London Borough of Tower Hamlets

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: 23 January to 16 February 2017

Report published: 7 April 2017

Children's services in Tower Hamlets are inadequate		
1. Children who need help and protection		Inadequate
2. Children looked after and achieving permanence		Requires improvement
	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 who need help and protection in Tower Hamlets. As a result, too many children remain in situations of actual or potential harm for too long. Insufficient scrutiny by the chief executive, the director of children's services (DCS) and politicians has meant that they did not know about the extent of the failures to protect children until this inspection. In the majority of cases referred to them by inspectors, managers and leaders had to take immediate action to ensure that children were safe, that their needs were met and that plans to safeguard them were progressed appropriately. In addition, as a result of identifying current risks to children, inspectors requested that the local authority review several aspects of the service urgently, including private fostering arrangements, care leavers in custody, the arrangements for the Public Law Outline (PLO) and the psychosocial team meetings.

Services for children in care or who need to be adopted and those for young people leaving care are not yet good enough. Some services have significantly deteriorated since the last inspection of children's services published in 2012, when the local authority was found to be good overall with outstanding features. The DCS took up an interim position in July 2015 before her permanent appointment in March 2016. Despite uncovering a deeply worrying picture regarding the services provided to children, there has been insufficient rigour by senior leaders in challenging weak management oversight. When changes have occurred, progress has been limited or not sustained, and improvements remain fragile. Senior leaders have accepted the inspection findings and are determined to improve outcomes for children.

A significant challenge facing the local authority is instability in the children's workforce. Staff turnover overall has reduced slightly, but in the assessment and intervention team it has significantly increased, from 10% in 2015 to 30% in 2016. An improvement and inspection board established in September 2016 has had limited impact. The board lacks an overarching strategic plan to systematically drive the extensive change required. This is a serious omission by senior leaders.

Performance management and quality assurance systems are not underpinned by reliable management information. This is largely due to social workers and managers not updating records on the electronic recording system. Many assessments and plans are of poor quality. Senior leaders have not been effective in challenging the entrenched culture of non-compliance with basic social work standards. The local authority as a whole has failed to ensure professional accountability and, as a result, too many children have remained in neglectful and abusive situations for too long.

Inspectors found a lack of understanding of what constitutes a private fostering arrangement. Superficial assessments failed to consider whether children had been trafficked or abandoned by their parents, and basic safeguarding checks were not conducted in most cases.

The application of statutory thresholds is inconsistent. This is apparent from the first point of children's services intervention, including out-of-hours services, core safeguarding activity such as section 47 enquiries, child protection investigations and entry to care. Strategy discussions do not include all relevant agencies.

Too many children spend an extensive period at the pre-care proceedings stage, with no review or progress against agreed actions. Consequently, some children and young people who need to be in care wait for too long. This leaves too many at risk of significant harm. When children do come into care, planning improves for most of them. This is despite the significant increase in care proceedings and numbers of children now in care, as a recognition of the previously high threshold. Children who are adopted or looked after or care leavers receive better and more consistent support. Stronger social work practice in discrete areas enables more children to settle and to have appropriate plans made for them. Many social workers visit children in care within statutory timescales. Children in care and care leavers report positive relationships with staff.

The timeliness of adoption is improving, and adopters are positive about the service that they receive. Prospective adopter reports and child permanence reports vary in quality. The agency decision-maker's scrutiny and oversight of adoption panel recommendations for children being adopted are not sufficiently effective, as a lack of capacity means that some reports are not read prior to decisions being made.

The local authority and its partners have been effective in prioritising and developing a strategic response to child sexual exploitation and actively delivering services to counter the risk to children from radicalisation and female genital mutilation. A wide range of awareness raising has taken place in the community. However, operational social work practice to tackle sexual exploitation is weak. The local authority recognises that it needs to understand better the connections between child sexual exploitation, missing children, youth violence, gangs and radicalisation.

An extensive range of services are commissioned to support children in the community. Effective monitoring and advice in relation to some complex cases take place through a well-established multi-agency social inclusion panel.

There is a wide range of resources and multi-agency working to support children who have disabilities. The local authority has good systems for identifying and recording those children who go missing from education. Headteachers in Tower Hamlets understand well the processes for monitoring and reporting absenteeism from schools.

There is strong partnership working between the multi-agency public protection arrangements and multi-agency risk assessment conferences (MARAC). MARACs take place every two weeks. They are well attended by relevant partner agencies, and there is timely reporting on actions.

The prevention of violent extremism team has developed an extensive knowledge of radicalisation. Skilled workers have a detailed understanding of the issues facing children in Tower Hamlets.

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Previous Ofsted inspections

- The local authority operates one children's home, which was judged to be good at its most recent Ofsted inspection.
- The last inspection of the local authority's safeguarding arrangements was in July 2012. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in July 2012. The local authority was judged to be good.

Local leadership

- The DCS has been in post since March 2016, following eight months as the interim DCS.
- The chief executive has been in post since October 2015.
- The chair of the Local Safeguarding Children Board has been in post since October 2016.
- The local authority uses the 'Signs of Safety' model of social work.

Children living in this area

- Approximately 65,000 children and young people under the age of 18 years live in Tower Hamlets. This is 22% of the total population in the area.
- Approximately 34% of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 33% (the national average is 15%)
  - in secondary schools is 42% (the national average is 13%).
- Children and young people from minority ethnic groups account for 81% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British and Black or Black British.
- The proportion of children and young people who speak English as an additional language:
  - in primary schools is 75% (the national average is 20%)

[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 secondary schools is 71% (the national average is 16%).

- Tower Hamlets is a very diverse borough and has the highest level of deprivation in England (the 'Income Deprivation Affecting Children Index 2016').

Child protection in this area

- At 31 January 2017, 3,149 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 2,895 at 31 March 2016.
- At 31 January 2017, 401 children and young people were the subject of a child protection plan (a rate of 62 per 10,000 children). This is an increase from 298 (46 per 10,000 children) at 31 March 2016.
- At 31 January 2017, 18 children lived in a privately arranged fostering placement. This is a reduction from 22 at 31 March 2016.
- In the two years before inspection, six serious incident notifications were submitted to Ofsted, and two serious case reviews (SCRs) were completed.
- There were two SCRs ongoing at the time of the inspection.

Children looked after in this area

- At 31 January 2017, 333 children were being looked after by the local authority (a rate of 51 per 10,000 children). This is an increase from 305 (47 per 10,000 children) at 31 March 2016.

  Of this number:

  - 275 (83%) live outside the local authority area
  - 25 live in residential children's homes, of whom 80% live out of the authority area
  - three live in residential special schools[3], all of whom live out of the authority area
  - 243 live with foster families, of whom 81% live out of the authority area
  - eight live with parents, of whom three live out of the authority area
  - 32 are unaccompanied asylum-seeking children.

