# Children's Care and Support Self-Evaluation

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

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lbbd.gov.uk


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## 1. Introduction

This is the latest Barking and Dagenham's Children's Care and Support self-evaluation as at end of February 2024/25. The self-evaluation provides an assessment of the quality and impact of social work practice; how we know this and plans for the next 12 months. The self-assessment also specifically references progress against the eight recommendations made by OFSTED in July 2023 where they felt improvement was most strongly required.

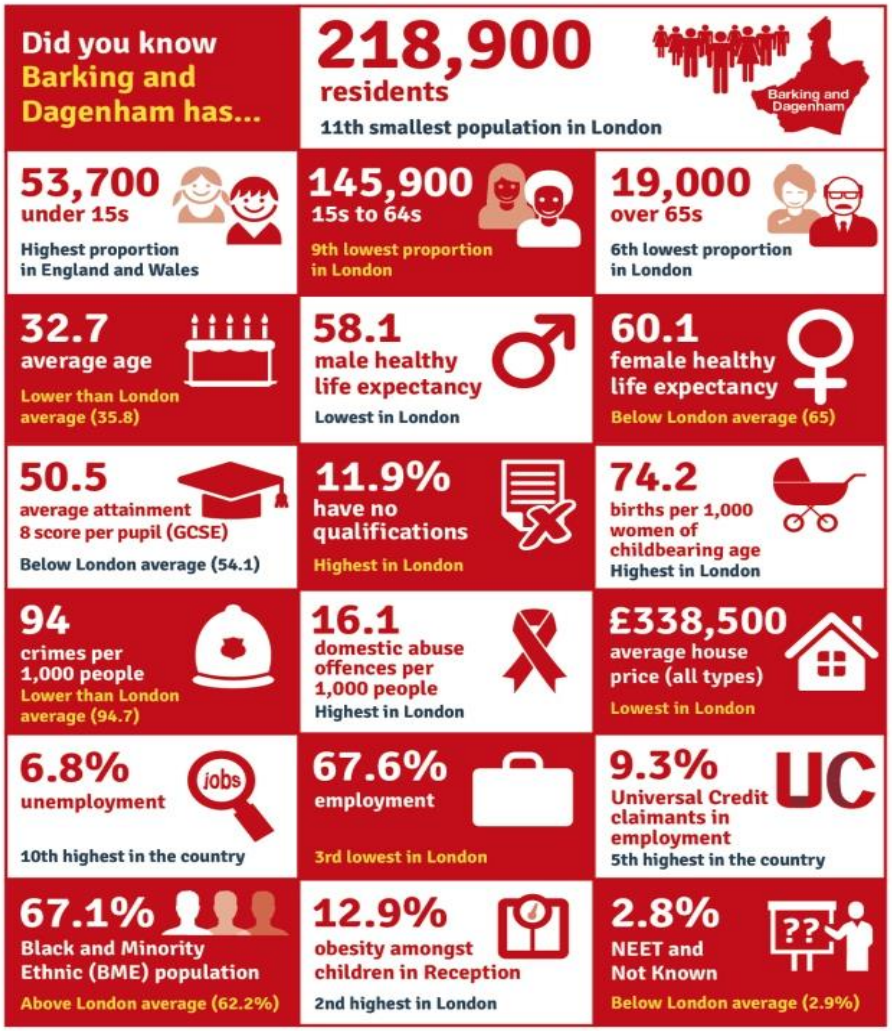
We continue to drive our improvement journey and implementation of the improvement plan. Good progress has been made, and performance has improved in many areas. We recognise, as ever, there is more to do , but we know ourselves well and are clear on the areas for further improvement .We remain steadfast in and ambition to deliver good social work practice, and ultimately improve the lives of children, young people, and their families.

The council is facing significant financial pressures and challenges. Despite this context, our plan for the future of our borough aims to address challenges and build on opportunities. The vision is to make Barking and Dagenham a place people are proud of and where they want to live, work, study and stay. Our 2023 Corporate Plan sets seven priorities to meet this vision, available here.

Our Best Chance strategy - which is our partnership plan for babies, children, young people and their families guides our partnership work, providing a baseline for our ambitions and makes clear the outcomes we are working on together i.e. every baby, child, young person and their family gets the best start, is heathy, happy and achieves, thrives in inclusive schools and settings, in inclusive communities, are safe and secure, free from neglect, harm and exploitation, and grow up to be successful young adults.

We are confident that our established partnership and its underpinning vision provides a solid foundation on which to build as we embark on children's social care transformation in line with the national social work families first reform.

## 2. Information about Barking and Dagenham




- Barking and Dagenham has one of the fastest growing (working age) populations. Approximately 219,000 people live here - an increase of 18% since the 2011 Census (3rd highest in England and Wales). A further 7% growth expected by 2025.
- Barking and Dagenham has the highest proportion (26.1%) of residents aged under 16 in England and Wales. 31.5% of the population are aged 0-19 the highest proportion in any comparator area and the largest growth in last 10 years compared to similar areas.
- We have high levels of population churn and are one of the most ethnically and culturally diverse communities in England with 2 in 5 residents born outside of the UK (16th highest in England and Wales).
- The borough faces some significant challenges with high levels of deprivation - 21st highest deprivation score of the 317 local authorities measured on the Index of Multiple Deprivation. Nearly half of children (46%) are estimated to live in poverty – 3rd highest rate in England and Wales. 6 out of 10 households are deprived, highest in England and Wales.
- This is interwoven with high unemployment rates, fuel poverty and debt. 6% of residents aged 16 and over were unemployed (including full-time students) – 7th highest proportion in England and Wales. 18% of economically inactive residents aged 16 and over have never worked.
- Barking and Dagenham had the highest proportion of households in London where at least one person identified as disabled (30%) and overall poor health outcomes and lower life expectancy.
- Domestic abuse remains a significant issue and impacts on all service areas – 17.5 domestic abuse offences per 1,000 people - highest in London. It accounts for 40% of violence with injury offences in the borough and is a presenting factor in nearly a quarter of children's social care contacts annually.

## 3. THE EXPERIENCES AND PROGRESS OF CHILDREN WHO NEED HELP AND PROTECTION

### Early Help

**What data and performance tells us.**

Demand has increased in the early help service with 3,381 targeted early help online referrals year to date, representing a 21% increase on the same time period last year. Effective triage and screening processes result in nearly a quarter of referrals result in targeted early help or continued social care involvement. The remainder are referred to other agencies or provided with guidance, information, and advice. This approach helps prevent children from being referred into MASH.

There were 405 families with 929 children open to targeted early help at the end of February 2024/25, an increase of 51 families and 146 children compared to this time last year.

Nearly a third of children open to targeted early help are white British (30%), a figure disproportionately high compared to the 22% of white British children in Barking and Dagenham's under 18 population. 23% are Black and 22% are Asian – those ethnic groups constitute 30% and 25% of the borough's child population respectively.

Children aged 10-15 make up 44% significantly higher than the 32% representation in the borough's child population. Conversely, children aged 0-4 constitute 19%, compared to 30% in the borough. For children aged 5-9, the figures are 29% for the service and 28% for the borough, while those aged 16-17 are 8% in the service and 9% in the borough. 55% of children open to the service are male, slightly higher than the 52% in the borough, while 44% are female, compared to 48% in the borough.

