

Central Bedfordshire

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 Board¹

Inspection date: 12 June 2017 – 6 July 2017

Report published: 25 August 2017

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

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

Executive summary

Central Bedfordshire provides good services for children who need help or protection. Senior managers and elected members have created and modelled an open learning culture, engaging staff successfully to drive and sustain service improvement. They have addressed the key areas for improvement from the last inspection and, with strong support from key partners, they lead effective services for children and their families. However, there is more to do to ensure that all children looked after receive a consistently good service.

The director of children's services (DCS) has strengthened her senior leadership team and built a resilient workforce, creating the right conditions to support effective, child-centred practice. Leaders and managers have focused practitioners' attention on working collaboratively with families. Social workers are tenacious in building positive relationships with children, and children speak positively about their workers. Morale across the workforce is good, supported by manageable caseloads.

The senior leadership team has concentrated on improving services linked to key performance targets. As a result, performance in some areas matches or exceeds top-performing local authorities in England. Leaders and managers have not maintained the same level of focus on measuring impact. Quality assurance systems, while established, are less effective, as they focus largely on compliance and not enough on the effectiveness of interventions and impact on children's progress and experience.

The local authority's investment in early help services has been effective in ensuring that children receive support quickly before their needs escalate. The creative use of family meetings across the service at every level, including early help services, ensures that children are supported to remain in their families wherever possible.

When families require statutory intervention, the response from the multi-agency safeguarding hub (MASH) is effective. Partners understand thresholds for services and identify concerns effectively. They work collaboratively with social workers, attending and contributing to child protection meetings in order to keep children safe. Timely, high-quality assessments lead to effective interventions. However, not all assessments and plans are routinely updated in response to children's changing circumstances.

The vast majority of children in need of help and protection receive effective support and their situation improves. However, for a small minority of children, the local authority is not proactive enough in taking decisive action to ensure that timely progress is made. Systems in place to drive pre-proceedings are not yet effective enough in preventing drift or progressing plans for all children.

Most children looked after live with carers who meet their needs well. Placement stability is strong, and many children remain with their carers long term. However, managers have not been effective in ensuring rigorous oversight of permanence

planning for all children and, as a result, some have experienced drift and delay in being formally matched with their carers and securing permanence.

Health assessments and emotional support for most children looked after are well supported. However, for children who are placed at a distance from home, these needs are not sufficiently prioritised. While social workers support children looked after to access education, many personal educational plans lack sufficient detail and are not updated often enough. Supervision and management oversight, though evident on case files, are not always effective in ensuring timely progression of children's plans. Intervention by independent reviewing officers (IROs) and child protection chairs has not been effective in preventing drift or ensuring permanence for all children.

Adoption and fostering services are good, and effective recruitment, training and support arrangements are in place. The majority of children receive the support they need to do well. Effective matching ensures that children with a plan for adoption move to live with their adoptive families in timescales that meet their needs. However, the agency decision-maker does not always evidence the rationale for decisions made.

Support for young people aged 16 and 17 at risk of homelessness is rapid and effective, with stringent efforts to engage family and friends in assessments. Alternative accommodation is immediately secured when required. Social workers advocate well on their behalf. However, their entitlement to request accommodation under section 20 of the 1989 Children Act is not always made clear to them.

Most children at risk of sexual exploitation receive timely, effective support that keeps them safe. Partnership working in this area is strong, led by the local authority chief executive officer and the DCS. Extensive work has taken place across the local authority and the Local Safeguarding Children Board (LSCB) to improve the response to the risks associated with child sexual exploitation. However, there is more work to do to ensure that intelligence from risk assessments and screening tools informs the problem profile. The response to children who go missing is inconsistently recorded. Collated records of missing incidents do not account for every episode; this results in missed opportunities to aggregate intelligence and fully understand potential risk.

Care leavers, including unaccompanied asylum-seeking children, receive a good service. They live in good-quality accommodation and receive effective support from their social workers and personal advisers to help them to feel safe and to make good progress.

Senior leaders demonstrate a strong commitment to engaging children and hearing their views. The impressive and influential Children in Care Council (CiCC) meaningfully participates in service developments and actively supports the work of the corporate parenting panel. The corporate parenting panel is ambitious in championing children's progress but needs to strengthen its challenge and better hold senior managers to account in driving improvements in services for children.

Contents

Executive summary	2
The local authority	5
Information about this local authority area	5
Recommendations	7
Summary for children and young people	8
The experiences and progress of children who need help and protection	9
The experiences and progress of children looked after and achieving permanence	14
Leadership, management and governance	22
The Local Safeguarding Children Board (LSCB)	26
Executive summary	26
Recommendations	27
Information about this inspection	31

The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates two children's homes. One was judged to be outstanding, the other good, in their most recent Ofsted inspections.
- The previous inspection of the local authority's safeguarding arrangements for children was published in April 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was published in April 2012. The local authority was judged to be adequate.

Local leadership

- The DCS has been in post since September 2014.
- The chief executive has been in post since October 2009.
- The chair of the LSCB has been in post since June 2014.
- The local authority uses a model of social work that is strengths-based and relationship-focused and includes motivational interviewing, family group conferencing and restorative practice.

Children living in this area

- Approximately 59,614 children and young people under the age of 18 years live in Central Bedfordshire. This is 22% of the total population in the area.
- Approximately 13% of the local authority's children aged under 16 years old are living in low-income families.
- The proportion of children entitled to free school meals:
 - in primary schools is 8% (the national average is 15%)
 - in secondary schools is 8% (the national average is 13%).
- Children and young people from minority ethnic groups account for 9% of all children living in the area, compared with 21% in the country as a whole.
- The proportion of children and young people who speak English as an additional language:

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.

- in primary schools is 8% (the national average is 20%)
- in secondary schools is 4% (the national average is 16%).

Child protection in this area

- At 31 March 2017, 1,344 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,518 at 31 March 2016.
- At 31 March 2017, 161 children and young people were the subject of a child protection plan (a rate of 27 per 10,000 children). This is a reduction from 225 children (38 per 10,000 children) at 31 March 2016.
- At 31 March 2017, three children lived in a privately arranged fostering placement. This is the same as at 31 March 2016.
- In the last two years prior to inspection, two serious incident notifications have been submitted to Ofsted.
- Three serious case reviews have been completed in the last two years.

Children looked after in this area

- At 31 March 2017, 304 children are being looked after by the local authority (a rate of 51 per 10,000 children). This is an increase from 285 (48 per 10,000 children) at 31 March 2016. Of this number:
 - 128 (or 42%) live outside the local authority area
 - 23 live in residential children's homes, of whom 57% live out of the authority area
 - 211 live with foster families, of whom 49% live out of the authority area
 - 12 live with parents, of whom 33% live out of the authority area
 - 47 children are unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 27 adoptions
 - seven children became subject of special guardianship orders (SGOs)
 - 112 children ceased to be looked after, of whom five subsequently returned to be looked after
 - 27 young people ceased to be looked after and moved on to independent living
 - nine young people ceased to be looked after and are now living in houses in multiple occupation.