- In the past 12 months:
  - there have been 12 adoptions
  - 21 children became subject to special guardianship orders
  - 196 children ceased to be looked after, of whom 9% subsequently returned to be looked after

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

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

Recommendations

1. Take immediate action to ensure that work with children and their families is compliant with basic practice standards and that poor practice is challenged across all service areas.

2. Take steps to ensure that thresholds are consistently applied and that children requiring statutory intervention receive it.

3. Ensure that strategy discussions include all relevant agencies and that robust arrangements are in place to protect children while child protection investigations take place.

4. Improve the quality of assessments and plans for children to ensure that purposeful work takes place to prevent drift, and to protect children in need of help and protection and children in care.

5. Ensure that independent reviewing officers (IROs) and child protection chairs provide sufficient challenge to plans.

6. Take immediate action to ensure that management oversight and supervision are strengthened and that all work is recorded appropriately to an acceptable standard.

7. Urgently improve the quality and timeliness of services for children who are at risk of becoming involved in gangs and serious youth violence. Ensure the alignment of those services with those for children who go missing and those who are vulnerable to sexual exploitation and radicalisation. Ensure that comprehensive and accurate intelligence and data inform service developments.

8. Ensure that risks to children who go missing from home or care are assessed by social workers and their managers, and that all 'missing' children are offered a return home interview within 72 hours.

9. Take urgent steps to ensure that social workers and managers receive relevant training to counter child sexual exploitation, and that children identified as at risk of sexual exploitation are subject to a risk assessment and offered responsive and appropriate help.

10. Review the arrangements for private fostering to ensure that practice is compliant with statutory requirements, that assessments include relevant information and that reviews are meaningful and timely.

11. Ensure that children benefit from effective and timely processes under the PLO that address all risks for children and are thorough and well managed.

12. Urgently address the sufficiency of emergency and unplanned placements so that children's needs can be met appropriately when they become looked after.

13. Improve the quality of child permanence reports to ensure that all areas are fully evidenced, including details of all brothers and sisters and relevant medical information.

14. Ensure that the agency decision-maker reads and considers all adoption panel paperwork, panel minutes and recommendations before reaching her decisions and that she clearly records her own reasons for the decisions made.

15. Implement the workforce strategy as swiftly as possible to improve workforce stability and capacity. Undertake a training needs analysis to ensure that the workforce is appropriately trained in order to achieve improvements and consistency in the quality of practice.

Summary for children and young people

- Inspectors found that services to children in Tower Hamlets have become worse since the inspection in 2012. This means that children who need help and protection do not always have the right help to keep them safe.

- Managers do not always check that social workers are doing what they should to make sure that children and families receive the help that they need quickly enough.

- Sometimes, social workers do not talk to all the people who have important information to help them to decide the best thing to do.

- Some children are left in unsafe situations for too long. Once the decision has been made for them to be looked after by the local authority, planning improves. Children who are adopted, children in care and care leavers have better support.

- Most children in care live in good foster homes, but there are not enough families who can offer homes to older children.

- Children living with family members and foster carers are generally settled. They are helped to keep in touch with their families if they cannot return home. Children have good support if they are sad or worried. They enjoy learning, and many are doing well at school.

- The Children in Care Council provides children with direct access to leaders in the local authority. Children suggest changes and improvements that they believe will make things better for children looked after. The Children in Care Council is actively seeking the involvement of younger children through the development of the Young Stars group.

- Care leavers are positive about the support that they have from their personal advisers. They like the warm, positive and safe environment at the care-leaving service centre.

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

Summary

Services to children in need of help and protection in Tower Hamlets are inadequate. Serious and widespread failings across all core social work teams, including the early help hub, the multi-agency safeguarding hub (MASH), assessment and intervention, and family support and protection teams, leave children at risk of harm. These failings are characterised by weak managerial oversight at all levels. The local authority has not ensured that basic social work practice is of a good enough standard. Managers, including child protection chairs, do not provide sufficient overview or challenge of social work practice. As a result, children do not receive timely responses to ensure that risks and needs are met.

Inspectors identified over 25 cases in which the needs of children in need of help and protection had not been recognised or robustly assessed. Senior managers took immediate action to address the concerns and to review a number of services as a result of inspection findings.

An inconsistent application of thresholds for statutory intervention and a lack of recognition of risk are common features in too many children's cases. There is chronic drift and delay at too many points of intervention, including for children who need statutory intervention, child protection enquiries, return home interviews or children who are subject to pre-proceedings work. Overall, assessments lack sufficient consideration of previous history, and the analysis of risk is poor. The majority of plans are weak and lack focus on the outcomes for children. This leads to a lack of purposeful and effective work, leaving children without the support that they need. The response to children at risk of sexual exploitation or who go missing is not good enough. The risks are minimised in a significant number of children's cases. Too many return home interviews do not take place or are too late, leaving children at continuing risk of harm.

There is a lack of understanding of what constitutes a private fostering arrangement, leaving children at risk.

An extensive range of services are commissioned to support children in the community. Intensive monitoring and advice in relation to complex cases take place through an effective, well-established, multi-agency social inclusion panel. There is a wide range of resources and multi-agency working to support children who have disabilities. The local authority has good systems for identifying and recording those children who go missing from education. Headteachers in Tower Hamlets understand well the processes for monitoring and reporting absenteeism from schools.

Inspection findings

16. Services for children in need of help and protection are inadequate. Senior managers were not aware of the extent of the serious failings until this inspection. These weaknesses have left children insufficiently protected from harm. Inspectors identified over 25 cases in which the needs of children in need of help and protection had not been recognised or robustly assessed. In addition, senior managers needed to take urgent action to ensure that children and young people were safe in several service areas identified by inspectors.

17. The local authority has very recently improved its early help provision to children and families through the creation of an early help hub. The hub provides a telephone advice line, facilitates access to services and supports professionals in completing early help assessments. Intensive monitoring and advice in relation to complex cases take place through an effective multi-agency social inclusion panel. However, in cases seen by inspectors, there is limited impact on improving outcomes to avoid problems escalating. Early help assessments sampled by inspectors are overly focused on educational issues and behaviour. Too many lack essential information to ensure that children and families receive effective support.

18. Responses to contacts and referrals from the public and partner agencies have recently improved, and the majority of decisions are now made within 24 hours. A review of the MASH in March 2016 resulted in action to address serious deficits. However, the application of statutory thresholds remains inconsistent. This is particularly evident for children living in situations of domestic abuse and children at risk of sexual exploitation. Inspectors referred to senior managers a number of children's cases that had been either stepped down to early help services or closed to the MASH, even though the threshold for statutory services had been met, because children were not receiving the right level of support and protection at the right time. Senior managers responded quickly to the inspection findings, and actioned a review of all domestic abuse referrals made to the early help hub to ensure that children were receiving the appropriate services.

19. While strategy discussions are mostly timely, not all relevant agencies are involved, which means that vital background information is not available to inform effective decision-making.

