carefully consider their recommendations for approving adopters and matching children. There were almost no adoption disruptions in 2016—17, and learning from the disruption has been appropriately disseminated to staff.

69. The ADM makes timely decisions and appropriately challenges staff when information and reports are not sufficient. The ADM meets regularly with the panel chair to maintain oversight and accountability. Panel members receive annual appraisals, as well as joint training with the adoption and foster panel and teams, to ensure that their contributions remain informed by current practice.

70. The adoption service undertakes comprehensive life-story work and later-life letters. However, the language and images used are not always appropriate to the age and understanding of children, and the later-life letters seen varied in terms of the quality and accuracy of information contained in them. (Recommendation)

71. The adoption service provides a range of effective post-adoption support, including the facilitation of direct contact, letterbox arrangements, birth records counselling and support groups for children, and adopter support. The local authority has been successful in supporting a large number of applications to the adoption support fund, resulting in financial and practical support to sustain permanence.

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

72. The care-leaving team is in touch with almost all of its care leavers (98% in March 2017, according to local authority data). Personal advisers visit care leavers frequently enough to monitor their well-being adequately and provide day-to-day support when needed. The range and skills of staff, many of whom have recently come into the service, match the diverse needs of care leavers. There is a good team ethos and desire to improve the quality of the service, as it has not been effective enough. The local authority undertook a thorough evaluation of provision, including an audit of the quality of pathway planning, and this is leading to a number of positive changes in the service.

73. Planning to help care leavers to move towards independence is insufficiently thorough. Advisers record the events of care leavers' lives accurately, including when care leavers achieve positive outcomes. However, in approximately half of the plans, advisers do not translate their observations effectively into pertinent and timely targets. All care leavers have a pathway plan. A small minority did not have a sufficiently up-to-date one until recently, but this has now been resolved.

74. In too many instances, planning for when children looked after transition into the care leaving service does not sufficiently build on care leavers' prior experiences and achievement, and plans routinely start too late. Too many care leavers do not have sufficient ownership of their plans. (Recommendation)

75. Care leavers receive appropriate healthcare. They receive a health assessment prior to coming into the care-leaving service. The service provides care leavers with access to health visitors for advice on both the dangers of drugs and on sexual health, and there are plans to make an agreement with the family nurse partnership so that older care leavers can access mental health services more easily.

76. The care-leaving service works well with a range of partnerships to support care leavers. Managers, for example, have strong working relationships with advisers who work for the Department for Work and Pensions, which makes following up difficulties with benefit payments easier for care leavers. Managers also work closely with the probation service and youth offending team, and are putting in place a strategy to support one of the two young people currently in custody, who is due for release. The centre holds emergency supplies for when care leavers occasionally need them. Partnership working helped to reduce effectively the risk to two young people who were at high risk of child sexual exploitation. Care leavers have effective support to make sure that they have bank accounts and national insurance numbers.

77. There are insufficient organised learning activities to support care leavers in life skills such as money management, which is an evident need that personal advisers record in many pathway plans. (Recommendation)

78. The centre already holds some events that acknowledge young people's achievement and activities to develop their personal and social skills. Managers have well-considered plans to develop a training centre for this purpose.

79. The majority of care leavers (57% in March 2017, according to local authority data) are in education, employment or training. Some of these are undertaking some well-planned learning. For example, an unaccompanied asylum seeker is successfully completing a course in English for speakers of other languages, and another care leaver is fulfilling a long-held ambition to follow a mechanical engineering course.

80. Managers monitor the attendance and progress of care leavers and their safety in the learning settings in which they study. They have valuable contact with care leavers' key workers in the settings. However, there are too many care leavers who are not in education, training or employment or who do not undertake learning that is right for them. A few do not complete courses, or they follow courses that repeat the same level of learning, and this reduces their ability to improve their life chances. Currently, 43% of care leavers are not engaged in employment or training, and the attempts to re-engage these young people have had mixed success.

81. The head of the care-leaving service is fully aware of the improvements that are required in the quality of the work and services provided. Managers have introduced better governance arrangements, and are introducing new ways of

working to improve corporate parenting and support staff by using group supervision. In addition, they understand that they need to make sure that they further improve the oversight of any risks to care leavers. They also have an honest and self-critical view of what they do well and what requires improvement.