Mental health issues (28.0%) and behavioural issues (16.9%) were the top two presenting issues for open children in February 2025, both increasing on last year especially mental health. Domestic abuse accounted for 20% of open children in February 2025, up from 15% in February 2024.

The majority of families have been open for 0-3 months (79%). Those families open for over 6 months has dropped significantly from 10% to 1.5%, indicating a shift towards prompt and effective intervention, and families closing in a timely way.

Since April 2024 to date, an average of 57 families and 125 children have had a completed early help assessment each month compared to a monthly average of 71 families (155 children) in 2023/24. This is lower due to the increasing number of referrals and number of families/children open to the service. We have the 10$^{th}$ highest rate of assessments in London

Caseloads across the targeted early help service are manageable and remain at an average of 9 families and an average of 21 children at end of February 2024/25.

**Good and improving performance**

Despite increase in demand, 96% of referrals are screened within 3 working days above local target of 95%. The TEHAS service continues to promptly address referrals to ensure children and families are triaged to receive the support they need without delay.

Repeat early help children and families is a key impact measure and the good news is that in this current year the re-referral rate is lower at 12% (below the set target of less than 15%). This demonstrates effective early interventions providing lasting support and reducing the need for repeated early help involvement.

Early help assessment (EHA) timeliness has improved with 91% completed in 35 working days above target. The service is prioritising timelier early help assessments i.e. within 20 days. The year-to-date percentage for EHAs completed within 20 days is 47% with a February monthly figure of 70%.

96% of families open to Targeted Early Help who have a completed and authorised Early Help assessment have completed a team around the family (TAF) meeting, 8% higher than 2023/24 outturn.

In addition, 88% with a completed EHA have a timely TAF meeting – although not at target of 90% is good performance overall.

Home visits to families completed within 5 working days of case allocation is an improving picture at 82% (81% last year) demonstrating the improvement in the early help service of seeing children and families quicker, ensuring earlier intervention and improved outcomes.

**Performance areas requiring improvement.**

80% of children are seen every 4 weeks as at end of February 2024/25 with a year-to-date average of 86.5%. This is lower than the 2023/24 figure of 91% and below target of 90%. Performance needs improvement to ensure children are seen monthly for continuous monitoring, timely interventions, and support.

Supervision timeliness at 4 weeks has improved - 84% as at end of February 2024/25 , a 13 percentage point improvement compared to January but has been 80% since September 2024. Further consistent improvement required to exceed target of 90%.

Performance on allocating children within 2 days is poor at 21% year to date at end of February 2024/25, and declining performance on end of year 2023/24 at 30%. This is also the case for allocating children within 10 working days with year-to-date performance at 67%, against at 95% target.

Children allocated in 10 days - stepped down children only – at end of February 2024/25, 88% were stepped down in 10 days compared to 94% at end of year 2023/24 (target 100%).Staffing vacancies has impacted here.

**Practice – quality and impact**

Children and families have access to a range of universal and targeted early help services, with more targeted intervention and complimentary support from the new Family Help Hubs. Monthly audits are demonstrating early help assessments and plans that are timely, of good quality, improved multi-agency work, appropriate interventions and consistent collaboration across targeted early help and children's social care. This ensures children receive comprehensive support from various professionals at the right time.

A programme of events with partners have been held with a focus on LBBD threshold document / continuum of needs /level and tiers of Intervention

The continuum of need threshold is firmly embedded across the partnership with audit evidencing most partners know when to refer for early help versus a MASH referral being needed. Audit and dip samples evidence that targeted early help and MASH apply thresholds appropriately to inform decisions, documented in manager's decisions. MASH and early help interface has been strengthened and there are now very few escalations from early help colleagues.

In addition, the screening team call the referrers where referrals seem inappropriate i.e. not meeting threshold and advise on services and signpost to relevant services. Partners use the advisory service to discuss concerns before referrer thereby reducing the number of referrals.

Joint MASH, assessment and targeted early help meetings has strengthened the collaboration between services and consistency of approach and mutual appreciation of respective pressures, roles and responsibilities.

Targeted early help managers continue to use the current step-up and step down protocol in collaboration with MASH and assessment colleagues. This contributes to timelier step across and a strengthened understanding of thresholds and mutual agreement on where family needs can best be met.

Priority work has been undertaken in domestic abuse and neglect. All early help staff have been trained in the use of DARAC (domestic abuse risk assessment tool). The use of the DARAC tool is monitored through the supervision process with workers. Domestic abuse oversight by managers is evident in supervision in the majority of cases (85%). Safety plans are completed with children and survivors and reviewed throughout the intervention. The quality of safety planning and ensuring the lived experience of the child is understood in those circumstances are areas of ongoing focus.

The Liquidlogic EHM system has been amended to enable greater accurate recording of neglect at the initial screening stage and again after the assessment. All staff training on neglect has been prioritised and supported by the quality assurance strengthening practitioner understanding of identification and holistic responses to neglect.

GCP2 training is ongoing delivered in house and across the partnership and use of the tool is monitored through the monthly performance meetings. We are seeing an increasing number being opened although this remains an area of

ongoing focus. LBBD have recently piloted the NSPCC GCP2, a pre-birth tool. We anticipate we will go on to use this as early indications are the tool supports a greater understanding of risk factors and vulnerabilities to unborn babies.

The proportion of children identified with neglect as a presenting need has more than doubled in the last year to 14% at end of February 2025, evidencing a positive impact of increased awareness and training across the partnership. The partnership lead neglect improvement programme has brought about new initiatives designed to offer practical support to families impacted by poverty, a key driver for neglect e.g. help for families who have mould within their properties and a 'Baby Box' provision which will be provided along with wrap-around package of care to ensure that new parents are provided with safe sleeping provision and essential items.

Regular thematic reviews of families with neglect are now completed on a quarterly basis with clear actions to address identified areas of improvement.

Management assurance boards are held quarterly. The focus is on the quality of interventions, key challenges for the localities and staff training and development. This supports single oversight and challenge at a senior level.

A permanent head of service was recruited in the summer of 2024 and has been leading the further development of the service. Vacancies and staff sickness have had an impact on the service, particularly allocation timeliness. The management team have worked hard to address this by recruiting agency staff and additional students. They have recently introduced a senior FSW role as a career development opportunity, supporting retention but also bringing added capacity to the management function.

Where there is delay in allocation, managers ensure robust oversight and risk assess on a case by case level. This includes contacting parent's and carers ensuring safe allocation prioritisation.

**Family Hubs**

Our three Family Hubs are fully operational and working well, meeting the minimum expectations during the life of the programme, with many 'go further' expectations also being satisfied. This is demonstrated in the most recent progress update to the DfE. The aspects relating to the Home Learning Environment (HLE) and Early Language have now been embedded.

Multiple new, or revamped, programmes are now in place through our hubs covering a wide range of disciplines from perinatal mental health and parent infant relationship programmes; through to parent/carer panels and infant feeding programmes, as well as our innovative SEND stay and plays. Effective links have been made with our midwifery team and have recently secured a co located midwife based in the Dagenham hub.

Family Navigators play a vital role for families in need of support and advice. Nearly 3000 individuals have been positively impacted by the six family navigators since the start of the programme in May 2023. Of those, just over 2000 have been supported within the last 12 months.

While families are presenting at the Hubs as anxious, worried, and stressed prior to asking for support, feedback highlights they are leaving feeling supported, optimistic and happy: over 90% tell us they got the support they need and 7% said that they got some of the support they needed.