20. Overall, the timeliness of assessments has improved from a low base. However, the assessment quality is poor, risk is not rigorously analysed, and there is insufficient consideration of children's historical information and their ethnic and cultural needs. The voice of the child and that of parents are evident in the majority of assessments, but direct work with children to understand their lived experiences is weak. Management oversight of

assessments is poor and does not provide sufficient action to ensure that children receive timely help and protection.

21. Too many child in need plans and child protection plans are inadequate. The objectives of the work are not clear, timescales are vague and children's voices are not evident. Social workers do not visit children regularly enough. Core group meetings include relevant professionals, but do not ensure that plans systematically measure progress. This leads to a lack of purposeful and effective work. There is a lack of urgency and understanding of risk, and too many children experience unacceptable drift and delay. Managers do not act quickly enough to address this, adding to the delay and leaving children in situations of actual or escalating risk of harm.

22. Child protection conference chairs do not have sufficient oversight and do not provide appropriate challenge. Most chairs acknowledged to inspectors that they are not good at recording concerns. They do not always use the formal alert system to challenge poor practice and, instead, have informal conversations with social workers and managers. There is no monitoring of agreed actions from informal conversations until the next review conference, which could be six months ahead. This adds to the drift and delay experienced by too many children.

23. Despite an extensive review in November 2015, work to strengthen the PLO and pre-proceedings work remains poor. Thresholds for instigating the PLO remain inconsistent, which means that children subject to pre-proceedings letters spend extensive periods at this stage with no review. A lack of robust tracking, poor management oversight and inconsistent planning continue to hamper timely decision-making about applications for legal orders. This leaves too many children at risk of continuing or actual harm when they have met the threshold to be in care.

24. Children living with neglect, parental substance misuse or domestic abuse wait too long to receive appropriate help. The deterioration in family relationships and escalation of emotional and behavioural difficulties increase children's vulnerability to becoming involved in gang activity and serious youth violence. In a survey undertaken by the young mayor, children said that their overwhelming concerns are gang violence and associated postcode wars. The level of serious youth violence and knife injuries in Tower Hamlets is high. As a result, some children live in an environment of violence and fear.

25. The arrangements and responses to the needs of children who go missing have been strengthened, with an operational panel in place and a commissioned service providing return home interviews. The 'missing' coordinator has recently taken responsibility for making all referrals for return home interviews. However, operational practice remains weak. Information sharing with the youth offending team is not well coordinated. Social workers do not consistently refer children for return home interviews. In just over half

of the cases seen by inspectors, there were no return home interviews, and there are delays to a significant number of those that do take place. As a result, the opportunity to uncover vital information, identify risks and take timely protective action is lost, leaving children at continuing risk. In most cases seen, social workers did not accurately record 'missing' episodes. This not only means that data is unreliable, but it also hinders management oversight, adding to delays and risks to children.

26. The operational response and practice to tackle child sexual exploitation are weak. The child sexual exploitation coordinator's work is separate from mainstream social work practice. Social workers and managers do not have sufficient understanding of sexual exploitation, and too many have not had essential training. Managers do not always comply with actions proposed by the child sexual exploitation coordinator. This results in continued risk to children.

27. At the time of the inspection, 18 children were reported to be living in private fostering arrangements. Inspectors found a lack of understanding of what constitutes a private fostering arrangement. Superficial assessments had failed to consider whether children had been trafficked or abandoned by their parents. Basic safeguarding checks had not been conducted in most cases. The private fostering panel, designed to review all private fostering arrangements, had not met for 12 months. As a result, the risks to children were unknown, leaving children in potentially harmful situations. The local authority took immediate action to review each case when inspectors brought this to its attention.

28. The local authority has good systems for identifying and recording those children who go missing from education. Headteachers in Tower Hamlets fully understand the processes for monitoring and reporting absenteeism from schools. Managers have good partnerships with other boroughs to share information about children coming to Tower Hamlets and children who are the authority's responsibility but who are placed out of the borough. They have effective systems to oversee the missing child register. There are 133 children currently on the register, three of whom are children looked after. The local authority has good partnerships with schools, which effectively implement the protocols and processes for referral when a child is missing. In addition, the local authority has well-established safeguarding arrangements for children who are found to be in unregistered schools.

29. Managers implement well-established and effective systems to monitor the 170 children who are currently electively home educated. Of these children, 68% are of primary school age and 32% are of secondary school age. The home education team at the authority keeps in touch with almost all families.

30. The local authority arrangements for considering allegations or concerns about staff or volunteers are safe and effective. There is a comprehensive tracking

system. The work is child focused, and strategy meetings are proportionate, independently chaired and inclusive of a range of appropriate agencies. There is evidence of effective links with faith communities and awareness raising in partnership with the Local Safeguarding Children Board (LSCB).

31. There is a wide range of resources and multi-agency working to support children who have disabilities. Social workers in the children with disability team demonstrate child-centred practice and a good understanding of children's needs. Assessments are comprehensive and include brothers and sisters. Children in need and child protection practice is satisfactory. Regular feedback sheets demonstrate that children and families are happy with the support that they receive.

32. There is strong partnership working between the multi-agency public protection arrangements and MARACs. MARACs take place every two weeks, due to the high volume of serious domestic abuse incidents in the borough. MARACs are well attended by relevant partner agencies, and there is timely reporting on actions. However, inspectors found that too many children living in families affected by violence do not receive the appropriate level of help and protection.

33. The prevention of violent extremism team has developed extensive knowledge of radicalisation. Skilled workers have a detailed understanding of the issues facing the children who live in the local authority. As a result, inspectors saw a number of examples of creative and sensitive work to engage families, thorough strategy discussions and child protection investigations to help to protect children from violent extremism.

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

Summary

Outcomes for children looked after are not yet consistently good enough. While recent decisions made to bring children into care are appropriate, too many take place in an emergency. Nevertheless, when children do come into care they are safer, and planning for them is better.

Choice and availability of placements are limited, particularly in meeting older children's needs. However, most children live within 20 miles of home in stable placements that meet their cultural, ethnic and religious needs. The fostering service is actively recruiting new carers, and it supports carers well. Care proceedings are effective for most children in progressing plans for permanence.

Social workers see the majority of children regularly, but assessments, plans and direct work are variable in quality or are not clearly recorded. Inconsistent responses for some children at risk of sexual exploitation, involved with gangs and violence, or missing from care mean that their needs are not fully understood or met soon enough. The timeliness of initial health assessments is poor, but review health assessments and support for emotional well-being are well established. Almost all children have their care plans reviewed regularly by IROs, who know the children well.

The majority of children in care attend good or outstanding schools. Personal education plans show an improvement in the setting and monitoring of targets, and a clearer picture of the child's behaviour and emotional well-being.

Corporate parenting is well established and the Children in Care Council is active, with effective plans in place to develop the Young Stars group. Annual events and activities are held to celebrate children's achievements.

Adoption is considered by the second statutory review for all children who cannot return home to their birth families. The local authority is successful in securing potential links for children who have complex needs.