Recommendations

1. Improve the effectiveness of frontline managers, IROs and child protection chairs in ensuring that children's assessments are updated in response to changes, plans are progressed and drift is prevented.
2. Ensure that pre-proceedings work is initiated promptly when children's circumstances do not improve and, as part of this, that thorough and holistic assessments are carried out to inform future planning.
3. Provide rigorous oversight and tracking of children's plans when children become looked after, to ensure that permanence is formally approved and achieved in a timely manner for all children.
4. Ensure that the performance management and quality assurance framework is strengthened to provide managers with a clear line of sight to practice and quality in all key areas, including the offer and completion of return home interviews and the use of child sexual exploitation screening and risk assessment tools.
5. Make sure that the corporate parenting panel is routinely informed about issues and areas for improvement, so that it is able to act as a critical friend, challenging and holding to account senior managers and driving improvements in outcomes for children in care and care leavers.
6. Improve the quality of personal education plans by ensuring that actions are based on a clear analysis of need and that targets are precise, detailed and time-bound.
7. Ensure that children's physical and emotional health needs are considered earlier when plans are being made for them to be placed at a distance from the authority, so that they can access any services they need in a timely manner.
8. Ensure that 16- and 17-year-old homeless children are provided with clear information about their entitlements to accommodation and support under section 20 of the Children Act 1989.
9. Ensure the agency decision-maker provides a coherent rationale for all adoption decisions and that this is recorded on children's files.

Summary for children and young people

- Services for children and families in Central Bedfordshire are good. Leaders and managers have built a strong service, where social workers are well trained and supported.
- Children have a strong voice. Their views are heard, and managers take action when they are told that things need to be different.
- When children and families need help, they get it quickly. Social workers try hard to find ways to support families to sort out their problems. Family meetings help children stay with their families whenever this is possible.
- When support does not improve children's situations, decisions are not always made early enough to prevent them becoming looked after in a crisis.
- Social workers visit children regularly. They know the children they work with well and work hard to build positive and lasting relationships.
- Professionals work well together to share information to make sure that they know when children may be vulnerable to sexual exploitation. For most of these vulnerable children, the help and support they receive makes them safer. However, senior managers have more work to do to ensure that all information is shared and that all children who have been missing receive return home interviews when they should.
- When children need to be looked after away from their families, they live with carers who look after them well and help them to succeed. Whenever possible, they live with their brothers and sisters, but sometimes decisions are not made quickly enough about how long they will stay with their carers.
- Children get good support to stay healthy and do well in school. However, when they live further away from home, health support is not provided quickly enough for some children.
- When children need to be adopted, this happens quickly and children live with families that support and care for them well.
- The remarkable CiCC works hard to make sure that senior managers and elected council members hear children's voices and understand their experiences. Because of their work, many services that children receive have improved.
- When young people leave care, their personal advisers keep in touch and help them to live independently. Most young people feel safe and are happy with where they live.
- The local authority has taken action to strengthen advice and support to children, but there is still more work to do to ensure that children are clear about all of the support that they are entitled to.

The experiences and progress of children who need help and protection	Good
<p>Summary</p> <p>Central Bedfordshire is providing a good service to children and their families who need help or protection. Children are offered extensive and effective early help services at the right time to support them within their family networks. There is a clear understanding among local professionals about thresholds for access to social care intervention. A well-established integrated safeguarding and early help hub provides good access to support and a safe and timely response to risk.</p> <p>The response to domestic abuse referrals by children’s social care is rigorous and timely. Social workers demonstrate a good understanding of the impact of domestic abuse on children.</p> <p>Social workers are persistent. They visit children regularly and develop meaningful relationships with them. There is a strong focus on working collaboratively with parents and carers. Good use is made of family meetings to help children remain in their families where possible and to strengthen the support available. Good-quality assessments and plans are evident and provide a strong sense of the child, but they are not consistently updated in response to the child’s changing circumstances. Vulnerabilities, such as parental mental health and substance misuse, are well considered. Pre-birth assessments are a particular strength. Risks are well managed and effective work to safeguard children is evident. However, opportunities to intervene more formally through the use of pre-proceedings are not always taken early enough.</p> <p>When children are at risk of child sexual exploitation, risk assessments for most children lead to effective interventions that ensure that children are safeguarded. Most children who go missing are offered return home interviews, which are comprehensive, with risk well identified and mitigated. However, recording of missing episodes is inconsistent and return home interviews are not always timely.</p> <p>While supervision of social workers is regular, it is not always sufficiently challenging to progress plans and outcomes for children in a timely manner. Clear and coherent processes for managing allegations against professionals ensure that children are safeguarded well.</p> <p>Children who are privately fostered receive an effective service.</p> <p>The local authority provides effective preventative support services for young people aged 16 and 17 who present as homeless. However, their rights and entitlements in respect of accommodation under section 20 of the Children Act 1989 are not always made clear.</p>	

Inspection findings

10. Children in Central Bedfordshire benefit from an effective and extensive range of targeted early help services. Clear pathways established through the integrated MASH and early help hub ensure that families who need support can get it quickly and easily.
11. Timely early help assessments are of good quality and contain relevant and proportionate information. Early help plans are specific, measurable and responsive to children's identified needs. Lead professionals are skilled and competent, identifying need early and providing effective support. Partner agencies own their responsibilities as part of the multi-agency team around the family. When children's needs escalate and require intervention to be stepped-up from early help to statutory services, or when children's needs have reduced and it is appropriate to step down to early help, transitions are well managed.
12. Feedback from parents in receipt of early help support shows that intervention makes a real difference for their children. Through tenacious, sensitive and patient work, skilled early help staff succeed in engaging children and parents, and they support their progress well. Families appreciate the time and investment made.
13. For the vast majority of children supported at this level, good early intervention support prevents the need for escalation to statutory services. Family meetings help to identify support from within family networks and enable children to remain in their families.
14. The integrated MASH and early help hub provide a timely and safely managed response when risk is identified for children. Referral pathways are clear and unambiguous. The vast majority of referrals are dealt with quickly and appropriately. Senior practitioners provide effective oversight of the work, parental consent is sought and managers provide the right level of direction. Children who are at immediate risk of significant harm receive an effective, timely response.
15. Issues in police capacity result in delays in progressing some domestic abuse risk assessments. Although high-risk domestic abuse assessments are progressed urgently to the MASH, and the children concerned are safeguarded effectively, a backlog of lower-level risk assessments from the police was causing delays in referrals for some children at the time of the inspection. The multi-agency risk assessment conference chair has been proactive in challenging police partners, seeking assurance that these issues will be resolved. The local authority and police are taking action, but there is further work to do to eradicate these delays.
16. The response by the MASH to domestic abuse referrals is robust and timely. Social workers have in-depth understanding of the impact of domestic abuse

on children. The local authority shares information about domestic abuse incidents with schools as part of a successful project, ensuring that schools are able to offer children timely and necessary support. Social workers and school professionals undertake sensitive direct work to support the emotional needs of children exposed to domestic abuse.