In addition to supporting families, the Family Navigators also support the workforce with the promotion and delivery of training within the Hub. Since April 2024, they have led on delivering multiagency training for the use of genograms in practice and our Lead Professional and Team Around the Family training. These are run on a rotating monthly basis throughout the three Hubs and resulted in approximately 80 staff from a range of services being trained. Feedback shows an increase in both worker knowledge and confidence : *"fantastic training. Thankfully with it being a small group we were able to have great discussions. I feel much more empowered. Thank you."*, *"I will use the knowledge gained to examine family system and dynamics", "I learnt the importance of mapping out a family from not only the family members perspective but also from the perspective of the child*" and "*this was a topic I really didn't understand but I am really glad I attended".*

Ongoing development of the Family Hub offer will continue during the forthcoming year, with plans to expand our HLE and early language offer considerably, and the range of our parenting interventions including adopting the Solihull parenting programme , due in May 2025 .

The Voluntary and Community Sector (VCS) also deliver programmes in the hubs. This is enabling improved connectivity between third sector, community, faith sector and education settings. This is particularly evident through the Strengthening Families, Strengthening Communities (SFSC) programme where VCS staff have been trained and have co delivered groups.

**Plan for next 12 months**

- Stabilise staffing to ensure improved timeliness of allocation.
- Further embed Solihull approach and the Solihull parenting offer Work with children's care and support colleagues and partners to deliver on the social work reforms
- Ongoing learning from audit.

## MASH – thresholds, contacts and referrals

**What data and performance tell us.**

Contacts made to children's social care multi agency safeguarding hub (MASH) remain relatively stable - monthly average of 1,095 so far in 2024/25 compared to 1,186 in 2023/24.

Contact timeliness has improved with on average 89% of all contacts completed within timescale this year. An average of 97% of RAG rated RED contacts are dealt within one working – day, amber contacts is at 88% and 95% of contacts RAG rated Green are dealt within three working days. In the month of February, contact timeliness improved to 100% for those RAG rated red.

Contact to referral rate is higher this financial year (40% at end of February 2024/25) compared to 33% in 2023/24 – conversion rate remains above London average and second highest contact to referral rate in London, an indicator of demand in the borough.

The number of referrals is on an upward trend, with a monthly average of 442, compared to 387 in 2023/24. The projected referral rate per 10,000 for 2024/25 is 824 (annualised) compared to 721 in 2023/24. The rate remains above all comparators (England 518, Statistical Neighbours 602, London 556).

Majority of referrals are received by Police and Schools (Education). An increasing proportion progress to a statutory single assessment (95% as at end of February 2024/25, 1% higher than 2023/24 and 8% higher than 2022/23).

Good performance is reported on feedback to referrer – a monthly average of over 90% this year comparable with previous year.

Repeat referrals is 22% at end of February this year compared to 21% in 2023/24 - now in line with England (22%), but slightly above similar areas (21%) and London (19%). Performance is lower than the 26% reported in 2022/23.

Just over 70% of strategy discussions are being in held in time (within 3 working days) and this is an ongoing priority area for further improvement.

On average 65% of strategy discussion are progressing to Section 47 enquiry - higher than the 2023/24 average of 58%, a positive direction of travel.

The number and rate of S47 investigations decreased from 1320 (206 per 10,000) in 2022/23 to 1160 (180 per 10,000) in 2023/24. Current numbers in 2024/25 are already higher than the previous year in total, with 1269 initiated as of the end of February.

The percentage of s47 investigations resulting in no further action has increased from 8% in 2023/24 to 13% as of the end of February 2024/25.

The proportion of s47s progressing to ICPC decreased to 29% in 2023/24 compared to 41% in 2022/23 and has remained at this level so far in 2024/25. We remain in line with comparators at around 30%.

The number of ongoing assessments is manageable at a monthly average of 588 so far this year – higher than the 550 in 2023/24, but lower when compared to over 700 in 2022/23. Average caseloads in Assessment and Intervention have remained stable – averaging around 20 children throughout the year. There tends to be fluctuations with caseloads related to duty week and social work capacity.

So far this year, 5297 assessments have been completed, nearly 900 more (20%) than this time last year – due to a higher number of referrals.

Overall, 90% of single assessments are completed within 45 days and performance is above average compared to statistical neighbours, London and national. The Assessment and Interventions service complete most single assessments and timeliness in that service remains high at around 95% throughout the year so far.

A high proportion of children are seen during assessment (93%).

**Practice – quality and impact**

MASH continues to operate effectively, with strong relationships between all partners. The partnership has been further strengthened with the education lead joining over a year ago, and with the dedicated Support to Safety team within the MASH committed to responding to domestic abuse related contacts.

Overall audit findings confirm decision making in MASH is robust, timely and informed by MASH enquiries where partners have contributed information enabling the MASH managers to make evidence-based risk assessment and decisions.

MASH has delivered presentations to a wide range of partners including MASH Partnership Meeting, MASH and Early Help drop-in session for community partners, Mental Health, Schools, NELFT – Health Visiting Team, Safeguarding Leads of Faith Groups. Those events have focused on the LBBD threshold continuum of needs; level and tiers of intervention; quality of referrals and improving partnership working. This has contributed to improvement in the quality of referrals, as well as the number of referrals made by schools and health visitors.

Professionals continue to make good use of the consultation line, offering an opportunity to talk through their concerns with a MASH social worker and whether to refer.

The MASH partnership is a committed team who work well together. Processes are well embedded ensuring clarity of roles and responsibilities. Regular MASH partnership meetings enable best practice to be shared and learning from research, audit, and serious incidents.

The quarterly MASH partnership board, chaired by the director of operations in children's social care, continues to keep oversight of the improvement work and quality of practice and performance in MASH.

The emergency duty team (EDT) led by Redbridge continues to provide timely and proportionate response to children's needs out of hours. Communication and handovers are well managed. When required, the EDT holds strategy meetings with the police, to ensure immediate action to safeguard children.

Multi agency audits of the quality of MASH contacts received, and MASH response continues on a monthly basis. Overall MASH is making the right decision in a timely way and children are not left at risk. The quality of MARFs from education and health partners are addressed directly by the MASH education partner and health safeguarding lead who both sit on the audit panel.

Majority of information-sharing between the MASH partners and professionals is timely, specific and effective. Most MASH enquiries are thorough referring to history, with a rationale for decisions being made. The impact of child is considered and parents views sought when right to do so. Over 60% of referrals into MASH now have a detailed MASH enquiry, which contributes to improved decision making.

Audits show some issues with timeliness of health information sharing delaying MASH enquiries or enquiry happens without health input. This is being addressed via the Health MASH practitioners. MASH social workers have also been advised not to cut and paste emails into the MASH assessment.

Regular re-referral audits and dip samples are undertaken on cases subject to re -referral. Findings highlight good MASH decision making, and appropriate and timely early help interventions -neither of which were contributing to the increase in re-referrals.

MASH head of service undertakes a weekly review of no further action referrals by the assessment and intervention service. Numbers remain appropriately low. This management oversight activity ensures learning, and improved application of threshold.

Joint MASH and assessment and intervention service meetings has strengthened the collaboration between the two services and consistency of approach and mutual appreciation of respective pressures, roles and responsibilities.