The care leavers' service stays in touch with almost all of its care leavers. Accommodation in the borough is well established and safe. A small minority of care leavers have some particularly good outcomes and are accepted into training or higher education. Too few care leavers are aware of their entitlements, but they receive good support when they get into difficulty.

Inspection findings

34. At the time of the inspection, Tower Hamlets was looking after 333 children. For too many children, the decisions to look after them are not timely enough. This impacts on the local authority's ability to keep them safe and to improve outcomes for them. Nevertheless, when children come into care they are safer, and planning for them improves. Better practice in discrete areas of the service results in more effective support and care, enabling children to settle and have appropriate plans made for them.

35. In most cases, recent decisions to accommodate children are appropriate. However, decisions are often made in an emergency and are not timely enough or effectively planned to respond to significant escalating risks while children remain at home. For example, the local authority reported that, of 22 children who became looked after in January 2017, only 10 admissions were planned. Three very young children had remained in a police station overnight, as there was no placement available.

36. Services to children on the edge of care are in place, but they are fragmented and require consolidation to address the complexity of older children's needs. A more systemic multi-agency service (Safer Lives) is due to be implemented in April 2017. Some children returning home from care do not receive sufficient support, leading to a small number returning to the care of the local authority.

37. Effective management action when children are subject to care proceedings avoids unnecessary drift and delay. Parallel planning and permanence plans are progressed speedily for most children, and appropriate use is made of family group conferences, connected people and special guardians to ensure that children are placed permanently with family members who reflect their ethnic, cultural and religious backgrounds. There has been an increase in the number of special guardianship orders granted since 2015–16.

38. Following action by the divisional director for children's services in 2015 to tackle drift and delay, there has been a significant increase in children subject to care applications. The judiciary and the Children and Family Court Advisory and Support Service (Cafcass) report positive and effective relationships with the local authority. Timeliness of care proceedings, at 29 weeks, is consistently improving and is almost in line with the national average of 28 weeks. An in-house parenting assessment team effectively manages and produces social work assessments, which the judiciary and Cafcass report to be of good quality. This means that, for most children subject to care proceedings, there are no delays in decision-making about their futures.

39. Cases seen by inspectors evidence that social workers visit most children regularly and within statutory timescales, and the children who met with inspectors reported positive relationships with staff. However, for a large

majority of children, the quality of work undertaken needs to improve. Their wishes and feelings are not fully recorded on case files, and direct work with them is superficial. Management oversight is inconsistent and variable for too many children. For a minority of children, there is better practice, with evidence of good engagement and an appropriate focus on ethnic, religious and cultural issues and use of interpreters.

40. Assessments seen by inspectors were not of good quality for most children, as they were not comprehensive or analytical enough, and some were either not in place or out of date. Not all assessments take account of the child's history. A lack of understanding of risks for some older children means that their needs are not fully addressed. Care plans for most children are not specific enough. Better plans identify effective and timely care planning, particularly for younger children and those in care proceedings.

41. Almost all children have their care plans regularly reviewed by IROs, who know them well. Caseloads for IROs are manageable. Managers are aware that current practice needs to improve further. Evidence of informal and formal escalations are appropriate, but escalations require more incisive challenge by IROs to improve social work practice further.

42. The local authority reviewed section 20 arrangements effectively in January 2016 and again in January 2017. The final confirmation of matching for a small number of children already living in long-term fostering placements is subject to delay, and means that these children do not benefit from the stability and emotional security that this will offer them.

43. Children in care who are at risk of offending are provided with a designated case officer, who also works out of the borough, to ensure continuity of relationships. Bespoke commissioned services are available for children who have substance misuse problems. However, the response to children who are at risk of sexual exploitation, involved in gangs and violent behaviour or missing from care is insufficient, as risks are not always understood or fully analysed. Therefore, some children do not receive the correct level of help and support.

44. The timeliness of initial health assessments is poor. For example, between April 2016 and January 2017 only 4.2% were conducted within expected timescales. Improvements to gain medical consent from birth parents when children first become accommodated are now in place to address this, but the impact is not yet evident. Performance of review health assessments is much better, at 85%, and both improvements to processes and an additional nurse are in place. The looked after children specialist nurse offers continuity to children and travels out of borough to achieve this. Emotional well-being and child and adolescent mental health service (CAMHS) support is well established. The 'CAMHS in social care' team offers timely and appropriate consultation and guidance to children and foster carers.

45. There are insufficient local placements for children looked after and a lack of choice and availability, particularly for emergencies and unplanned placements. Inspectors saw evidence of the impact of this for children. For example, senior managers did not know that a child was in an unsafe placement until this was identified by inspectors. Placements for children who show challenging and complex behaviour do not always fully meet their needs.

46. However, a large majority of children are placed with their brothers and sisters, with carers who meet their ethnic, religious and cultural needs. Long-term placement stability is high. Contact arrangements with family members are well supported and supervised by trained staff. Children who met with inspectors reported that social workers had acted on their requests for changes to contact with family members. Children also reported being able to access sporting and educational activities and to benefit from interesting holiday experiences.

47. Effective and specific fostering recruitment has led to an increase in the number of fostering households, but there is still a limited availability of placements for older children. Commissioning plans to improve residential provision have been developed with other nearby local authorities, but these plans will not address immediate pressures or priorities.

48. The fostering service is well established and is mostly compliant with statutory guidance. There are some weaknesses in the timeliness and quality of fostering assessments, and delegated authority is not in place for all carers. Foster carers benefit from established support through relevant training, support groups and CAMHS consultations. The Mockingbird initiative provides linked foster carers with consistent peer support and promotes placement stability.

49. Corporate parenting is well established, and the Children in Care Council is active and influential in suggesting and making changes to service developments. The new Young Stars group is in development. Appropriate annual celebratory events and activities, including a successful summer school, are in place. Advocacy services are available for children, and the independent visitor service offers positive support and opportunities to 12 young people.

50. Most children looked after (85%) attend good or outstanding schools. None attends an inadequate school. The recently appointed virtual school headteacher is improving the support that children looked after receive with their educational attainment and progress. In 2015–16, the large majority of children achieved good skills at the expected standard in English and mathematics by the end of primary school. By the end of key stage 4 at secondary school, a small minority of children achieved five good GCSEs, better than their peers nationally. However, at key stages 1 and 4, children's

attainment remains too low. The very large majority (92%) of the authority's children looked after go on to participate in post-16 education and training.

51. The majority of personal education plans include a clear picture of the child's progress, emotional well-being and behaviour. Targets for helping children to improve their skills are specific and useful. For a few children, there are delays in establishing a baseline of achievement at the start of secondary school. There is insufficient continuity and planning for children when they progress to post-16 education and training, and there is not enough clarity in plans about the impact of additional funding (the pupil premium). However, the virtual headteacher has good oversight of the strengths and areas for improvement.