17. Assessments undertaken are commensurate with need and carried out within the child's timeframe, although they are not routinely updated in response to the child's changing circumstances. While the quality of chronologies is variable, most assessments set out an explicit analysis of risk and protective factors, informed by historical information. Inspectors were able to gain a strong sense of the child's lived experience and the views of parents. Agencies contribute to assessments and particular vulnerabilities, such as domestic abuse, parental mental health and substance misuse, are well considered. Pre-birth assessments are a particular strength, with sensitive and comprehensive analysis evident.
18. When children are at risk of significant harm, social workers take decisive action to safeguard them. The majority of child protection and child in need plans are outcome-focused, clearly setting out responsibilities and timescales for professionals to action. The local authority has recently implemented a strengths-based approach to child protection work, with a clear focus on what needs to change. Core group meetings are held regularly, and there is appropriate multi-agency attendance. In the large majority of children's cases, child protection reviews and core groups are effective in driving plans, and intervention successfully improves their circumstances. However, practice in respect of children living at home whose circumstances do not improve through the child protection process is not consistently robust. The council has a range of effective edge-of-care services in place, and there is a strong emphasis on supporting children in their families. In a small number of children's cases, however, this has been over-emphasised, so that pre-proceedings are not used proactively to try to prevent further escalation and to support early assessment and planning. Consequently, when concerns escalate to the point that a child is considered to be at risk of significant harm, the council is having, in some cases, to make urgent applications to the court, with insufficient pre-loading of key assessments to inform critical decision-making. (Recommendation)
19. Social care services provided for children who are disabled are effective across the range of need, and there are clear and agreed transition pathways to adult services. These services are child-focused and good at securing the views of parents and dealing with their concerns. Comprehensive assessments of children's needs inform funding arrangements, which are agreed at a joint allocation panel. A stable workforce ensures continuity of children's relationships with their social workers and is strengthened by a visible and active service leader.

20. Authoritative action is taken to ensure that children who are privately fostered are safe. Assessments are timely and consider risk and protective factors, children's needs for education and contact with brothers and sisters. However, contingencies are not considered. Support to private foster carers is creative and sensitive, and most placements meet the child's needs. The local authority has in place a range of measures to raise the profile of private fostering, alongside a dedicated coordinator who provides advice and guidance to professionals.
21. An experienced, specialist social worker provides comprehensive support for 16- and 17-year-olds at risk of homelessness. A swift response was evident in all children's cases seen by inspectors, with good liaison with a range of other agencies within and beyond Central Bedfordshire to secure appropriate immediate accommodation with family or friends. However, children's rights and entitlements in respect of accommodation under section 20 of the Children Act 1989 are not always made clear. In response to inspectors' feedback, the local authority took immediate action to address this and to ensure that managers and staff are clear about their responsibilities going forward.
22. There are effective arrangements for safeguarding children when allegations are made against professionals and carers. The designated officer provides appropriate advice and proportionate follow up. When concerns progress to referral, the management of allegations is robust and children are kept safe.
23. An effective out-of-hours duty service shared with two neighbouring authorities helps to ensure that children are well supported. Children's social care teams only transfer cases to the out-of-hours service in exceptional circumstances. For the most part, social workers continue to work intensively at evenings and weekends, visiting as required to ensure that children can remain safely in their families.
24. Children are safeguarded well through multi-agency public protection arrangements, which ensure good inter-agency risk analysis and timely information-sharing. Although local authority staff provide the necessary information to support effective decision-making, their attendance at meetings is not consistent.
25. In most instances, steps are taken promptly to safeguard children who are at risk of sexual exploitation. Child sexual exploitation risk assessments inform effective and appropriate responses. Consultation and information-sharing with the child sexual exploitation coordinator help professionals to share intelligence and identify linked children and risky adults. In a very small minority of children's cases, a delay in undertaking risk assessments meant that the response they received was not sufficiently rigorous.
26. Return home interviews for children who go missing are not always timely, although when completed they are mostly comprehensive, with risk identified

and mitigated well. Not all missing incidents are recorded, making it difficult for senior managers to have a full picture of the prevalence of these incidents. (Recommendation)

27. At the time of inspection, 334 children were being home educated. Staff carry out home visits and provide a detailed information pack for families, helping parents to ensure that the home education is a broad experience for their children.
28. Well-established, thorough procedures ensure clarity regarding any action required for children who are missing from education. At the time of the inspection, the authority had identified 46 such children. Children's records are clear and the key issues understood. Work is conducted by a range of internal and external agencies to bring these children back into education or to establish that they are no longer in the local authority's area. Many of those missing education are from a traveller background, and staff work well with their community to provide tuition for these children.
29. The local authority and its partners have appropriate procedures in place for children who may be at risk of radicalisation. A programme of training has been used to raise awareness of the 'Prevent' duty, and good use is made of train-the-trainer programmes to maximise impact and take-up. Staff work well together and with a wide range of other agencies to share information and support good practice.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Requires improvement to be good</p>
<p>Summary</p> <p>Most children looked after live in stable, good-quality placements with carers who meet their needs well. However, in its efforts to support children to remain with their families, the local authority does not consider pre-proceedings early enough when care might be required. Once initiated, care proceedings are timely, concluding on average within 27 weeks. When children return home in a planned way, risk assessments ensure that this is safe for them.</p> <p>Some children experience delays in having their plans for matching with permanent carers formally approved. Performance management systems have not been effective in reducing this delay or identifying where drift is occurring.</p> <p>Effective foster carer recruitment, together with good support and training for carers, is leading to an increase in in-house fostering households, although there is a lack of parent and child placements.</p> <p>When a plan for adoption is agreed, children move quickly to live with their adoptive parents. Adoptive parents and birth families benefit from good-quality adoption support.</p> <p>Stable teams of permanent social workers provide continuity of support to children. Social workers receive regular supervision, although managers do not sufficiently identify or challenge where children’s plans are drifting or when children’s records are not updated or accurate. Children’s plans are regularly reviewed and their IROs make every effort to keep in touch with them before their reviews. While reviews are timely, IROs do not always identify where drift and delay are occurring or challenge the quality of the reports that social workers provide.</p> <p>Children’s education needs are well met, although personal education plans do not reflect children’s needs or the ways in which desired outcomes are to be achieved clearly enough. Children’s health outcomes are good. However, access to physical and emotional health assessments and support is more challenging when children live at a distance. When children go missing or are at risk of child sexual exploitation, risk assessments are undertaken, but return home interviews are not always timely. The CiCC is a highly enthusiastic and committed group of children who have directly influenced the improvement of services.</p> <p>Care leavers live in safe, good-quality accommodation. Their physical and emotional needs are well met and they receive good support to access employment, education and training.</p>	