The Support 2 Safety (S2S) domestic abuse team in MASH shows consistently strong decision making and application of threshold. The expertise within this team continues to strengthen the quality of decisions with the needs of perpetrators being routinely considered, safety planning included and has seen a marked increase in referrals to MARAC.

Domestic abuse features in repeat contacts and repeat referrals, and whilst this is still evident, dip sampling shows this is less so with the S2S improving signposting and strengthen decision making at the front door on threshold for assessment or strategy meetings.

Performance data highlights there is an increase to Cranstoun (perpetrator) with the implementation of S2S. Multi agency MASH monthly audits has also highlighted good and outstanding MASH responses by the S2S, showing children living with domestic abuse are being better understood and responded to.

Rigorous tracking and oversight regarding timeliness of strategy meetings takes place , an Ofsted recommendation for improvement. All improvement actions have been completed.

Despite this rigorous oversight of the booking process with BSO support, a dedicated slot system and weekly timeliness dashboards, strategy meeting timeliness was still too variable especially for missing and exploited children. An urgent end to end review of the process was undertaken with the end product being a revised flow chart of the process. In addition , a joint police and social care manager workshop was held promoting the agreed process signed off by MASH board with police partners sharing that this approach should be adopted London wide.

Audits highlight that strategy meetings are more effective, with strong partnership attendance and contribution, clear focus on the child's voice and follow through of actions being agreed. The timeliness not impacting on the safeguarding of children.

ICPCs held within 15 days of the S47 is now consistently strong and over 90% at end of February 2024/25 compared to 85% at end of 2023/24. This shows the impact of improving timeliness and quality of strategy meetings.

The positive impact of the wider partnership led CSA improvement work , the CSA social care liaison role and embedding of the CSA referral pathway is evidenced by improved MASH responses to CSA referrals. LBBD has the highest number of children, across the northeast London footprint, referred to the NEL Sunrise Hub, with an increasing number having access to medical examinations and emotional wellbeing support. Audit is also highlighting CSA paediatricians are now being routinely invited to CSA strategy.

Workers undertaking assessments where child sexual abuse is a factor, have access to a CSA think space where they can get expert advice and support, helping them navigate their way through this sensitive area of practice. Audit highlights some social workers struggle with how to communicate with children impacted by CSA. We have recently enrolled a further cohort of staff to undertake the child sexual abuse practice leads 10 month training course. This will lead to a total of 60 staff having received this intensive training led by the CSA centre of expertise.

Overall the quality of assessments has improved, leading to more timely and effective interventions supported by some quality, sensitive direct work with children. Children are seen quickly and not left at risk. All services have worked hard to embed the letter writing style approach to their recording of visits and parts of supervision, bringing the lived experience of the child to life. Some good quality direct work has been highlighted in audits.

The pace of improvement has, however, been impacted by staff vacancies and turnover in the last year. This and staffing changes at team manager level has impacted on our endeavours in tackling variability in the quality of assessments and planning work. The new leadership team in the service are working tirelessly to achieve consistently good assessment and interventions for families. Applying a high challenge, high support approach they have effectively used performance management to address poor performing staff. They have focussed on robust senior management oversight of work, for example, the regular dip sample of re-referrals. Dip samples found for a few cases inconsistency of threshold decision making at the conclusion of an assessment. In those instances, the assessments

lacked professional curiosity and were closed rather than stepped down to early help for ongoing support and intervention. Some had limited use of partnerships to support assessment, and for a minority the focus was not on the primary issues and seemed to follow the views of the parents.

Safety planning appeared to be unrealistic in some instances and in relation to domestic abuse put the onus on the victim. There was an overoptimism when closing. No child was found to be at risk of harm as a result of the decisions however we recognise the practice has impacted on them achieving the right outcomes. The dip sampling regime has allowed for cases to be re-opened where required and we have seen a reduction in those needing to be re-opened.

Another initiative to support improvement in the quality of assessment work has been the child exploitation lead sitting alongside assessment workers over a 5 week duty cycle period – supporting 'in situ' learning on best practice when responding to children at risk of exploitation . This has had a positive impact with assessment workers feeling more knowledgeable and confident. We have since seen an increase in exploitation risk assessment tools being opened and in turn an increase in children being discussed at MASE and CEG.

The transfer protocol and its application is contributing to timelier and seamless transfers between assessment service and other service areas. The number of cases in the weekly transfer tray are now at an appropriate level.

**12 month plan**

- Continued focus on the timeliness of strategy meetings
- Assessments and analysis of risk and need, must be more consistently informed by the risk assessment tools and practice guidance available when assessing exploitation, sexual abuse, neglect, and domestic abuse.
- Further work is required in this service to privilege the Safe and Together approach to domestic abuse, placing more focus on the role of the perpetrator and fathers.

## Children in Need and Child Protection

**What data and performance tells us.**

The number of children on a Child in Need (CiN) plan increased to 647 as at end of February 2024/25 compared to 565 this time last year and 580 at end of year 2023/24. The 12 month rolling average is 619 so an upward trajectory.

A large majority of children on CiN plans are seen regularly with six-weekly visits improving to 90% at end of February 2024/25 – up by 2% on 2023/24.

93% of children have their CiN plan reviewed in timescale – a 2% decline on the 2023/24 performance, but higher than the 86% seen in 2022/23.

Children on CiN plans for more than a year but less than two years has decreased from 93 (16%) at year end 2023/24 to 83 (13%) as of the end of February 2024/25. Those open for 2 years plus has increased from 15 (2.6%) to 21 (3.2%) over the same period. This cohort tends to be made up of vulnerable adolescents who require longer term intensive intervention, children with disability and those open to no resource to public funds team.

The number of children on child protection plans (CPP) has increased from 250 (39 per 10,000) at year end 2023/24 to 315 (49 per 10,000) as of the end of February 2024/25. We remain lower than the 2022/23 figure of 394 (62 per 10,000) however. Rates are above all comparators.

A large majority of children on CPP have been seen in the last 2 weeks (87%), an improving area of performance compared to the 85% at year-end 2023/24. Almost all children on CPP are seen every 4 weeks – good performance.

Seeing children alone on child protection plans alone fluctuates but on average 66% of children aged four and over have been seen alone as at end of February 2024/25, comparable with previous year end. On average 3 in 5 of all children on CP plans are seen alone.

Almost all child protection reviews are completed in timescale (98%). This is above comparators and comparable with our end of year 2023/24 outturn.

Child protection core groups held in timescale has declined to 70% in February 2024/25 but has averaged around 80% throughout the year – similar to our end of year 2023/24 performance (81%).

Few children are subject to subsequent child protection plans and performance is at 18% (60 children). This compared to our 2023/24 performance of 19% (51 children).We have the 3rd lowest repeat CP rate across London .

Very few children (7%) have a ceased CP plan lasting more than 2 years – 20 out of 272 children. Performance has improved when compared to our 2023/24 outturn of 9% (35 children).

80% of ICPC's result in a CP plan – slightly higher than the 75% in 2023/24.

A large majority of ICPCs are now completed within 15 days - performance is at 92% compared to 85% at the end of 2023/24 and 72% at end of year 2022/23, a significant improvement.