52. No child looked after was permanently excluded from school in 2015/16 and fixed-term exclusions were 8% in 2015/16, down from 12.2% in 2013/14. The proportion of children looked after who miss school due to authorised or unauthorised absences is around the average rate for England as a whole, according to the most recent published data in 2014/15.

53. The local authority's arrangements for alternative provision provide a good range of learning options and alternative strategies to help children looked after to re-engage in learning, both in and out of the borough. Currently, three children looked after attend alternative provision.

The graded judgement for adoption performance is that it requires improvement

54. Adoption is being considered by the second statutory review for all children who cannot return home to their birth families. Since April 2016, 10 children have been adopted whose profile shows a mix of ethnicities, brother and sister groups, or an age of over five years. The local authority is successful in securing potential links for children with complex needs or disabilities, and one child is currently placed under a foster-to-adopt arrangement.

55. In most cases seen, permanency planning meetings are held regularly, ensuring that the progress of a search is kept under review. The local authority works well with the East London Adoption Consortium, the Adoption Register, Adoption Link and other agencies to exchange information and secure links for children and waiting adopters.

56. Recent data shows that the timeliness of adoptions is improving, but it is still some way off national thresholds. As only a small number of children are adopted each year, a delay for one or two children can have a dramatic effect on timescales, and this has been the case in Tower Hamlets. The year to date figure for the average time between a child entering care and moving in with his or her adoptive family is 509 days. Although this is an improving picture, it is still behind the current threshold target of 426 days.

57. The average time between a local authority receiving court authority to place a child and the local authority deciding on a match to an adoptive family also shows some recent improvement. The year to date figure of 233 days is close to the England average, but is still behind the threshold target of 121 days.

58. The recruitment and preparation of prospective adopters are thorough. A range of information, guides and a website provide useful information regarding adoption. The preparation course, run in conjunction with the East London Adoption Consortium, is comprehensive and provides adopters with a good, basic understanding of the needs of adopted children. Adopters spoken with during the inspection talked of the value of the course, along with the learning that they had gained from guest speakers such as adopters, foster carers and birth parents.

59. The quality of prospective adopter reports is too variable. While all reports seen were detailed and contained all required checks and references, assessments were not adequately quality assured. Some contained grammatical and recording errors, while others lacked sufficient analysis of prospective adopters' history and experiences to assist workers in the matching process. Not all assessments are completed within the six-month timescale.

60. Child permanence reports are of mixed quality. All reports seen consider various permanence options and reasons for an adoption recommendation. In the better-quality reports, social workers' descriptions and observations bring children to life, along with detailed accounts of their birth family and origins. In the weaker reports, information such as evidence of adoption medicals, the medical adviser's comments and details of brothers and sisters are missing. In these cases, accurate and up-to-date information is not available for children and adopters to assist them in understanding a child's identity and history, either now or in the future.

61. Overall, the quality of matching is effective. There have been no adoption disruptions since 2014–15. Adoption placement reports and adoption support plans clearly describe how adopters will meet a child's needs and the support available. Adoption panel minutes reflect a thorough scrutiny of cases, with panel members asking relevant questions and providing clear reasons for recommendations. However, panel minutes also show that missing or muddled information is insufficiently challenged. This means that adoption paperwork is not updated to assist workers who are considering a match or to help children's and adopters' understanding of events.

62. The agency decision-maker's scrutiny and oversight of adoption panel recommendations are poor, as she is not reading the papers presented due to a lack of capacity. This means that she is not taking a sufficiently considered or thorough approach to lifelong and life-changing decisions. This also means that she is not able to form a view about the quality of the adoption panel's recommendations or the quality of frontline practice.

63. In the small number of cases in which adoption decisions are reversed, there is no evidence that children's looked after reviews are being held to change care plans, and no reports are being sent to the agency decision maker requesting that a decision is rescinded. This lack of oversight by team managers, independent reviewing officers and the agency decision maker means that these children's permanence plans are being allowed to drift.

64. A range of effective post-adoption support is provided, which includes the facilitation of direct contact, letterbox arrangements, birth records counselling and intermediary support. Requests for support from the agency or to the adoption support fund are detailed and well argued, resulting in financial and practical support to sustain permanence.

65. Life-story books and later-life letters are of good quality. Life-story books start from where the child is now, and are beautifully presented with clear information regarding the new family, birth family and the adoption process. Later-life letters are sensitively written, with anecdotes and observations which bring the child's history to life.

66. Adopters who met with inspectors were positive regarding the preparation, assessment and support received from the agency, and all said that they would recommend Tower Hamlets to others.

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

67. The care leaving service team is in touch with 98% of its care leavers (200 out of 204). Personal advisers know most of their care leavers well. Twenty-seven young people currently stay with foster carers after the age of 18 under the local authority's arrangements for staying put. Personal advisers develop sustained working relationships with young people.

68. The team is ambitious in its work to improve outcomes for care leavers. Personal advisers create a positive and safe environment at the care leaving service centre. They help young people to understand how to look after themselves, for example in developing skills such as cookery and money management, and support them if they need help. Care leavers said that these sessions have enabled them to understand better the importance of healthy eating and setting aside budgets for their daily and weekly necessities, such as food and utilities.

69. A local authority audit in 2016 found that the service is not aspirational enough for some young people. This group of young people consists of unaccompanied asylum-seeking minors and young people who were left in neglectful and abusive environments in their early life and who became looked after in their adolescence. More work is needed to improve earlier joint planning and effective transition between the children in care and care leaving

services. There are gaps in services. Some young people have difficulty accessing post-traumatic abuse work, for example, and there is ineffective work to prevent youth violence or involvement in gangs.

70. Support to care leavers in custody (15 at the time of inspection) is variable and inconsistent. Young people in young offenders' institutions, who will move to an adult prison at the age of 18, experience a decline in the level of support from the care leaving service. Personal advisers lack the necessary skills and knowledge to undertake the complex work. Therefore, young people are not adequately prepared for release with the ability to change their previous negative patterns of behaviour. In cases sampled by inspectors, all involving young people serving long sentences for serious youth violence, none had received effective help at the earliest point of need. Most had been displaying challenging behaviour from a young age, but their needs were unassessed, and poor intervention failed to recognise and prevent exploitation by gangs.

71. Almost all care leavers have up-to-date pathway plans, and there are notable examples of good outcomes. However, many plans lack clarity on priorities and actions. Target setting is too often not specific enough, and too many deadline dates for actions are linked to the date of the next review rather than the needs of the young person. There is insufficient knowledge about care leavers' prior educational achievements or barriers to learning in order to understand and identify their needs better.

72. Team managers do not undertake routine quality assurance checks of pathway plans. The views of young people about their experiences are not sought. The majority of management oversight on cases is task and action focused. The analysis does not contextualise history and previous abuse or the impact on the young person's emotions, behaviour, future risk-taking behaviours and outcomes.

73. The care leaving service and the service for children looked after are now under a single service manager. The manager is building a stronger collaborative working relationship with the virtual school to establish better transition arrangements for young people, as they become care leavers. The local authority has recently employed a key stage 5 worker and a specialist to provide better advice and guidance on options for learning, post 16.