Inspection findings

30. The local authority takes decisive action to respond to immediate risk of harm, and decisions to take children into care are appropriate. However, a lack of consistent use of pre-proceedings results in some children becoming looked after in a crisis, without key assessments carried out in sufficient depth to fully inform initial decisions by the court about whether children should be removed from their parents' care. (Recommendation)
31. Despite delays in initiating pre-proceedings in some children's cases, care proceedings are timely and well managed. In the last 12 months, the vast majority of children's cases have concluded on average within 27 weeks, and the court has agreed the local authority's final care plan for most of these children. This demonstrates that the local authority's interim plan for removal was correct, but not well enough evidenced at the interim stage.
32. When children return home in a planned way, risk-based assessments are undertaken to ensure that it is safe for them to do so, and purposeful visits and ongoing support are provided for as long as necessary.
33. There are delays in progressing permanence plans for some children. In these circumstances, children are uncertain about their futures, although the impact of this is lessened for those who experience stability by remaining with the same carer. Processes for ensuring management oversight and regular review have not been systematically effective for children in short-term arrangements, including those in residential care. Spreadsheets currently used are inaccurate, and they do not evidence where drift and delay are occurring. Senior managers responded swiftly to these concerns during the inspection and took decisive action to strengthen oversight for children who do not yet have a permanence decision. (Recommendation)
34. Children benefit from consistent relationships with their IROs. Children's plans are regularly reviewed, and their IROs make every effort to see them before their review. Although reviews are timely, IROs do not always identify where drift and delay are occurring or challenge the quality of the reports that social workers provide. Not all reports provide sufficient information about children's progress or consider where their needs have changed. Resultant plans do not consistently focus on the outcomes to be achieved or the timescale for the child. Children are encouraged through a variety of methods to participate in their reviews. A newly commissioned advocacy and independent visitor service is available to children. Although the number of children accessing these services is increasing, overall numbers are still low.
35. Short- and long-term placement stability is good. This enables children to remain at their schools whenever possible, and maintain contact with family and friends when appropriate. Children experience regular contact with their families, supported by an effective commissioned service that manages risk well and is responsive to children's needs. A large majority of children are

placed with foster families and live either locally or within 20 miles from home. The use of independent fostering agencies increases the pool of available foster carers, increasing choice and avoiding delay for children.

36. Good use of family meetings helps to identify family placements. Viability and connected persons' assessments are very thorough, and fostering team social workers are skilled in supporting prospective carers to prepare for their roles. Children's social workers and fostering social workers jointly write connected persons' assessments. This ensures rigorous consideration of the carer's ability to meet the child's current and future needs. Although special guardianship arrangements are supported, family carers are not consistently encouraged to apply for SGOs to provide legal permanence for children.
37. The local authority has developed its use of in-house and independent agency carers, to ensure that effective placement choice is available to match current and future demand. This includes placements for unaccompanied asylum-seeking children, brothers and sisters and disabled children.
38. Foster carers value the stability and support of their supervising social workers, who always 'do what they say they will do'. Assessments of foster carers are timely and thorough. Supervising social workers visit carers regularly and work closely with children's social workers to promote placement stability. A dedicated group of foster carers routinely provides other carers with respite care. This has been effective in promoting the stability of placements in very challenging situations. Foster carers receive good training to help them to understand attachment theory and the impact of trauma. The number of placement disruptions is low, and learning is used to improve practice. The independently chaired fostering panel is effective. It has a dedicated panel adviser, who ensures that all reports are of a suitable standard. The central list of panel members includes experienced individuals from a range of diverse backgrounds. The panel is consistently curious and uses penetrating questions to assure members about the quality of the work.
39. Most children benefit from good relationships with social workers who know them well. Statutory visits to children are regular, but recording of these important visits does not always comply with visiting guidelines, or fully evidence the extent of the direct work that takes place with children. Caseloads are appropriate and provide opportunities for relationship-based work, including social workers accompanying children in activities, such as horse-riding and ice-skating. Much care and thought goes into celebrating children's birthdays and their achievements.
40. Social workers receive regular supervision and value the support they receive from their managers. However, some supervision records are compliance-led, emphasising key performance indicators without sufficient focus on the quality of social work interventions and on the difference they are making for children. Supervision does not consistently drive children's plans or challenge

a lack of progression of key actions. This contributes to drift and delay in some children's plans. (Recommendation)

41. Most children's health needs are well met. Initial and annual health assessments are timely for the vast majority of children. A small number of children placed at a distance have experienced delays in having their health needs assessed or met. The designated children looked after nursing team continues to challenge these delays, but late notifications of new placements by some social workers reduces the team's capacity to ensure that health arrangements are in place. (Recommendation)
42. Children living within the local area receive support from a dedicated child and adolescent mental health service worker, who coordinates triage and support for children in care. However, there are delays in children receiving treatment. Bespoke packages of support have been commissioned for children on an individual basis when they are looked after. Strengths and difficulties questionnaires are completed for all children looked after; the scores that these generate are better than national averages and indicate an improving picture in relation to children's emotional well-being.
43. Children who go missing from care or who are at risk of sexual exploitation are safeguarded effectively. Risk assessments are undertaken and strategy meetings held where appropriate. Return home interviews are not recorded consistently. This means that opportunities to gather information and intelligence about children's experiences and whereabouts can be missed. Performance information does not include all missing episodes; this makes it difficult to provide an accurate missing profile of children in care. (Recommendation)
44. Children's social workers work effectively with the youth offending service to try to prevent offending behaviour. When required, the service supports children who have committed offences; currently 11 children are being supported in these circumstances, a reduction from 14 children in 2015–16.
45. The virtual school provides good support for children in care. Primary-age children looked after achieve very well at key stage 1. They achieve nearly as well as other children, and staff are working to close this gap further. They achieve less well at key stage 2. At the end of secondary school, key stage 4, attainment figures are lower for children looked after than their peers nationally. Virtual school staff provide rigorous challenge to schools about the help they are giving to children looked after. Staff have been successful in significantly reducing the number of days children looked after lose education as a result of fixed-term exclusions. No child looked after has been permanently excluded. None of the children on the active register for children missing education are children looked after. All children looked after are receiving 25 hours of education, or more, a week. The attendance of children looked after at primary schools is very high, and the virtual school has been effective in improving their attendance in Years 10 and 11. Pupil premium

funding is used to best effect to help children looked after make progress, and the virtual school evaluates the impact of schools' use of this funding.