As at end February 2024/25, the number of children open to the children and young people disability service (CYPD) stands at 171 compared to 164 at end of year 2023/24. Average caseloads are manageable at 12 children per social worker. Performance has improved significantly in this service under the current head of service with both children in need visits and CiN reviews at over 90%. Two weekly CP visits are at 86% and six weekly children in care visits are at 92%. Supervision at 4 weeks in the CYPD service is currently 68%, and whilst further improvement to be made is considerably higher than the 40% reported in 2022/23.

The number of children in pre-proceedings is relatively stable - at end of February 2025, 21 children (7 families) compared to 20 children (7 families) this time last year. The number of children in pre-proceedings for over 16 weeks is higher due to a large sibling group – 11 children (2 families, comprising 1 large sibling group of 9 and one of 2) compared to 4 children (1 family) this time last year.

Private fostering numbers have decreased from 6 to 3 over the last year and the service has received a similar number of private fostering referrals to date at 29.

**Practice – quality and impact**

The quality of practice in planning for CiN and CP is improving. Throughout 2024 and 2025, quality assurance has been strengthened with an increased number of children being audited on the quality and impact of practice. Audits are showing increasing 'good ' and more recently pockets of some 'outstanding' practice being identified. This corresponds to fewer audits graded as inadequate.

Statutory interventions are making a positive impact on the majority of children and young people. Practitioners demonstrate a strong understanding of risk; most files effectively include a genogram and chronology, albeit some are not up to date or as comprehensive as they could be. The majority of plans are up to date and contributing positively. Audits report improved capturing of family views and evidence of social workers building positive relationship with children and families, a strength noted in previous inspections. Child centred practice in the form of child-centred letter writing recording, continues to be a notable strength.

Audit findings report evidence of regular supervision and good levels of management oversight, in particular some excellent management oversight by the exploitation lead where CSE/CCE are concerns.

Audits report child protection plans are progressing well and stepping across to CiN or being closed appropriately. Child protection plans are becoming more comprehensive, SMART, and outcome-focused with a good range of recordings of conferences, but there is more work to do to crack consistency on the quality of plans.

There is a need to increase the consistent use of the suite of risk assessment tools where required to provide insight into the analysis of risk, which then informs the assessment and planning. Managers are striving to ensure four weekly quality supervision. The supervision training and action learning sets attended over the last year have made a positive impact with more reflective supervisions evidenced on files and less instances where plans have drifted. Where delay has happened, it tends to have been impacted by unplanned staff sickness or vacancies. Similarly, targeted training and robust monitoring of permanence planning has supported improved quality permanence planning meetings with clear planning for children, particularly those in PLO.

Audit of plans reported that there was an absence of sufficient focus on the perpetrator in domestic abuse. We need to further embed the Safe and Together model and the DARAC tool to improve assessment, planning and interventions for children experiencing domestic abuse in Barking and Dagenham.

Heads of service in Family Support and Safeguarding, Adolescent service and CYPD have increased scrutiny and oversight of CiN plans at 9 month plus. Demand is up and we know that staffing instability in FS&S and a lack of SMART outcomes focused planning is impacting on the progress of some CiN plans. For others, there is a reluctance for the professional network to step down to early help. Children at risk of exploitation is a feature in the nine month plus cohort. We know those children require intensive multi-agency input to bring about change which is seldom achieved within a short time. Audit and case oversight at the MASE and CEG highlight excellent examples of tenacious social work together with committed parent/s and a comprehensive wrap around package of intervention by partners bringing about positive change and reduced risk to children .

The head of service and service managers in FS&S continue to keep firm oversight of CiN work at the CiN panel, aiming to ensure improved quality and timely ending of a CiN plans. Of the last 250 children whose plan ended, only 12 have been re-referred. Those children were audited for learning purposes. Of the 12, most new referrals were not linked to the original referral concerns. However, two indicated there had been over optimism and insufficient challenge of parents who were believed to misuse substances. This piece of audit work was able to give assurance regarding appropriate thresholds being applied at the point of ending CiN plans, and a reminder of the need for holistic child focused assessments.

We now have in place the Child Protection Oversight Meeting (CPOM) which has oversight of repeat CP plans and those longer than 12 months. Chronic neglect is a key feature with some being in the PLO process, another theme being young adolescents at risk of exploitation. Overall, the meeting is seeing evidence of social workers building positive relationship with children and parents, and significant impact of the specialist intervention service practitioners. The meeting is supporting strengthened oversight of CP planning, helping practitioners reflect where plans ''feel stuck '' and allows for more decisive decision making around progressing to step across to CiN or PLO.

However, the CPOM has also noted the inconsistent use of risk assessment tools available to workers and the negative impact of changes in social worker and manager.

Regarding repeat child protection plans, for a few, it was noted that the previous decision to take a child off a plan was somewhat over-optimistic and not necessarily informed by a robust risk assessment. The early help offer had not been sufficient to sustain any change too.

As highlighted in the performance section, children being seen alone is variable. The head of service undertakes routine dip samples to better understand why children on a plan are not being seen. This highlights some recording issues at times, children being seen with siblings, a duty worker undertaking the visit and the child does not know them, so a proportionate decision is made about seeing the child alone especially if they are anxious. Dip sampling is showing improved quality of observations of babies, infants and nonverbal children.

Social workers continue to make good use of the specialist intervention service (SiS), a real strength in audit outcomes. The family group conference and restorative intervention team is impacting positively on children on the edge of care. Audit highlights the family support workers (FSW) having a notable impact where neglect is a feature finding strong identification and escalation of neglect.

The FSWs build confidence in parenting and reducing risk, together with appropriate and impactful matching of resources to need. The volunteer service is now supporting families through mentors, parent befrienders, care leaver buddies and the Little Things Project e.g. garden clearance, house de-cluttering, building flat packed furniture.

Child centred recording and communication is evident across the SiS service. The therapeutic team is bringing the voice and lived experience of children to the fore, influencing case planning and safeguarding. The service supports decision making forums e.g. CPCC, TCLPM and care proceedings care plans.

The SiS is leading on the implementation of an expert court assessment team, aimed to improve PLO timeliness and reduce the use of external experts. Overall audit findings conclude that the SiS intervention service offers evidence based interventions positively impacting the progress of children on a CP plan and or in pre proceedings. We view this service as a 'stepping stone ' to implementing the national social work family first reforms.

Children and young people going to Initial Child Protection Conferences and Review Conferences are now being referred to the Barnardo's Advocacy service. This supports children and young people to understand why their conference is taking place, helping them to attend if they wish to, as well as supporting them to share their wishes and feelings. Drop-in sessions take place for practitioners to attend and support understanding as a means to increase the referral rate.

The CYPD service goes from strength to strength with improved management oversight performance and audit outcomes. The new leadership in this service has delivered clarity, grip and improved pace. The service has been stabilised by recruitment to key posts and now has a strong management team of permanent staff and only one locum. It is clear that practitioners know their children, understand their needs, and are able to advocate for them when required. Training regarding specialist communicating with disabled children has strengthened the practitioner's ability to capture the child's lived experience.

We have more to do to ensure that our best practice becomes our consistent practice, but most children with disabilities are receiving the right support at the right time from a skilled practitioner working together with multi-agency partners.

**Assessment and decision-making for children experiencing neglect** - significant work has taken place across the partnership to address neglect experienced by so many children in the borough. A neglect improvement lead is in place, and an independent chair continues to support the partnership with strategic planning and implementation. A recent successful partnership event reviewed progress made against the neglect improvement plan.