74. In 2015–16, 58% of care leavers progressed to further or higher education, employment and training. This was above the average for England as a whole, but remains too low. The proportion has remained around this figure for the past three years. The care leaving service has well-established arrangements for helping young people, who may not have been successful in their learning, to find useful traineeships. Advisers provide good support for the small number of care leavers in higher education. In 2015–16, around 40% were not in education, employment or training, which is too high. However, managers have recognised this and have secured funding to expand work-based learning opportunities.

75. Most care leavers live in suitable accommodation (94% in 2015–16), and personal advisers have helped to sustain this well, over time. The local authority has a good range of housing available at short notice, particularly in the borough, to support young people's move towards independence. Personal advisers assess fairly when a young person is ready to move into independent accommodation. Almost all care leavers said that they feel safe in their accommodation.

76. Insufficient availability of suitable accommodation outside the borough has resulted in a small number of young people living in unsuitable accommodation. The local authority is revising its commissioning arrangements with the intention of improving the service, particularly for out-of-borough placements.

77. Appropriate arrangements for mental health and health assessments are in place for young people coming into the care leaving service. The looked after children specialist nurse makes sure that they have documents on their health histories. When a young person has complex needs, the nurse who works with children looked after makes sure that the care leaver has access to health services in their local area. Emotional well-being for care leavers is appropriately considered, and support is available for them currently via consultation with CAMHS for children looked after. Plans for a new post for CAMHS, based in the care leavers' service, are due for consideration in spring 2017.

78. Care leavers who met with inspectors presented a fair and balanced view of the service. They recognise the good work that the care leaving service does to support them. However, they did not know about either their legal entitlements or some aspects of the service well enough, such as the 'pledge' and the Children in Care Council. This concurs with the manager's view that the service needs to be more user focused and that the young people need to be encouraged to have a more active role in shaping the service.

Leadership, management and governance	Inadequate

Summary

The leadership, management and governance of children's services in Tower Hamlets are inadequate. The chief executive, DCS and elected members did not know about the extent of the failures to protect children from harm until this inspection. An inspection of safeguarding and looked after children services in July 2012 judged services to be good with some outstanding features. Against a backdrop of significant instability and change in leadership at political, corporate and managerial levels, services have significantly declined, particularly for children in need of help and protection. A lack of critical enquiry, combined with an over-reliance on inaccurate performance information and an over-optimistic self-assessment, means that senior leaders and politicians have failed to take effective action, leaving children at risk of harm.

An improvement and inspection board established in September 2016 has not been effective. It lacks an overarching strategic plan to drive the extensive change required. Political and operational leaders are not members of the board and do not have an accurate understanding of the weaknesses across the service. Leaders and managers are unable to assure themselves that children in Tower Hamlets are safe.

At every level, the application of thresholds is inconsistent. Weaknesses in recording in children's case files mean that it is impossible to understand how critical decisions about children's lives are made or what has happened as the result of intervention. Performance management and quality assurance systems have not been effective in challenging the entrenched culture of non-compliance with basic social work standards. This is a corporate failure by the local authority that leaves too many children in neglectful and abusive situations for too long.

The local authority and its partners have been more effective in prioritising and developing a strategic response to child sexual exploitation and actively delivering services to counter the risk to children of radicalisation and female genital mutilation. A wide range of awareness raising has taken place in the community. Nevertheless, more work is required to understand the crossover between child sexual exploitation, being missing, youth violence, gangs and radicalisation.

Corporate parenting arrangements are a strength, and there is good engagement from children and young people. Political leaders have been effective in ensuring additional financial support in response to increasing demands across the service.

Following this inspection's findings, senior politicians and local authority leaders gave assurances that immediate action will be taken to protect children and that they will fully accept all inspection recommendations.

Inspection findings

79. Inspectors identified serious and widespread failings across the service for children in need of help and protection. Services have deteriorated in all areas since the inspection of safeguarding and looked after children services in 2012. Attempts to drive improvement have had little impact. Senior leaders have not accurately addressed critical weaknesses in management oversight or social work practice. As a result, elected members and senior leaders cannot be confident that children in Tower Hamlets are safe.

80. The DCS took up an interim position in July 2015 before her permanent appointment in March 2016. Despite uncovering a deeply worrying picture regarding the services provided to children, actions taken to tackle some of the deficits, such as a review of the MASH, workforce development, increased child-level data and an improvement and inspection board, have not been sufficiently systematic or effective in addressing the widespread concerns, and consequently children in Tower Hamlets have been left at actual or potential risk. Senior managers and leaders have not been successful in delivering the changes quickly enough to tackle the deficits in frontline operational activity. When service improvements have occurred, they remain fragile and, in some areas, the progress has been too limited or not sustained. In response to the inspection findings, the current senior leadership team has demonstrated a determination and commitment to improve services.

81. The divisional director's span of responsibility is too broad to address the widespread and serious concerns. Consequently, senior managers were unaware of a number of serious and critical practice issues identified during the inspection, for instance babies and young children living with domestic violence. Further examples include children left unprotected and at risk of significant harm due to poor management oversight, and weak assessment and recognition of what constitutes a private fostering arrangement. In response to concerns raised by inspectors, the local authority took appropriate action to provide additional senior operational management capacity. This lack of capacity should have been identified and tackled sooner.

82. During the five months prior to the inspection, the improvement and inspection board, chaired by an external consultant, has overseen a wide range of practice issues through monthly meetings. The board has had limited impact. While board minutes evidence detailed discussions about data and audit findings, the board lacks a coherent, overarching strategic plan to drive the change required. This impedes the local authority's ability to track and evidence progress. Service plans are in place, but they lack sufficient detail regarding the delivery of key targets. Leaders are not held to account for improving services. The lack of involvement in the board by the DCS, the chief executive and the lead member has limited its effectiveness and contributed to a lack of corporate ownership of the shortfalls in services for vulnerable children. This is a serious omission.

83. Senior managers have not been effective in addressing poor practice by first- and second-line managers. An entrenched culture of non-compliance with basic social work standards continues to be a significant weakness. This has led to delays in progressing work effectively, which have left some children in situations of escalating and actual risk of harm. Inspectors identified a number of children for whom senior managers had to take immediate action to ensure their safety.

84. At every level, the application of thresholds is inconsistent. This is apparent from the first point of children's services intervention, including core safeguarding activity such as child protection investigations and entry to care. Children spend extensive periods in the pre-proceedings stage of the PLO, with no review or progress against agreed actions. As a result, too many children experience significant delay and remain in situations of risk for too long. Case recording by social workers and managers in many children's case files is so poor that it is not possible to tell how decisions are reached regarding children's lives or how intervention is reducing risk.