82. Almost all care leavers value highly the quality of accommodation in and outside the borough. This year, 98% of care leavers are in suitable accommodation and the majority live independently. Approximately one in 10 care leavers have remained with their former foster carers after the age of 18. Arrangements for housing in the borough are well established, and the service allocates accommodation swiftly. Care leavers are given a high priority for accommodation and receive a five-year flexible tenancy. A few care leavers stated that their initial temporary accommodation was of poorer quality.

83. Arrangements for the small minority who live out of London are suitable, apart from a few instances in which arrangements have not been so straightforward. Care leavers reported that they feel safe in their accommodation.

84. Care leavers are supportive of the service and trust their advisers. They discussed positively the work that advisers do to help them out. One described their accommodation as a 'palace'. Care leavers said that personal advisers help them well with their day-to-day living. However, too many are unclear about the local authority 'Pledge' and care leavers' entitlements. Care-leaving managers are aware of this, and work is underway to improve the promotion of both. Care leavers gave a mixed response to the usefulness of pathway plans. Again, managers are appropriately aware of the need to make plans a more integral and useful part of young people's futures.

Leadership, management and governance	Inadequate

Summary

Services for vulnerable children in Barnet are inadequate. Leaders and all managers have not yet addressed the legacy of practice deficits to ensure that children are adequately safeguarded. Since the local authority was last inspected in 2012, there has been a significant deterioration in the quality of services that children and young people receive. Recognition and action taken by the director of children's services in January 2016 enabled senior leaders to understand the depth and breadth of the service failures. As a result, the local authority has commenced an improvement programme to promote wholescale organisational and cultural change, focusing on creating the right environment for effective social work to develop. While this has achieved some key elements to support and develop children's services, improvements in the standard of social work practice are much less advanced. Consequently, the quality of service for children in need of help and protection and children looked after is inadequate.

The commissioning of a collegiate partner in April 2016, alongside the creation of a social work improvement board, has established a programme of planned activities to address deficiencies in service provision. Senior leaders have successfully gained corporate support and resources to make improvements, although these have been ineffective in improving standards of core social work practice for children.

A lack of challenge from the Local Safeguarding Children Board has not assisted in raising safeguarding standards in the local authority. The recent engagement of key strategic partners is beginning to assist in improving services for children. However, this is limited, as services are newly commissioned or are at the planning stage, and there is not yet an evaluation of improvement.

The oversight of practice by heads of service and team managers is weak. Evaluation of practice by managers is often too positive and plays down the risks to children. Managers do not provide enough guidance or direction to frontline practitioners to improve outcomes for children or keep children's progress at the centre of improvements. Heads of service and operational directors rarely record their involvement in decision making.

The corporate parenting panel is committed to improving the lives of children looked after but, until recently, had not received full performance information, which limits its ability to challenge any deficits in services effectively. The local authority is beginning to strengthen and stabilise its social work workforce with the creation of new posts and the successful recruitment of permanent social workers and managers. There is more work to do to address the existing culture of poor social work practice.

Inspection findings

85. The local authority recognises that a restructure of children's services in 2014 was wholly unsuccessful in achieving a positive social work service for children. The increased demand for services and a significant number of staff leaving, following the restructure, resulted in widespread instability throughout children's services, contributing to deteriorating practice standards. The extent of the decline was not fully recognised until the recently appointed director of children's services commissioned a diagnostic review of the service in January 2016 and entered into a collegiate partnership with a local authority that is able to share considerable, relevant social work knowledge and expertise. This has enabled and assisted senior leaders to understand the depth and breadth of service failures. Since April 2016, senior leaders have focused on creating the right infrastructure and staffing requirements to support wholesale practice improvement. Improvements include the creation of additional social work posts and teams to reduce caseloads, significant investment in improving the local authority's electronic recording systems and more accurate performance management reporting. In October 2016, there was further investment in senior practice leadership to enable a focus on quality of practice and children's experiences. The very recent improvements are a result of this. However, there is recognition that there is much more work to do to ensure that all managers and staff embed a culture of positive social work practice across the organisation.

86. Senior leaders and elected members demonstrate a clear understanding of areas for development within children's social care, and a commitment to improving services for children and families in Barnet. The local authority has secured ongoing financial support and expertise across the council to support improvements. Collaboration with its collegiate partner and strengthened governance arrangements, including the social work practice improvement board chaired by the chief executive officer, monitor and scrutinise performance in areas already identified for improvement and development.