46. Personal education plans require improvement. For too many children, actions are vague and timescales not clearly defined. Targets lack clarity and are not precise. (Recommendation)

<p>The graded judgement for adoption performance is that it is good</p>
--

47. Children in Central Bedfordshire for whom adoption is the right plan receive a good service. Adoption is considered promptly for all children looked after, including children whose brother or sister has previously been adopted. In the last 12 months, 27 children have been adopted; of these, 15 children had additional complexities to consider when matching with adoptive families. This is an improving trajectory. At the time of the inspection, all children waiting for adoption were either matched or linked with prospective adopters.
48. Family group meetings support early parallel planning for children effectively, by helping to ensure that potential adopters come forward at the earliest opportunity. Effective viability and connected persons' assessments result in detailed evaluations of the options for permanent placements. Good oversight of these processes enables managers to anticipate and match the needs of children with potential adopters at an early stage. As a result, the local authority is matching children quickly with prospective adopters and has consistently reduced the time taken between children entering care and moving in with their new families.
49. Recruitment and preparation of adopters are effective. In the year leading up to the inspection, 18 adopter households from diverse backgrounds were approved, most of whom were matched or linked with Central Bedfordshire children. Staff respond promptly to enquiries about adoption. Historical delay in the first stage of the assessment has now been addressed, and newly approved adopters are satisfied with the time taken for assessment. Most prospective adopters undertake voluntary work to increase their experience with unrelated children. This has strengthened the assessment process and enabled applicants to use their experience to reflect on their understanding of children's needs. As a result, potential adopters have been willing to consider a broad range of children, including disabled children and sibling groups. Adopters are encouraged to undertake a wide range of training on offer to increase their skills, and they report that this is of high quality.
50. Assessments of prospective adopters are consistently strong, and there is good use of curiosity to explore personal histories and motivations to adopt. Reports clearly analyse adopters' strengths and vulnerabilities and ensure that the matching process is robust. A full range of checks is undertaken to ensure

that children placed are safeguarded. There has been a strong focus on seeking to recruit prospective adopters for fostering-to-adopt, which is discussed as part of the assessment. In the last year, three children were adopted from foster-to-adopt placements, benefiting from reduced placement moves and promoting children's attachments.

51. Monthly matching project meetings with the regional consortium have enabled the authority to increase the pool of adopters available for children and to make inter-agency placements without delay. To strengthen family finding, staff make referrals to national and regional systems three months after approval, if there is no local match.
52. Child permanence reports are of high quality and describe the needs and attributes of children effectively. This ensures that successful matches are made to potential carers. Children are prepared well for adoption. Most have a 'wish you well' visit with birth relatives who, in many cases, also meet with prospective adopters. Introductions are sensitively managed and paced to meet children's needs. Birth parents are encouraged to accept counselling for support.
53. The adoption service comprises a stable team of experienced, well-trained professionals, who provide a highly effective service. Adoption social workers work closely with children's social workers to achieve a comprehensive understanding of the child's needs and the adopters' strengths and potential vulnerabilities. This thorough approach ensures that matching decisions are effective. Adopters are extremely positive about their experience. They value their social workers, their experience at panel and the support that they receive.
54. The well-run adoption panel is effective in improving practice standards within the authority. Under the leadership of an experienced independent chair, it scrutinises information provided and carefully considers recommendations made. All reports to panel are rigorously quality assured by the panel adviser, who also provides training to staff. Minutes are thorough and evidence the recommendations succinctly. The chair provides an annual report to the authority, including recommendations for improvement. Learning from previous adoption disruptions is used to improve practice standards. For example, the panel now gives closer attention to support for inter-agency placements.
55. The agency decision-maker is challenging and child-centred in his decisions, but does not record the rationale for his decisions. This would make it difficult to explain decisions in the event of a challenge and results in a lack of a clear record on file for the child. (Recommendation)
56. The adoption tracker is not effective in supporting senior management scrutiny of the whole adoption process. It does not include all children for whom a decision has been made by the agency decision-maker, or extend

oversight of the child beyond the adoptive placement. As a result, some adoption decisions have not been rescinded when the child's care plan has changed. This has not stopped revised care plans for children being progressed.

57. A good range of adoption support is available, including specialist therapy and support for disabled children. Adoption social workers are trained in therapeutic techniques, enhancing their contribution to post-adoption support. Adopters receive a quarterly newsletter, and there are annual seasonal and celebrational events. The adoption team is currently supporting 30 children. Life-story books and later-life letters are routinely provided when the child is adopted. The vast majority of life-story books are creatively presented and thoughtfully written and contain suitable information to support the child in their developing attachments and identity. A minority of later-life letters are overly long and too blunt in their narrative. Careful consideration is given to post-adoption contact, and 121 children currently benefit from these arrangements.

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

58. Care leavers are safe and feel safe. They are confident young adults who have pride in themselves. The local authority takes seriously the need to engage with care leavers, hear their views and to celebrate their achievements, for example at the annual awards ceremony. Care leavers appreciate the contact they have with senior leaders, who are rightly proud of them.
59. Personal advisers support care leavers very well and help them to understand their choices. For example, one care leaver found their own independent accommodation, but staff identified that this location would put the young person at risk, and helped them to find good alternatives. Care leavers understand the risks associated with their behaviour and what they can do to improve their lives. Those who are at risk of harm are supported effectively to reduce such risks.
60. Pathway planning is good. Plans provide a rich picture of each young person. Case histories are very detailed. Care leavers are fully involved in producing their pathway plans, and their views and experience shine through. Transition planning is good, and staff ensure that there is always an overlap to ensure continuous support. Pathway plans provide a detailed analysis of care leavers' health needs and show how they will be met. Basing a lead mental health practitioner in the care leavers' team has helped to ensure smooth transitions for young people from child and adolescent mental health services to adult mental health provision.