85. Social work practice in response to the risks of child sexual exploitation is inconsistent. Social workers and managers lack an understanding of sexual exploitation and do not consistently use assessments to identify risk or focus plans on reducing vulnerabilities and improving outcomes for children. Inspectors identified a number of children for whom social workers had not recognised the potential signs of child sexual exploitation. This was particularly evident in the MASH and in the paediatric psychosocial hospital meeting, at which inspectors referred seven children's cases back to the senior managers. This demonstrates that too many children are not having the protection and support that they need.

86. The local authority and its partners have been more effective in prioritising and developing a strategic response to child sexual exploitation. A wide range of awareness raising has taken place in the community. However, more work is required to understand links between child sexual exploitation, being missing, youth violence, gangs and radicalisation. Children who go missing from home and care are a priority for the local authority and its partners. Nevertheless, too few children who go missing receive a return home interview. This is a missed opportunity to learn, understand and identify patterns and trends to reduce further incidents.

87. The overview and scrutiny panel meets regularly and has appropriate cross-party political attendance. The panel has considered a wide range of issues, including the Children and Families Plan, and the chair has led a comprehensive review on the 'Prevent' duty. However, scrutiny does not offer robust challenge to senior managers on the effectiveness of services for the most vulnerable children in Tower Hamlets. For example, the improvement and inspection plan has not been on the panel's agenda, and members were not aware of its existence at the time of the inspection.

88. The collation and analysis of reliable performance information remain a challenge to the local authority. This is largely due to social workers and managers not updating records on the electronic recording system. Daily child-level data is now available to managers, and the local authority reports that this has led to some very recent improvements, but more work is required to ensure that measures are in place to understand performance in all areas. For example, the local authority does not report on children in need, and the performance information relating to missing children is inconsistent. This weakens the local authority's capacity to analyse and respond to dips in performance.

89. A quality assurance framework, relaunched in June 2016, provides a robust case auditing and management oversight model. However, it is not yet delivering much-needed scrutiny of performance management. This is due to non-compliance by managers in conducting audits, combined with a lack of understanding of what good practice looks like. There is no robust system in place to ensure that specific tasks from audits are consistently completed, resulting in continuing drift and delay for too many children. For example, an audit of section 47 child protection enquiries carried out in May 2016 identified significant weaknesses in safeguarding practice. These weaknesses included poor assessment of risk, an over-reliance on parental explanations and a lack of professional curiosity and judgement. These weaknesses continued to feature in a subsequent audit carried out in December 2016 and were common features in a number of cases seen by inspectors.

90. A significant challenge facing the local authority is the instability in the children's workforce, with high vacancy rates and use of agency staff at both social worker and manager levels, although overall vacancy rates are lower than the London average. Caseloads remain variable across the service, and the highest caseloads are in the assessment and early intervention teams. This has directly affected this area's turnover of staff, which has increased significantly from 10% in 2015 to 30% in 2016. A draft workforce strategy (January 2017) has informed the children's services transformation redesign, which is ready for implementation. The local authority expects to reduce caseloads to a maximum of 18 children, but, at the point of the inspection, this had not been achieved.

91. An appropriate range of training is available to staff, but a training needs analysis has not been conducted, and there is no overall record of staff training. The local authority does not rigorously evaluate the impact of training to inform understanding regarding its effectiveness or enable it to focus attention on areas of the greatest priority. Most supervision records seen by inspectors contained brief records, and did not demonstrate reflection or challenge to poor social work practice.

92. The local authority has a variety of commissioned and in-house services for children and families. Services commissioned are based on identified needs, informed by the joint strategic needs assessment (JSNA) and a separate

safeguarding children's factsheet. The local authority has agreed key priorities and has recently set up a joint executive commissioning group to take this work forward, in the absence of a commissioning strategy. Senior leaders and partners recognise that a more integrated approach is required from across the partnership to provide effective services and to improve outcomes for children and families.

93. Established links are in place to the Health and Wellbeing Board (HWBB), the children and families partnership and the LSCB. The DCS is a member of all of these forums. The Children and Families Plan appropriately focuses on a range of key priorities for children. The JSNA has shaped the HWBB strategy. For example, a key priority is to develop an integrated system to strengthen commissioning arrangements at an operational level to support and prevent children coming into care. Children, led by the young mayor, have attended the board and directly influenced the CAMHS transformation plan, resulting in the clinical commissioning group changing the language used in its written materials regarding children with mental health issues. Further work is required to ensure greater collaboration between various boards, in particular the community safety partnership.

94. The DCS was active in the recruitment and appointing of a new chair of the LSCB in October 2016. Links between the chief executive, DCS and lead member are clear, and there are regular, formally recorded meetings. The chief executive chairs bi-monthly corporate safeguarding meetings to ensure awareness of risks across the council. However, there are no formal links between this group and the improvement and inspection board, and this reduces the chief executive's knowledge of frontline practice and impedes his understanding of the widespread and serious concerns.

95. Corporate parenting arrangements are strong. The lead member chairs the corporate parenting board effectively and has good representation from elected members. Children looked after and care leavers attend and co-lead the meetings. The board utilises appropriate challenge to partners to improve services for children looked after and fulfils its responsibilities well. For example, the board endorsed a successful growth bid to increase the provision for the education and training needs of care leavers, organised a summer school and increased social activities with the Children in Care Council.

96. Strong partnership work to counter the risk to children from radicalisation is having a positive impact. The preventing violent extremism team works with children and families and completes good-quality assessments and targeted work to reduce risks and improve outcomes for children.

97. There has been effective work through community events, including a 'harmful practice' conference, to raise awareness of female genital mutilation. The female genital mutilation specialist social worker has forged effective links with health and education, identifying 133 children who could be at risk.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The LSCB in Tower Hamlets is judged to be inadequate, as it is not discharging all of its statutory functions. Insufficient monitoring of the quality of frontline practice has meant that the board was not aware of the failings to protect children until this review. An independent review of the board was commissioned by the DCS in September 2016. A new independent chair was appointed in late October 2016, with a view to responding to the findings and recommendations of the LSCB review. The chair is effectively refocusing the board's priorities by increased scrutiny and challenge.

The LSCB annual report 2015–16 provides an assessment of the effectiveness of local services and some analysis of their impact. It identifies three key priorities for the board in 2016–17, although without a clear rationale for their prioritisation with regard to competing issues. Further work is required to ensure synergy between various boards, in particular with the community safety partnership, to ensure tighter joint priorities and to reduce duplication. The board receives a quarterly performance report that highlights issues that require further understanding or analysis. The performance dataset requires refinement, and there is insufficient alignment to the board's key business and priorities. There has been limited case file audit activity during 2016–17, impairing the board's ability to be assured of the effectiveness of frontline practice with respect to the safeguarding of children at risk of sexual exploitation and neglect. However, funding for a data analyst is in progress, and the LSCB is undertaking an audit of harmful sexual behaviour, in partnership with the NSPCC.