87. The practice improvement board has successfully promoted structural developments and improved working conditions. However, the accompanying practice improvement plan 2016—17 remains largely focused on management systems, structures and processes. While the local authority is at the beginning of its improvement journey, to date the activity has not focused quickly enough on securing improvements in frontline practice to improve outcomes for children. When practice changes are identified and appropriate action is taken to achieve these, they are not revisited to ensure that improvement is secured and sustained. Other changes, such as the review of the child protection chairs and independent reviewing officers, the review of 16- to 17-year-old homeless young people and the implementation of the permanency planning panel, are still ongoing or are too recent for their impact to have been monitored or evaluated. The local authority recognises that there is still much more to do to ensure that plans sustain the focus on

resolving the significant deficits in frontline operational practice quickly enough. (Recommendation)

88. The local authority's investment in improving electronic systems means that children's services now benefit from access to good-quality performance data. However, monthly reports are lengthy and unwieldly, and do not include analytical commentary to help the focus on required performance areas. Patterns of deterioration and fluctuation of key data in these reports indicate that the local authority is not yet consistently sustaining practice improvement. Weekly reports are circulated to managers for oversight and action. It is not evident that managers and staff routinely use this performance information to support, improve or sustain frontline practice.

89. Quality assurance of casework is now established through auditing and the use of practice weeks over the past year. These have been a helpful development. However, audits are overly focused on process, with insufficient weight given to the impact of poor decision making, creating drift and delay for children. Consequently, findings from audit sometimes give a falsely positive view of practice. This was replicated in the local authority self-assessment that was presented to inspectors. Of the cases audited for this inspection, inspectors considered 40% of the cases audited by the local authority to be over optimistic. While senior leaders demonstrate an understanding of what constitutes good and acceptable practice for children in Barnet, this has not been effectively communicated or translated to staff and managers or integrated into frontline practice.

90. Senior leaders' commitment to reducing caseloads by increasing the numbers of social workers and frontline managers has not yet produced the desired improvements in practice. Social workers report having to 'catch up' on uncompleted work, and changes to their line management arrangements contribute to delays. The practice development worker posts were created in November 2016 with specific responsibility to support and embed changes in practice. All roles were filled until an urgent requirement arose to cover a head of service post. This has limited the success of this initiative. The implementation of a 'resilience' model of practice is currently being established, but it is not used coherently across the service to improve outcomes for children.

91. There is a legacy of poor oversight, and casework direction of practice by managers at every level is weak and fails to drive performance effectively, leading to positive change. Supervision notes seen by inspectors are poor and there is little evidence of the direction given or the actions set by managers or any follow through to ensure accountability, but a revised template is improving the quality. The challenge from child protection conference chairs and independent reviewing officers is too often ineffective, and escalation processes are underused. Senior managers do not routinely record on children's records the direction and decision making. Their involvement in and accountability for decisions reached is not demonstrated, particularly in

circumstances in which children are at significant risk. Poor case recording compounds these failures, and it is not always possible to understand from the records the reasons for decisions or plans. (Recommendation)

92. Arrangements for commissioning services for families appropriately reflect priorities for children within the borough's comprehensive joint strategic needs assessment. Strong commissioning partnerships at a strategic level have ensured that a range of culturally sensitive services are available for children and families. These include services for children and their families in households affected by domestic abuse and drug and alcohol substance misuse. Stronger partnership working is resulting in the early identification of hidden harm and is strengthening multi-agency working. Through the work of the Health and Wellbeing Board, the local authority has successfully secured joint commissioning arrangements with the clinical commissioning group. Together, they have commissioned innovative children's mental health early help services through schools and children's centres, and have ambitious plans to further transform child and adolescent mental health services. However, many commissioned services are still in the planning stages or too new for the impact on children to be fully felt or evaluated.

93. Strategically, there is further work to do to ensure that multi-agency service provision responds more appropriately to meet the needs of children. This includes the need to clarify pathways with all partners to strengthen and embed the early help offer across all services and to secure accommodation to enable the local authority to appropriately discharge its duties to homeless 16 to 17 year olds. More positively, engagement with Barnet's housing providers is leading to better accommodation for care leavers.

94. The Local Safeguarding Children's Board (LSCB), while challenging other partners, has not been effective in challenging the performance of the local authority. Not enough has been done to understand the deficiencies in either practice or the outcomes for children. Recognising the need to strengthen strategic arrangements, the chief executive has been proactive in commissioning a review of the LSCB. A leadership forum to progress recommendations from the review was held with the police borough commander and the chief executive of the clinical commissioning group in May 2017, and it is intended to address these deficiencies and to plan improvements.