61. All care leavers are supported by a personal adviser and a member of the council's youth support team. These arrangements work well for young people, including those who have learning difficulties and disabilities.
62. Care leavers have had to wait too long for access to their health records and health histories. The local authority is addressing this by introducing 'health passports' for young people. This is a recent development, and only a minority of care leavers had received these at the time of the inspection.
63. The local authority works well to ensure that care leavers develop the skills needed for independent living. Foster carers and semi-independent accommodation providers support young people with a range of training and development to help them work towards independence. Care leavers spoken to are rightly positive about the help and support they receive from social workers and personal advisers, who have a detailed knowledge of their needs.
64. The local authority supports young people effectively to remain looked after until their 18th birthdays and a high proportion do so. Good support for young people ensures an effective progression to independence. Accommodation for care leavers is appropriate to their circumstances. However, the number who stay put with their foster carers is low; there are only six in such arrangements in the year to date and there were nine in the previous year.
65. The service monitors care leavers' progress closely. Youth support specialists and personal advisers help young people to access education, jobs and training. They work well with education providers to help young people to overcome any barriers to their progress and to set challenging goals for themselves. As a result, the proportion of care leavers who are in education, employment or training has increased year on year. At the time of the inspection, seven care leavers were at university.
66. Virtually all care leavers are in suitable accommodation. Bed and breakfast accommodation has not been used for the last four years. The local authority undertakes rigorous monitoring and quality assurance of accommodation. Staff in semi-independent living accommodation provide a range of opportunities for young people to socialise. Personal advisers take good action, at an early stage, to prevent tenancy breakdowns or find alternative places for the young people to live. Personal advisers ensure that unaccompanied asylum-seeking care leavers integrate well, meeting their accommodation needs and helping to build their confidence.
67. Care leavers know about the leaving care grant and are able to obtain more information about their entitlements through their personal advisers and youth support workers. The local authority is continuing to develop the information that it provides through its website and a new smart-phone application (app) that it is planning for care leavers.

Leadership, management and governance	Good
<p>Summary</p> <p>Senior managers and leaders in Central Bedfordshire share a clear vision and sense of purpose. By engaging staff and partners successfully, they drive and sustain service improvement. They listen to, and act on, what children and young people tell them. Elected members are visible and active and provide an appropriate level of critical challenge. Governance arrangements are robust.</p> <p>Partnerships, particularly with health, are well established. Strategic priorities are closely aligned. Strategic boards work well together to avoid duplication or overlap. Reporting arrangements are clear and coherent. The children’s leadership board is driving the shift towards integrated locality services.</p> <p>Partners understand the needs of their local communities. Commissioning and de-commissioning decisions are evidence-based. Contract monitoring is outcome-focused, but the draft sufficiency statement is not specific or measurable.</p> <p>Partners work well together to combat child sexual exploitation but do not routinely collate and analyse data on the identification, assessment and reduction of risks. The CiCC is influential and effective. The corporate parenting panel works well with the CiCC. The panel is able to show that it is helping to improve outcomes for children, but it is not used to best effect to hold senior managers to account.</p> <p>The local authority is proud of the progress it has made against key performance indicators. However, senior managers do not have a clear line of sight on some important areas of activity. The quality of data on the offer and completion of return home interviews is limited. Senior managers are not rigorously tracking the use of the Public Law Outline. Although managers act on audit findings, some audits focus too much on process and compliance. As a result, audits do not always fully reflect the child’s experience.</p> <p>Social workers receive regular supervision, which is increasingly reflective, but the level of challenge and oversight is not always effective. This also applies to IROs and child protection conference chairs. On occasion, this leads to drift or delay for children.</p> <p>Senior managers and leaders are outward looking and open to challenge. They have succeeded in creating a learning culture, one in which social work can flourish. The social work academy has made a major contribution to improving workforce stability. It has also been successful in promoting professional development across children’s services.</p>	

Inspection findings

68. Senior managers and leaders have a clear sense of vision and purpose. The way in which the DCS is leading the transformation programme encourages shared ownership. The emphasis is on sustainability and resilience. Partners support the move towards integrated locality services. Managers and staff are involved in the transformation programme, and there is widespread support for the direction of travel.
69. The corporate centre is fully engaged with the children's services agenda. Corporate and children's social care strategic priorities are aligned. Elected members are supportive and engaged and provide appropriate critical challenge. Governance arrangements are well established and effective. The chief executive meets regularly with the DCS and at regular intervals with the chair of the LSCB. He has been influential in strengthening the local response to child sexual exploitation.
70. The Children's Leadership Board is well chaired and well led and is effective in promoting partnership working. The Health and Wellbeing Board (HWBB), the community safety partnership and the children and adult safeguarding boards work together to avoid duplication, agree priorities and keep children and young people on the agenda. The local authority works well with health and the two neighbouring unitary authorities, which is helping to deliver better outcomes for children. There are good strategic and operational links between children and adult services. This supports effective pathways to adulthood.
71. The joint strategic needs assessment gives a clear picture of local needs. The local authority's analysis of current and future demand for services is very sophisticated. However, the draft sufficiency statement includes too many objectives, some of which are not specific or measurable. This undermines its effectiveness.
72. The local authority's approach to commissioning and contract management is suitably outcome-focused. The online performance dashboard is impressive and provides live performance management and contract monitoring information. This ensures that commissioning and decommissioning decisions are evidence-based. Four young people, including two previously unaccompanied asylum-seeking children, assist in reviewing care leavers' placements. Providers are very positive about their dealings with commissioners and describe relationships as dynamic, responsive, supportive and challenging.
73. Senior managers recently decommissioned the advocacy and independent visiting service and brought it back in-house because they were not happy with the support that children were receiving. Take-up is increasing. Twenty-seven children have requested support since the beginning of April, and most have received a service. Advocacy drop-in sessions are in the early

developmental stages in local children's homes. Three new volunteers have been recruited to act as independent visitors.

74. Members of the CiCC are making a real difference. The CiCC has influenced the way in which looked after reviews are organised and run. It has been influential in instigating a review of life-story work by the local authority. Members of the CiCC help to induct and train elected members and staff, including newly qualified social workers. The CiCC website is interactive and easy to use and provides plenty of useful information and helpful links. The local authority is good at celebrating children's achievements. The council is very proud of its CiCC. Members of the CiCC said that they feel valued and that they are confident that senior managers and leaders take what they say seriously.
75. The corporate parenting panel works well with the CiCC and can evidence its impact in improving outcomes for children. Children looked after have free access to leisure services. Elected members are signed up to the children looked after pledge and use their contacts to try to increase opportunities for young people. Good progress has been achieved in gaining appropriate housing and supported accommodation for care leavers. However, the corporate parenting panel is currently not used to best effect to hold senior managers to account. For example, panel members need to know about issues and things that are not working so well and what action is being taken to improve them. (Recommendation)
76. Performance in relation to key performance indicators is good, including, for example, the timeliness of initial health assessments and statutory visits. Placement stability is good. The vast majority of care leavers are living in suitable accommodation and the percentage who are in employment, education or training is good.
77. Senior managers are not always measuring the right things. They are not using performance management information to drive permanence. Some children looked after have experienced drift and delay. Others, who live in long-term foster placements, lack certainty about their long-term future. Information about children who are missing from home or care is cross-checked against information about those who are missing from school, are home educated or the subject of fixed-term exclusions. However, analysis about the offer and completion of return home interviews is under-developed. Similarly, the analysis of the impact of interventions in respect of child sexual exploitation is also under-developed. Managers do not know how many screening or risk assessment tools are being completed, or use this information to inform subsequent planning. (Recommendation)
78. The local authority has a well-developed approach to quality assurance. Managers audit 30 case files every month. IROs and child protection conference chairs review the quality of social work practice, and senior managers systematically consider the learning from this activity. The principal

social worker uses this information to inform practice and shape the training offer. Despite these strengths, the quality of case management audits is variable. A minority are over-optimistic and focus too much on compliance at the expense of quality. There is a need to build more 'soft' measures into the performance framework, to better reflect the experiences of children and young people.