Significant progress has been made across corporate and partnership spaces to improve earlier identification and responses to neglect to reduce crisis point referrals to statutory space.

The **GCP2** tool is promoted across the partnership to support practitioners assessing families with neglect. In social care, the GCP2 tool is being used increasingly with room for improvement on greater consistency of use and incorporation of findings into analysis of risk for children on CIN and CP plans.

We have piloted the **GCP2a tool** – an assessment pre-birth tool across assessment and intervention and FS&S. The aim being to enable social workers to identify neglect risk factors from the outset. The recent Adoption London East annual report highlighted LBBD had a higher proportion of children aged under one adopted than other NEL boroughs, highlighting proactive prebirth assessment, earlier safeguarding and permanence planning for babies.

The much-awaited hidden harm worker starts in the SiS in February 2025. This post will support children who live with parents with alcohol and drug problems, helping us better understand their lived experiences, wishes and views. Parental substance misuse, alongside mental health are the key features for children subject to pre-proceedings and care proceedings.

Part of the domestic improvement work has led to the introduction of a SISDAS - (Specialist Intervention Service Domestic Abuse Service) offer via the SiS . There are a variety of support services available to women, children and perpetrators of domestic abuse. Audit highlighted referrals were not always timely as practitioners did not necessarily understand how to access these. The SISDAS has streamlined access for domestic services for children and families. Dip sampling is beginning to highlight early identification of the right services for children, survivors and perpetrators. More men are being referred and engaging with Cranstoun perpetrators programme.

A domestic abuse practice lead is in place with a view to embed Safe and Together approach and ensure the language and approach synonymous with S&T is routinely reflected on files and more engagement with fathers. Audits show improvement with more workers using the DARAC risk assessment tool. However, this is not yet consistent, and workers have not all grasped how to use the findings to inform analysis.

A comprehensive pack of practice guidance re neglect and DA is available on the CARES academy intranet site for all staff,

All private fostering children are assessed and visited in time with assurance being provided about their care.

**Consistency of response to 16- and 17-year-olds who present as homeless.**

Good progress has been made on responses to homeless 16 /17-year-olds. A quarterly vulnerable 16-25 year homelessness strategic group chaired by the director of operations continues to drive practice improvement. The assessment and intervention service has recently appointed a homeless lead to support the delivery of best practice in line with the homeless 16/17 year guidance, as well as strengthening partnership with housing colleagues. This role will extend to include families facing homelessness.

The homeless lead has delivered joint training with housing colleagues to support a service wide understanding of the correct response when a young person is at risk or faced with homelessness.

Heads of service are required to review any case where a 16/17 year old comes into care and complete a need-to-know notification to the director of operations. This enables stronger oversight of practice in this key improvement area.

Rapid restorative intervention offer is available from the SiS to support young who present as homeless. Our children's rights officer is readily available to meet with young people to support them in making independent informed decisions regarding their accommodation route, ensuring their voice is also heard in terms of wider support needs.

A recent audit highlighted some strong practice with all with all young people now being offered an independent advocate. The only issue is some workers did not appreciate the importance of the young person seeing the advocate after they had the joint assessment and had all their options explained to them. Some workers invited the advocate to the joint assessment.

All children's files audited evidenced a joint homeless assessment was undertaken, with the young person being able to meet with both a social worker and a housing officer. However, for some the assessment by the housing officer was slightly delayed. File records are child centred and assessments holistic , with clear evidence of the options being clearly explained to the child . Evidence that they have been provided with a letter and leaflets with further explanations of the options .

It was positive to see holistic assessments considering the child's needs beyond the need for accommodation e.g. education, health and well-being. Also, importantly referrals to the specialist intervention service were made providing restorative intervention and a family group conference. We know coming into care at this late stage does not always benefit young people and therefore our aim should always be to help children return to safe parents/family members. Where FGCs were not offered it was due to the family refusing to share details of wider family.

The LBBD Homeless 16/17 protocol has been updated and due to be published. This together with tools and resources will be added to our CARES intranet site for staff to access.

**Timeliness of pre-proceedings pathways –** an Ofsted recommendation for improvement in 2023 – is an improving picture. Tracking of children in pre-proceedings by the care proceedings case manager and TCLPM has improved with cases stepping out of the pre-proceeding process if it is safe to do so whilst assessments are underway. We now see fewer numbers in pre proceedings as quicker decisions are being made with the increased oversight in place.

For those that go over the 12 weeks, reliance of externally commissioned expert assessments continues to be the main reason for delay, either due to the assessor not meeting deadlines, the availability of experts or the quality is poor and requires re doing .

It is envisaged that the implementation of the in house expert court assessment team will positively impact on timeliness and quality of assessments in pre-proceedings. An outcome we would expect to see with this new team is children stepping out of pre proceedings back to CiN plans in a timelier way. Alternatively where care proceedings are necessary, the front loading of good quality assessments in pre proceedings should lead to shorter court timescales and permanence plans being endorsed by the court within the 26 weeks. This piece of transformation work will be imperative particularly in

light of the fact the president of the family courts has re-issued PLO expectations directing all parties to adhere to this.

The care proceedings case manager provides training, run jointly with our legal team and offers day to day support to practitioners. We recognise many staff have limited court experience due to being fairly newly qualified or from abroad. Audit evidence good management oversight and tracking by the care proceedings case manager. Improvement is needed in the skill of the case manager to incorporate the oversight and recommendations into supervision reflections and planning.

Quality of letters before proceedings is improving. However, dip samples highlight the need for increased support and guidance as letters are not consistently succinct or sufficiently written with the reader in mind.

**12 month plan**

- Stability of staffing especially in FS&S - recruitment of permanent Social Workers and Team Managers and strengthening the retention of staff.
- Embed revised CIN Panel.
- Continued focus on seeing children alone and their views being used to shape planning.
- Continued focus on supervision taking place on a 4 weekly basis and contingency arrangements when managers are absent.
- Embed and strengthen tracking oversight of the use of risk assessment tools in relation to domestic abuse and neglect, CSE/CCE, GCP and DARAC to enhance quality planning.
- Further focus on the quality of planning for children and families.
- Ongoing focus on chronologies and genograms.
- Ensure that children subject to CP plans are routinely offered independent advocacy to support them to express their views.
- Continued joint working to address rates of Police protections .
- Develop an Expert Court Assessment Service (ECAS).

## Safeguarding Vulnerable Children and Young People

**What data and performance tells us.**

Currently, there are 75 children open to the adolescent team (up from 70 at year end 2023/24. Average caseloads are 1:8, lower than the 1:10 at year end.

Performance on statutory visits to looked after children and children in need are high – 100% and 97% respectively. This is also the case for CiN reviews at 97%. Four weekly supervision has improved significantly - from 48% at year end to 86% at the end of February 2024/25.

51 children have an open CSE Episode, 16 of which have a NRM decision. The majority of this cohort are female, and while this pattern is reflected nationally, it is likely that there is an under identification of boys.

All 51 children have a completed CSE risk assessment.

There are currently 57 children with an open CCE marker, the majority being male and 18 have a current open marker regarding county lines. 61 of these children have an NRM decision for child criminal exploitation. Of the 61 children with an NRM for CCE, 11 are looked after and living in a placement and none of them are currently subject to deprivation of liberty orders.

In 2024/25 to date, the number of children missing from home has risen slightly to 237 but repeat episodes have reduced to 616 (224 and 744 at the same point in 2023/24).