95. The links between child sexual exploitation, sexually harmful behaviour, gangs and missing children is recognised at a strategic level, and has resulted in the creation of a new multi-agency team known as REACH. However, more widely, thresholds are not consistently recognised or applied. Frontline practitioners have, on occasions, inappropriately tolerated risks to children at risk of criminal exploitation and interpreted the behaviour of young people at risk of child sexual exploitation as a lifestyle choice. Once a risk of child sexual exploitation is recognised and managed through the multi-agency sexual exploitation panel, more effective protection for children results. The panel's

response also includes successful disruption of perpetrators' activity. (Recommendation)

96. The corporate parenting panel has strong cross-party membership and keeps itself informed of matters relating to children looked after and care leavers. The panel has been effective in championing issues for children, including being instrumental in care leavers gaining housing priority status and progressing the deficiencies in initial health assessments. While securing some successes, its ability to provide effective challenge and scrutiny is limited, as comprehensive performance information is not made available. The DCS has incrementally addressed this gap over the last few months.

97. Young people are involved in corporate parenting panel meetings through #BOP. While they provide a report for panel on their activities, the children require more support to challenge effectively the deficiencies in the services that they receive. Panel processes do not support children to bring individual concerns or complaints to panel members' attention, and members do not have direct links with children. Neither do they routinely attend children in care meetings, so they are missing opportunities to gain insight into the life experiences or concerns of the children in their care.

98. Not all children who would like to make a complaint are able to have support from a trained advocate when they need it. While children are able to access some advocacy support that is available through a commissioned contract, this does not support all children. A detailed report on complaints is reviewed at the children, education and libraries committee on an annual basis. However, as a result of this report, scrutiny and learning have had little impact on changes to practice. Action plans are weak, and progress and impact are not measured from a child's perspective.

99. Involvement of children is reported to be at the centre of many of Barnet's plans, and children are routinely consulted and encouraged to give their views and wishes. However, monitoring to ensure follow through on children's views is very recent and is only now beginning to be embedded. For example, the children in care 'Pledge', created with children, is a detailed list of sound promises with plans for an annual review, but its performance monitoring has only recently been put in place. Involving children and keeping their views and experiences at the heart of their care planning, and evidencing their participation, remain weak. (Recommendation)

100. The local authority has made significant progress with the recruitment of permanent staff at all levels. Effective working relationships and support from corporate human resources have allowed Barnet to successfully reposition itself to attract new workers and to innovatively change terms and conditions to convert agency staff into permanent posts. Most social work and management vacancies are recruited to and are waiting for the formal processes to be completed. The recruitment of suitably experienced senior leaders who have filled the newly created operational directors' posts requires

further consolidation to ensure permanent staffing arrangements. However, the experience of change and churn is still a reality for some teams, and this has an impact on the services provided for children. Social work practitioners have access to a range of training and development opportunities through the Barnet children's academy partnership. However, key basic practice improvement training to support consistent social work practice, while recognised and planned for, is not yet available.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The Barnet Safeguarding Children's Board is inadequate, as it is not effective in discharging all of its statutory functions. Monitoring of frontline practice has been poor and insufficient, therefore the board was unaware of the failings to safeguard children that were identified by this inspection.

The board does not have robust scrutiny of statutory requirements, such as the arrangements for children in private fostering or the monitoring of the quality of multi-agency safeguarding training. The business plan does not include specific actions to drive improvement in how the board discharges its statutory duties. Some annual reports to the board do not provide analysis and do not contribute to action planning. This has not been recognised or challenged by the board.

Some partnership financial contributions to the board have been maintained at a low level, and this prevents the board from funding core safeguarding training and evaluating the quality of training offered across the partnership. This has been recognised strategically, and recruitment for a learning coordinator post has commenced.

The chair has led 'challenge panels' across the partnership to enhance learning from section 11 audits, and themes arising from this are taken forward by the board. However, it was a serious oversight not to have conducted this process for the local authority. The chief executive commissioned an independent review of the board in January 2017 which recommended substantial improvements. A new executive strategic group is due to meet in May 2017 to improve the effectiveness of safeguarding across the partnership.