79. Senior managers actively promote a 'business as usual' approach to continuous improvement, with an emphasis on learning rather than blame. Team meetings share information about the learning from audits, complaints and serious case reviews. Practice and performance are discussed in service area meetings and a regular learning bulletin aims to ensure that everyone gets the message. The number of complaints from children is small, and the local authority acts on them all.
80. The local authority is open to challenge. It uses learning from peer reviews, inspection activity and best practice from elsewhere to improve outcomes for children. This reflects a genuine commitment to continuous improvement. The DCS knows there is variability in the quality of management oversight. Many managers, especially those in the family support teams, are still new. The challenge is to strengthen the quality of plans. Ensuring that they are all outcome-focused, specific and measurable will increase accountability and help to drive improvement in outcomes for children. During this inspection, the DCS has acted on the feedback from inspectors. (Recommendation)
81. The local authority has positive working relationships with the Children and Family Court Advisory and Support Service (Cafcass) and the local judiciary. Care proceedings are timely. There is more work to do to develop better three-way communication with Cafcass and the family justice board, and to strengthen the quality of pre-proceedings and evidence presented to the courts.
82. The success of the social work academy has helped to increase workforce stability. It also promotes the development of staff in children's social care, early help and early years. All staff, including agency workers, have access to high-quality training. Social workers are well supported during their assessed and supported year in employment.
83. The local authority is creating an environment in which good social work can flourish. New members of staff appreciate the quality of their induction and having small teams and manageable caseloads. The results of the staff survey are very positive. Staff feel valued and morale is high. All but one of the heads of service are now in permanent posts. The local authority's reliance on agency workers has reduced, and is down from 52% three years ago to 17% at the time of the inspection. Staff turnover is low. Children and families are benefiting from the continuity that this provides.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

Central Bedfordshire Safeguarding Children Board is good. Clear governance arrangements and systematic scrutiny ensure that accountabilities are clear and enable rigorous oversight of safeguarding arrangements.

The influential independent chair has created a strong and engaged partnership, with collective determination to safeguard children. A collaborative approach to partnership working ensures that partners benefit from shared work-streams with neighbouring LSCBs under a pan-Bedfordshire arrangement.

The board maintains critical oversight of the effectiveness of services provided to children in need of early help and children looked after. It has ensured that safeguarding arrangements are effective for children who have disabilities, those in private fostering arrangements and other vulnerable groups. Close partnership working supports effective disruption activity and ensures that children at risk of sexual exploitation receive the help they need. There is a need to build on this good work to ensure that the analysis from return home interviews, child sexual exploitation risk assessments and screening tools informs future planning and mapping activity.

Comprehensive performance analysis, audit and monitoring ensure that the board has a triangulated understanding of safeguarding practice across the partnership. While this enables scrutiny in most key areas, the board does not currently review data relating to contacts and there have been gaps in the submission of performance information in respect of missing children. Consequently, the board is not yet assured of the effectiveness of practice in these areas.

The board has been proactive in consulting children and young people about their views of the effectiveness of safeguarding arrangements.

The board robustly scrutinises frontline practice through a well-embedded programme of audit activity, which provides a line of sight to frontline practice, but action planning and evaluation need strengthening.

The learning and improvement framework draws on a range of learning, including learning from child deaths and serious case reviews. A comprehensive training programme equips staff with the knowledge and confidence to carry out their work.

The annual report provides a comprehensive overview of local performance and the work of the board over the preceding year, but it is too descriptive, with insufficient evaluation of the impact of the board's work.

<h2>Recommendations</h2>

84. Ensure that the annual report provides a rigorous assessment of the effectiveness of local services and the impact of the board.
85. Strengthen current arrangements to ensure more effective analysis and scrutiny of return home interviews and child sexual exploitation risk assessments.
86. Strengthen audit activity so that learning and recommendations are coherently set out, and action plans are specific and measurable.

Inspection findings – the Local Safeguarding Children Board

87. An influential independent chair, diligent business manager and strong partnership ensure that the board is effective and that it meets its statutory responsibilities. Well-attended, proactive sub-groups rigorously drive the work of the board and ensure delivery of its core priorities. Short-life task-and-finish groups are an efficient way of achieving the board's development work. Two active lay members positively contribute to the board's scrutiny and monitoring function.
88. Strong governance arrangements ensure that accountabilities across the partnership are clear. The board has a good interface with other strategic partnerships, including the community safety partnership, the HWBB and the adult safeguarding board. The independent chair meets regularly with the chief executive and the DCS, and the chairs of other strategic groups, to ensure that priorities align and that safeguarding is a high priority across the partnership.
89. Partnership working is effective. Well-engaged partners make an active contribution to improving the delivery of services for children. The board's priorities are clear and there is a shared commitment to improving safeguarding practice. Partners benefit from a collaborative approach to joining work-streams on areas of common concern with neighbouring LSCBs, through the pan-Bedfordshire arrangement.
90. Board members express confidence in the credible and influential independent chair. He has created a culture of openness, where curiosity and challenge are encouraged, and, combined with the highly effective support provided by the business manager, ensure coordination of the board's activities.
91. The board rigorously oversees safeguarding arrangements, consistently scrutinising partner agencies' work through its performance analysis, audit programme and scrutiny of activity across the partnership. A detailed multi-agency dataset ensures that the board has oversight of frontline practice and

the effectiveness of safeguarding arrangements. Although it enables the board to identify dips in performance, informing planning and priority setting, there are some omissions. There is a lack of data on contacts received by children's social care, and the proportion of which lead to referrals, to support the board's analysis of thresholds. The performance sub-group reviews performance against comparators, but the omission of comparator data in the performance framework means that trends and dips may not be easily identifiable. Agencies provide some analysis of their performance information, but this is not always sufficiently analytical. The board is already aware of most of these weaknesses, with the exception of the lack of contact data, and had begun work to strengthen practice in these areas prior to the inspection.