The number of children in care missing more than 24 hours reduced by 15 at 47 (from 62) with 205 missing episodes compared to 375 missing episodes last year. Almost half of the missing episodes are not from young people that are not LBBD children, but children placed in LBBD.

Improved performance on Return Home Interviews (RHI)- continues with 98% of LAC children were offered at least one return home interview (of which over 85% of children accepted at least one) - some children go missing on more than one occasion in a short space of time so the RHI can sometimes cover more than one missing episode.

**Practice – quality and impact**

We saw significant improvements in the offer for adolescents after the joining of the youth justice service and the adolescent service in 2019. The focus on the safeguarding needs of adolescents through a contextual safeguarding lens has brought about improved practice, partnerships and understanding of our borough profile. Contextual safeguarding is a strength in the borough

Joint supervision between the adolescent worker and YJS (Youth Justice Service) worker has most recently been introduced in the service showing positive impact for children. A schedule of joint auditing across services where the children are known to both youth justice and children's social care services is now in place.

The addition of a specific exploitation practice improvement lead across wider children's care and support has assisted in the development of new ideas and practice as well as building quality and consistency across service areas. The lead has been able to refresh and deliver training sessions for wider staff groups and bespoke workshops targeting the specific training need for individual services and practitioners.

The establishment of this role has been key for us in addressing some of the more stubborn practice issues that have been noted across services outside of the adolescent service. This lead has begun to make tangible changes and improvements for young people and the practitioners working with them.

Training for all managers across children's care and support on the concordat for children in custody has been completed and practitioners are now more aware of time scales and expectations for visiting children in custody. We monitor local responses to children in custody through oversight of a regular custody report.

The vulnerable adolescent resource hub has been created on the CARES internal intranet site for staff to ensure they have access to all practice guidance and resources for working with adolescents.

The comprehensive training programme addresses victim blaming language with reference to exploited children . In addition, an appropriate language guide is embedded into the CSE and CCE risk assessments and is contained on the vulnerable adolescent intranet site. Online risk is now part of the training offer as MASE is seeing more children being groomed through online abuse. It is important practitioners feel confident to assess and intervene in those circumstances.

Trauma informed training commissioned from Rockpool has been introduced as a means to further embed this approach which is central to our CARES practice framework.

Audit highlights a strong partnership which provides a wraparound offer to safeguard young people and support families. Information sharing across services is ensuring more robust planning and support for children.

Practice in the adolescent service is strong in particular safety planning with appropriate risk assessments, strong management oversight and reflective supervision, supporting social workers in complex and challenging situations for children. Strengths include good quality direct work with children's voices heard and influencing plans. Workers know their children well. Timeliness of strategy meetings is improving, and quality of decisions are strong in the majority of cases. Areas of development include timelier CSE/CCE risk assessments to better inform the analysis of risk and planning. Practitioners showing more curiosity regarding risks outside the home is a further recommendation from audit.

A tenacious teens project offering tailored interventions to adolescents in a state of flux was piloted in the SiS by the therapy team . The project holistically considered physical, psychological, and neurological changes within the adolescent social and cultural context. Theoretical and therapeutic insights were shared with parents, carers, social workers, and decision-makers, which enhanced the effectiveness of partnership working. This ensured the views, hopes, and experiences of the young person was conveyed and understood by all, leading to better outcomes, increased stability, and lower risk levels. Pilots completed and evaluated, and systemic team meetings are now in place with the SiS service now having a bespoke adolescent offer.

There is strong oversight from the exploitation practice lead and the service manager for adolescents. Audit and dip samples are overwhelmingly positive about the quality of this oversight on files including their support and challenge of practitioners regarding risk assessments and return home interviews. However, in too many cases this oversight is not properly considered by practitioners and managers in supervision. It is anticipated that the new learning

approach being delivered by the Lead whereby she embeds herself alongside practitioners and managers will help address this issue.

The approach to safeguarding children at risk outside the home continues to be innovative and current in LBBD. We remain a partner of the national contextual safeguarding network and are considered to be a leading authority in how we approach the work.

The NRM devolved decision making has shown significant improvements in the timeliness of reasonable and conclusive grounds decisions. With consistent referral to the NRM panel, multi-agency discussion and agreement of decisions are made within an average of 45 days. The positive impact of this for children is shared at the monthly MASE and CEG meetings . Our NRM pilot is regarded as an example of best practice across Home Office pilot sites.

The risk outside the home (ROTH) tool and conference pathway are new innovative developments. The tool allows us to proactively identify children at risk of exploitation, enabling allocation of an exploitation risk assessment early on, reducing chances of risk escalating. The ROTH conference pathway will be an alternative to a CP conference for adolescents where risk outside the home is the main presenting safeguarding issue. Training is underway with CP chairs and key partners. This will be launched in May 2025.

The strategic oversight of this work remains strong with a quarterly adolescent safety and wellbeing strategic partnership meeting chaired by the director of operations. This is a subgroup to the community safeguarding partnership board and working group within the new MASA arrangements.

MASE (Missing and Sexual Exploitation group) and CEG (criminal exploitation group) monthly multi agency tactical partnership meetings chaired by the Director of Operations has single oversight of all new children open to MASE and CEG and makes decisions on children coming off the list due to reduced risk. No child with an open exploitation marker can have this marker or flag closed without consent of MASE or CEG who must be assured that services have been provided, and that the child is safer.

The meeting always hears feedback from children and families regarding 'what worked' to reduce the risk for them. The themes from this are: consistency of social worker or YJS worker; involvement of a mentor; moving away from a place of risk , parents not feeling judged or criticised but supported and working to the young person's strengths and talents. This feedback informs partnership and commissioning arrangements and the adolescent safety and wellbeing strategy and action plan.

A missing children operational panel discusses the most frequent or risky missing children on a monthly basis to ensure multi agency oversight and planning to reduce the frequency and duration of missing episodes for the most vulnerable children in this cohort. Themes and quality of practice are shared at the MASE meeting.

The LADO service remains effective and continues to ensure a timely and robust response to allegations of harm involving those who work and volunteer with children across Barking and Dagenham. This complex area of safeguarding continues to be well understood across the partnership, with the LADO raising awareness through providing multi-agency training and targeted training to schools in line with the London Safeguarding Children Procedures and DfE guidance. In recognition of the increasing demand on the service, the quality assurance service is exploring ways to increase capacity. There have been no changes to the service since the Ofsted inspection in July 2023 when it was deemed an effective service which ensures that children are adequately safeguarded.

Children Missing Education in the borough (not on school roll at a school or home educated) increased to 126 as of the end of February 2025; a real increase of 18% compared to the end of February 2024 (No. 107). The DfE estimated an 19% increase in CME from the autumn term 2023 compared to the autumn term 2024.

Children Missing Education - who left a borough school and have moved to another part of the UK (but did not transfer direct to another school) has dropped to 201 as of the end of February 2025; a decrease of 44.0% compared to the end of February 2024 (No. 359). This drop is attributed to temporary staff support for an interim period. However, due to changes in how we manage these cases, we expect to maintain higher numbers of cases being closed.