The learning and improvement framework is not fully implemented, as there is no programme of multi-agency audits. Case file audits in the last year have been infrequent and on a very small scale, and the board has not been provided with partners' own quality assurance findings. The processes to review child deaths work well, and there is an effective multi-agency rapid response to unexplained deaths. The board has published a serious case review. However, inspectors found very little awareness of the 'lessons learned' among frontline practitioners.

The board has historically kept a strong focus on children at risk of exploitation and going missing, and has a detailed strategy and action plan in place. However, the sub-group has not met to advance this work for several months and the interface with other strategic groups is not clear. The board has yet to assess the quality of early help services, although data on common assessment framework assessments is included in a new performance data set.

Recommendations

101. Ensure that a programme of quality assurance is established to monitor the quality of frontline practice across statutory work and early help.

102. Ensure that all partner agencies and their staff are aware of thresholds for intervention.

103. Increase scrutiny and challenge of practice for privately fostered children and raise awareness of the notification process.

104. Ensure that the effectiveness of multi-agency safeguarding training is monitored and evaluated.

105. Review the function of the child sexual exploitation and missing sub-group, and align this with other strategic forums to incorporate children at risk of youth violence and gang affiliation.

Inspection findings – the Local Safeguarding Children Board

106. The Local Safeguarding Children's Board (LSCB), Barnet Safeguarding Children's Board, is inadequate as it is ineffective in discharging all of its statutory functions. It has not assessed the effectiveness of the help being provided to children and their families, quality assured practice or comprehensively monitored and evaluated the quality and impact of safeguarding training for multi-agency practitioners.

107. The governance and structure of the board meet statutory requirements, although there is no clear protocol that sets out the relationship with other strategic groups. The chair is an active member of the Health and Wellbeing Board, and children's needs such as adolescent mental health are prioritised. The board works with community safety to align action plans and avoid duplication. The lead member attends board meetings regularly, but inspectors saw limited evidence of challenge between by the board to the local authority. A wide range of agencies are represented on the board, including the voluntary sector. However, some partners experienced the board as unwieldy, making it challenging to participate in, and they valued opportunities to work in small groups, to be more effective.

108. The board does not have a comprehensive programme of planned multi-agency audits. Two multi-agency audits were completed in the last year, reviewing a total of six social care cases. This has meant that the board does not have sufficient insight into the lived experiences of vulnerable children in Barnet. A very recent audit of domestic abuse highlights areas for practice improvement, but mechanisms are not in place for the board to drive the improvements forward and to hold partners to account. (Recommendation)

109. Quality assurance activity has been focused on developing a comprehensive performance data set, which includes a range of data across the partnership. The relevant sub-group recognises that the analysis of data and trends is an area for development. There is a significant time lag in the data reviewed by the sub-group, which reduces the potential impact of any actions agreed.

110. Securing sufficient financial contributions from partner agencies has been an ongoing challenge for the board. A relatively low level of funding in proportion to the child population has resulted in a very limited administrative capacity. The chair continues to challenge this with senior leaders across the partnership at a strategic level, but it has impacted negatively on the capacity of the board to deliver its functions.

111. The business plan does not include specific actions on core statutory responsibilities. The reliance on annual reports that are of variable quality and depth has not supported a systematic and rigorous approach by the board towards key priorities. The board's plan covers a very wide spectrum of activity, some of which lacks specific outcomes for children.

112. The board has published a serious case review and commissioned a further two serious case reviews. There is evidence of robust decision making and appropriate referrals to the national panel. The board has driven immediate action, when required, ahead of publication (such as a partnership audit of children who are unaccounted for). The chair has shown great tenacity in driving these reviews and there has been good engagement from partners. However, inspectors found limited awareness among frontline practitioners of the 'lessons learned' from reviews, despite the board conducting a number of learning events.

113. There are effective processes to review child deaths. Good partnership working contributes to an efficient rapid response process, led by an experienced designated doctor. The annual report needs to set out more clearly the learning from any deaths that have modifiable factors.

114. Challenge panels have enhanced the section 11 audit process. However, it is of note that a challenge panel for the local authority's children's social care services has not occurred. This is in contrast to evidence of strong and consistent challenge to police, probation and health partners by the board. This has contributed to improvements, such as a dedicated education post in the multi-agency safeguarding hub that is funded by the local authority, and improved identification of parents using drug and alcohol services. The quality of arrangements for privately fostered children has not been sufficiently scrutinised by the board. The board has been unaware of the quality of assessments or compliance with statutory visits. A very limited annual report in 2015—16 indicated a sharp drop in private fostering notifications, but the board has not yet taken any decisive action or held partners to account for this. (Recommendation)

115. Some sub-groups have been at 'stop start' over the last year, due to gaps in key roles such as group chairs. Not all sub-groups have forward plans of their work in progress and how the board drives forward the work of the sub-group or the reporting lines back to the board is not always clear.