92. The board's priorities rigorously drive a comprehensive multi-agency audit plan. Audits carried out over the last year include a focus on domestic abuse, neglect, adolescent mental health and children subject to SGOs. Well-engaged partner agencies participate in case file auditing. The learning and improvement sub-group monitors audit action plans and ensures that learning is disseminated. Audit reports do not always distinguish effectively between findings and learning, and actions are not always sufficiently specific or measurable. (Recommendation)
93. Partners provide challenge, and the independent chair is robust at holding agencies to account. Agencies' compliance with safeguarding practice is monitored through a pan-Bedfordshire section 11 audit process, which includes agency self-assessment, multi-agency challenge events and development of a multi-agency action plan. These audits are carried out on a three-yearly basis, followed by progress reporting against action planning in year two, and then a thematic audit in year three. Partners have engaged readily in this scrutiny process, enabling the board to assure itself about agencies' compliance with safeguarding standards.
94. There is a robust and effective process in place for ensuring systematic review and revision of policies and procedures through the pan-Bedfordshire policies and procedures group. Lessons learned from audit activity and case reviews and other learning purposefully inform policy development. The Central Bedfordshire threshold guidance is a comprehensive and clear document, which supports professionals in making threshold decisions. However, it is lacking in specific references to section 20 and section 31 of the Children Act 1989, to support clearer understanding about thresholds for children to become looked after.
95. Despite the low prevalence across Central Bedfordshire, the board has taken action to equip partners to identify and respond to honour-based abuse, forced marriage and female genital mutilation. Work carried out by a dedicated task-and-finish group includes the development of a multi-agency strategy, service pathways and awareness-raising. The board has sought to ensure that the additional vulnerabilities of children who have disabilities are recognised and understood. These children's needs are well considered in the

threshold guidance, and the board has engaged with a neighbouring LSCB to deliver a well-attended disabled children's spotlight event as a means of raising awareness across the partnership.

96. The board has been active in overseeing the effectiveness of arrangements for early help and children looked after. It has been influential in driving improvements in practice for children looked after and care leavers, including the timeliness of initial health assessments and strengthening the focus on care leavers' engagement in employment, education and training.
97. There is a strong and committed approach to tackling child sexual exploitation across the partnership. Children benefit from a joined-up approach with the neighbouring local authorities and LSCBs, driven by the three local authorities' chief executive officers. The development of a comprehensive, pan-Bedfordshire-wide problem profile has informed awareness-raising and disruption strategies effectively in Central Bedfordshire, including targeting of hotels, fast food outlets and licensed premises. Awareness-raising has been extensive, including the board's role in commissioning Chelsea's Choice for secondary schools and the use of the electronic e-safety tool, Looking Out for Lottie. The board's child sexual exploitation and missing children sub-group ensures that intelligence is shared to inform disruption strategies. However, there is further work to do to ensure that intelligence from sexual exploitation screening tools and risk assessments also informs wider problem profiling, mapping and service development.
98. The board monitors the incidence of children going missing from home or care and the completion of return home interviews through its multi-agency performance dataset. The board has been robust in challenging deficits in respect of police practice in response to missing children. Although progress has been slow, recent changes in practice have resulted in a significant reduction in the use of the absent categorisation, and more children have had a risk assessment. Despite this progress, the scrutiny and analysis of data in respect of children who go missing is not yet sufficiently robust or consistently effective. There have been gaps in data-sharing by the police over recent months, which means that the board has not had full assurance that the response to missing children is effective. There is no formal structure in place to ensure that the intelligence from return home interviews is used systematically and strategically to inform analysis and disruption activity. (Recommendation)
99. The board's joint training and development sub-group and the training unit oversee an extensive range of multi-agency training opportunities across the partnership effectively. Again, a pan-Bedfordshire arrangement ensures that the burden on partners is minimised and that economies of scale are achieved across the Bedfordshire-wide area. The training needs analysis is under-developed and is not yet informed by an understanding of partners' engagement in single-agency training to ensure that training is targeted effectively. Work is already under way to address this shortfall.

100. Rigorous monitoring ensures effective take-up of courses on offer and good completion rates, with continuous improvement evident. Participant satisfaction rates are generally high. The board uses end-of-day surveys, dip sampling and interviews with managers and staff at various points after the delivery of training to assess the impact of training on behaviour and performance. Impact analysis is included in evaluation reports to the board. Some evidence of impact on learners' skills, knowledge and confidence is demonstrated, although poor engagement in surveys at the six-month review stage means that evaluation of longer-term impact is limited.
101. An effective, independently chaired case review group oversees all serious incident notifications, to maximise opportunities for learning. The board initiates serious case reviews appropriately when the criteria set out in statutory guidance are met, resulting in the completion of three serious case reviews in the last two years. There is multi-agency challenge and an openness to learning, including from those cases that do not meet the criteria for serious case review, with one such case currently under consideration. The board provides presentations and briefings to agencies and seeks assurance that messages have been cascaded effectively. Social workers spoken to during the inspection were able to cite the key learning points from a recent serious case review, providing evidence to demonstrate that the board has been effective in ensuring that learning is embedded across frontline practice.
102. The pan-Bedfordshire child death overview panel reviews child deaths effectively, identifying modifiable factors and undertaking proactive work to reduce the incidence of preventable child deaths. There has been extensive work to raise awareness of safe sleeping, as well as work to reduce smoking in pregnancy, among other activity. This has improved knowledge, although it is difficult to evidence impact, given the small number of child deaths across the local area. The panel has taken action to ensure a good interface with the case review panel, in response to findings from a previous inspection. Awareness-raising takes place, including dissemination of a twice-yearly newsletter, to ensure that learning is shared.
103. Through the creation of the voice of the child sub-group, the board has begun to explore mechanisms for gaining an understanding of children's experiences of the help they receive. The tenacious and proactive approach of the sub-group chair has helped to secure good partnership engagement and a line of sight to children and young people who are receiving frontline services. A number of workshops and a conference have taken place to inform the development of a questionnaire to capture children's views. This will be used agency-wide after the current pilot is complete.
104. The annual report provides a comprehensive overview of local safeguarding performance and the work of the board, including some evaluation of local effectiveness. However, the report is descriptive and does not sufficiently analyse the impact of the board's work. (Recommendation)

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 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 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 seven of Her Majesty's Inspectors (HMI) and one Additional Inspector (AI) from Ofsted.

The inspection team

Lead inspector: Margaret Burke

Deputy lead inspector: Nigel Parkes

Team inspectors: Pauline Higham, Tracey Metcalfe, Cathy Blair, Derrick Baughan, Donna Marriott

Senior data analyst: Judith Swindell

Quality assurance manager: John Mitchell

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.gov.uk/government/publications/complaints-about-ofsted. 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, further education and skills, adult and community learning, and education and training in prisons and other secure establishments. It assesses council children's services, and inspects services for children looked after, safeguarding 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 1231, or email enquiries@ofsted.gov.uk.

You may reuse this information (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit

www.nationalarchives.gov.uk/doc/open-government-licence, write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

This publication is available at www.gov.uk/government/organisations/ofsted.

Interested in our work? You can subscribe to our monthly newsletter for more information and updates: <http://eepurl.com/iTrDn>.

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