The board has developed a local profile of child sexual exploitation victims and trends, and delivered a wide range of awareness raising activities, including the recruitment of young safeguarding champions, to engage with schools with regard to sexual exploitation and associated risks. An essential profile of perpetrators and of the relationship between youth violence, gang activity and child sexual exploitation is not yet in place.

The board has effective processes to review child deaths, serious incidents and cases of concern. Learning from SCRs has been widely shared, and partnership learning led to a review of threshold guidance and some positive service developments. The board has a thorough learning and improvement framework, following a comprehensive review of its priorities for learning, built from national and local findings from SCRs and thematic reviews. There is an extensive and well-utilised multi-agency training offer. However, the board cannot yet demonstrate the impact of learning on frontline practice and outcomes for children.

Recommendations

- Urgently review monitoring and governance arrangements to ensure that the board is fulfilling all of its statutory functions.
- Prioritise multi-agency monitoring of frontline practice to ensure that the board has effective awareness of the quality of practice and its impact on outcomes for vulnerable children.
- Ensure that the business management capacity of the board is sufficient to meet the need.
- Ensure that the board prioritises the response of the partnership to the issues of youth violence and gang activity and their relationship to child sexual exploitation, including the development of a comprehensive problem profile.
- Ensure that the effectiveness of multi-agency training is monitored and evaluated, including training for staff in recognising and assessing risks to sexually exploited children.

Inspection findings – the Local Safeguarding Children Board

98. Tower Hamlets Safeguarding Children Board is judged to be inadequate, as it is not effectively discharging all of its statutory functions. The relationship between the recently established executive board and the wider LSCB is not effective in facilitating the monitoring and evaluation of the impact of the board's work programme, and there remains confusion over the differing functions and purpose of the two bodies.

99. The board has an excessively large membership, limiting meaningful debate and effective decision-making. The lead member has not exercised her responsibility as a participating observer at board meetings since her appointment in May 2015, weakening her ability to scrutinise and hold the DCS to account. Board agendas are extensive, but are not sufficiently focused on the core business and key priorities. The new independent chair is reviewing the board's governance arrangements, structure and membership. He is also seeking to ensure connected priorities across the community safety partnership, the Safeguarding Adults Board and the LSCB. There has been limited case file audit activity during 2016–17. Board member agencies have signed up to the pan-London information sharing protocol, but legitimate concerns with respect to information sharing and consent issues have delayed the completion of the two multi-agency case audits commissioned by the quality assurance and performance subgroup. Consequently, the board is not assured of the effectiveness of frontline practice with respect to the safeguarding of children at risk of sexual exploitation and neglect.

100. The board has not ensured a timely oversight of key practice areas. The 2015–16 annual private fostering report has yet to be considered. The annual

IROs', child protection conference chairs' and designated officer's reports for 2015–16 have yet to be presented, leaving the board insufficiently sighted on the effectiveness of these critical service areas.

101. The LSCB website requires significant improvement, as much information is basic and it does not promote the work or function of the board to the wider community. This has long been recognised by the board, and progress has been too slow.

102. The LSCB annual report 2015–16 provides an assessment of the effectiveness of local services and some analysis of their impact in respect of the nine 2015–16 LSCB priorities. It identifies three key priorities for the board in 2016–17, although without a clear rationale for their prioritisation.

103. The LSCB has not has sufficient administrative capacity. Additional business support has recently been secured. The chair has appropriately identified that the additional capacity should be targeted to ensure that the board can deliver its core functions, in particular in the areas of governance and quality assurance.

104. A thorough section 11 audit was undertaken in 2016, and the independent chair held meetings with each partner to hold them to account for the progress of actions identified. Thematic areas for improvement have been identified and progressed, for example in ensuring that commissioning arrangements include explicit reference to safeguarding responsibilities in line with section 11 standards, although compliance with this has not yet been tested.

105. The performance dataset received by the board is too large and is not sufficiently focused on core business and key LSCB priorities. There is no performance dashboard in place to ensure the easy identification of trends.

106. The board has undertaken innovative work in engaging with children and young people through the awareness raising and engaging communities (AREC) sub-group. Consultation with the youth council identified risks associated with social media as a major issue for children. This led to the active recruitment of young safeguarding champions. These children have been trained and supported by the National Society for the Prevention of Cruelty to Children (NSPCC) and the youth service, and are currently developing a social media awareness raising video, which they plan to take into schools during 2017.

107. The AREC sub-group ensures that the board has an interface with the voluntary sector. The group collates and distributes a safeguarding calendar of key national and local safeguarding events and associated activities, and supports networking around the mutual sharing of safeguarding information and learning opportunities. For example, the group is coordinating a programme of events on and around the national child sexual exploitation

awareness day. In addition, the LSCB holds a joint annual safeguarding awareness month in collaboration with the Safeguarding Adults Board.

108. The board has a robust learning and improvement framework, which is appropriately ambitious and informs the board's well-utilised training offer. The impact of learning on practice and on outcomes for children has not been evaluated.

109. Learning from the 'Troubled Lives, Tragic Consequences' thematic review and the last two SCRs has been disseminated across the partnership, resulting in positive multi-agency collaboration. For example, CAMHS developed a new conduct disorder pathway, co-locating staff within children's social care effectively and providing consultation for children who display harmful behaviours. However, the board has not been sufficiently rigorous in ensuring an effective partnership response to the safeguarding risks associated with youth violence and gangs, which have emerged from these reviews.

110. The LSCB has an effective process in place to ensure the review of serious incidents and cases of concern. The case review sub-group ensures that the commissioning of learning, training and audit activity is linked to its findings. There is an effective child death overview panel (CDOP) that takes a proactive approach to identifying themes and issues emerging from its work. There is good multi-agency engagement, which supports the timeliness of reviews. Actions are tracked and monitored effectively. The CDOP annual report 2015–16 identified that, when modifiable factors are identified, positive action has been taken to ensure that learning leads to appropriate preventative action.

111. The board has a comprehensive child sexual exploitation strategy and action plan. However, the delay to the thematic case file audit has meant that the impact of the strategy on improving frontline practice remains unassessed. Progress against the action plan is reported on a quarterly basis to the board and, when appropriate, issues preventing progress are escalated. For example, the lack of a multi-agency sexual exploitation data analyst and intelligence officer limits the LSCB's ability to understand the borough's perpetrator profile and the links to youth violence and gang activity, or to ensure that activity and resources are appropriately targeted. This has been escalated, and a funding decision for an analyst post is awaited.

112. The child sexual exploitation sub-group has developed a local profile of victims and trends in relation to the nature of exploitation activity. Together with the AREC sub-group, this has led to more targeted and focused work in key schools and greater emphasis on the increasing prevalence of online grooming. A wide range of activities have taken place to engage with communities to raise awareness of child sexual exploitation. Of particular note has been the engagement with imams and other community leaders to secure their promotion of awareness raising seminars being held in mosques, schools and other community venues. This has led to an increase in related referrals

in the borough, and consequently the identification of more children at risk of exploitation.

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 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 young 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 and one social care regulatory inspector.

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