116. While section 11 audits monitor the delivery of single-agency safeguarding training, the evaluation of multi-agency safeguarding training (delivered by the Barnet workforce development team for the partnership) is underdeveloped. The relevant sub-group restarted in 2016, and a training programme is now in draft form. This sets out bespoke training aligned to the board's priorities and informed by case reviews, such as recent self-harm in adolescents. There is limited capacity to evaluate the impact of this training or to commission further training. A learning coordinator is currently being recruited to address this challenge. (Recommendation)

117. The board historically played an important strategic role to improve practice in relation to child sexual exploitation, with consistent scrutiny of the return home interviews offer for children who go missing. A problem profile informs interventions, and there is a detailed child sexual exploitation strategy and action plan in place. A 'champions' network has been successful in improving recognition and referrals. However, the sub-group has not met for five months, and specific planned activity of the group is not clear and does not yet reflect youth violence and gang affiliation risks. The sub-group's remit overlaps with that of two other strategic groups and requires alignment to be most effective. (Recommendation)

118. The board has recognised that the lack of formal escalation across the partnership hampers opportunities for improvement. A revised escalation policy was reissued in February 2017, but it is too early to determine any impact. The board launched a revised thresholds document in early 2017, but engagement across the partnership was limited. While numbers of early help assessments are monitored, the board needs to use performance data to understand whether all agencies are responding to needs at an early stage.

119. The board has maintained scrutiny of key priorities, such as domestic abuse, focusing on developing services for adult victims such as independent domestic violence advocates in hospital settings and the effective use of police enforcement powers. However, there has been insufficient focus on children affected by domestic abuse, and the board does not yet understand their experiences.

120. The board launched a neglect strategy in 2016. Champions to combat neglect have been trained and a neglect assessment tool agreed. So far, there is little evidence of impact on practice. The data set does not yet reflect neglect measures, and the take-up of training has been low.

121. A range of schools are very much engaged with the work of the board. A headteacher chairs an online safety working group and the safeguarding leads

have network meetings with the chair of the board. The chair has recruited a second lay member. However, the role of lay members requires further development to ensure that their contributions add value.

122. 'Youthshield' acts as a youth consultative group for the board. Following its survey of young people, the group rolled out 'Healthy relationships' workshops to hundreds of children in local schools. The chair facilitates young people's participation through tabling their challenges and questions to the board.

123. A review of the board commissioned by the chief executive sets out a programme of significant transformation. Recommendations for developing a smaller, more strategic executive group have been positively received by the partnership, which reports that the board membership is too large always to function effectively.

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.

The inspection team

Lead inspector: Louise Warren

Deputy lead inspector: Margaret Burke

Team inspectors: Paula Thomson-Jones, Shirley Bailey, Tara Geere, Steve Stanley, Brenda McInerney, Ian Young

Senior data analysts: Patrick Thomson, Pete McLaughlin, Hywel Benbow

Quality assurance manager: Sean Tarpey

Any complaints about the inspection or the report should be made following the procedures set out in the guidance, 'Raising concerns and making complaints about Ofsted', which is available from Ofsted's website: www.ofsted.gov.uk. If you would like Ofsted to send you a copy of the guidance, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

The Office for Standards in Education, Children's Services, and Skills (Ofsted) regulates and inspects to achieve excellence in the care of children and young people, and in education and skills for learners of all ages. It regulates and inspects childcare and children's social care, and inspects the Children and Family Court Advisory and Support Service (Cafcass), schools, colleges, initial teacher training, work-based learning and skills training, adult and community learning, and education and training in prisons and other secure establishments. It inspects services for children looked after and child protection.

If you would like a copy of this document in a different format, such as large print or Braille, please telephone 0300 123 4234, or email enquiries@ofsted.gov.uk.

You may copy all or parts of this document for non-commercial educational purposes, as long as you give details of the source and date of publication and do not alter the information in any way.

To receive regular email alerts about new publications please visit our website and go to 'Subscribe'.

Piccadilly Gate
Store Street
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk
© Crown copyright 2017