As of the end of February 2025, 556 children are home educated compared to 480 the same time last year, an increase of 16%. This academic year, apart from October and December (when the number was in the 520's) the mean average per month has been between 550 to 560. This increase is reflected nationally (DfE estimated a 21% increase in the autumn term 2023 compared to the autumn term to 2024). The team continues to manage the increase in demand

Information sharing between services remains efficient and timely. The virtual head for CiN has brought increased focus on the role that social care plays in supporting improved school attendance. Regular information of the attendance of children on CiN/CP plans is shared with managers and a quarterly joint audit with education colleagues and social care managers drives continued improved practice. As a result, we are seeing improved evidence of education and attendance being central to a child's plan.

Education colleagues are involved in London and regional networks where best practice and training is shared.

Robust systems and thorough procedures to safeguard children missing education, and home educated children, remain in place. Social workers have access to the vulnerable pupil hot clinics allowing for partnership planning for children at risk of poor attendance or disengaging from school.

**12 month plan**

- Improve consistency of reviews of child exploitation risk assessments
- Roll out trauma informed training across all services, embedding it as our key CARES practice approach.
- Refresh and restart the Contextual multi agency safeguarding champions' network
- ROTH conference pathway system tests to be completed and multi-agency training to be delivered with expected roll out in May 2025.
- Single risk assessment and exploitation space within the Liquid logic system to be created to ensure one process for all children experiencing extra familial harm with single oversight of opening and closure process.
- Ongoing work across other service areas to improve consistency and quality of practice with regard to children at risk of extra familial harm.
- Expansion of vulnerable adolescent resource hub to include partners.

## 4. Experience and progress of children in care (and permanence)

**What data and performance show us.**

The number of children in care has been decreasing over the last few months, after reaching 461 in October 2024. Numbers are currently 433 as of the end of February 2025, slightly below end of year 2023/24 figure of 436. Rate per 10,000 comparable at 67, lower than similar areas (69) and England (70) but above the London rate (51).

Stable proportion of children in care on interim care orders at 27% and slightly decreasing proportion on full care orders from 41% to 37% over the last year. Proportion of children on Section 20 is up from 28% to 31% over the same period – higher than the London average (29%), national average (19%) and similar areas (21%).

The number of Unaccompanied Asylum-Seeking Children (UASC) has increased to 25 (end of February 2025) compared to 20 at end of year 2023/24. This equates to 0.04% and is below the national threshold of 0.1%.

Repeat episodes of children in care is at 25 (13%) at end of February 2024/25 – no change on the same point last year.

The number of children entering care has increased over the last year. 200 have entered care in the year-to-date February 2024/25. This is an increase on the 164 that entered care as of the same point last year – an increase of 36 children (22%).

Children entering care on police protection is increasing – 53 children (27%) compared to 37 (23%) at the same point last year and 42 (22%) at end of year 2023/24. Large sibling groups is impacting on police protection data and performance with families made up of five and four siblings. Performance remains higher than all comparators (London 14%, England 9%, similar areas 15%).

A high proportion of children in care live in family settings (77%) - above similar areas, London, and England demonstrating our commitment to ensuring children in care live in stable homes built on love. 42% of children in care are placed with LBBD foster carers (3 out of 4 children placed in foster care are placed with LBBD foster carers). A lower proportion of children are placed more than 20 miles away at 15% (comparators are between 18% and 22%).

37 children are currently placed with parents (9%). This is an increase on the 22 (5%) as of year-end 2023/24 and is now above all comparators (similar areas and England 6%, London 3%).

14% of children in care have currently experienced more than three plus placements – this is above our 2023/24 performance of 12%, as well as all comparators (10-11%).

Long term placement stability has seen a decrease during the year – declining from 74% in 2022/23, to 69% in 2023/24 and is currently at 60% as of the end of February 2024/25 (this equates to 44 children). This is performance is now below all comparators (68%).

The number of children placed in residential is currently at 36 young people (8%) – a decrease on the 39 as of the end of 2023/24. 28 are placed in registered children's homes/schools (down 3), mother and baby units at 3 (down 1). One child is placed in a secure unit (down 1) and four children are placed in a YOI/Prison (up 4). 0 children are placed in Hospital (down 1). Our figure of 8% is below the London average of 15% and the England/similar areas average of 13%, and this is a positive direction of travel.

At end of February 2024/25, three children under the age of 16 are placed in unregistered children's homes (up 1 compared to this point last year). Those three children are visited more frequently and have robust oversight via supervision and the monthly residential oversight meeting.

Children in care proceedings has reduced to 120 children (62 families) compared to 130 children (73 families) a year ago. A smaller number of families have been in proceedings over 26 weeks - 37 families (77 children) compared to 46 families (85 children) at the end February 2024 and remains much lower than 2022/23 at 71 families (117 children). This is a positive with court capacity and delay issues improving and the impact of improved tracking, oversight, and permanence planning

The large majority of children in care are visited every 6 weeks (95%). This is up by 6% on end of year.

A large majority children in care have their review in timescale (89%) – monthly performance has averaged 95% in 2024/25 to date.

Almost all children in care have a permanence plan recorded. Latest data shows that 96% of children in care have had a permanence planning meeting (PPM) – up from 94% at the same point last year and 99.5% have had a PPM by second LAC review. This is excellent progress.

A large majority of children in care (94%) have an up-to-date Personal Education Plan (PEP), a slight decline on the 97% outturn for 2023/24.

Significant improvement was made in the timeliness of initial health assessments (IHA's) with performance increasing to 70% in 2023/24 compared to 33% at the end of 2022/23. A challenging target was set in 2024/25 to maintain this level of performance. At end of February 2025, IHA performance has declined to 49%.

Medical check performance has decreased from 87% a year ago to 68% as of the end of February 2025. Dental checks have also declined over the same period from 58% to 49%. Children in care for a year or more health performance has declined from 73% to 62% over the last year. This decline in performance is usual at this time of year due to the volume of review health assessments (RHAs) required within the last financial year's quarter. Performance increases at end of year once all RHAs and dental data is finalised.

78% of children in care one year plus submitted an SDQ - above the England average (77%) but London (88%) and similar areas (82%). The average SDQ score (the lower the better) for children in care for one year or more has slightly increased from 10.3 in 2022/23 to 12.4 in 2023/24, but remains below average (England 14.7, London 13.8, similar areas 13.9).

The year-to-date percentage of adoptions is (9) 4%. Adoption numbers increased in in 2023/24 with 14 children adopted (7%) compared to 4 children (2%) in 2022/23. Low numbers are in line with a national trend, especially in London (4%).

27 children (14%) have left care on a special guardianship order (SGO) so far in 2024/25 up by 3% on the previous year (20 children) and higher than London (9%), England 12% and statistical neighbours (11%). These are permanent care arrangements with reduced likelihood of breakdown compared to children who remain in long term care of the local authority.

The average time between a child entering care and moving in with their adoptive family for children adopted (A10) increased from 656 days in 2022/23 to 771 in 2023/24. The three year rolling average, therefore, increased from 515 days (2020-2023) to 650 days (2021-2024) and performance is 224 days above the DfE threshold of 426 days. On current trends, the 2022-2025 rolling average is projected to be around 800 days.

The average time between the Local Authority receiving court authority to place a child and deciding on a match to an adoptive family (A2) increased from 206 days in 2022/23 to 370 days in 2023/24. This increased our 3-year rolling average from 198 days (2020-2023) to 280 days (2021-2024). Performance is now 159 days above the DfE threshold of 121 days. On current trends, our 2022-2025 rolling average is projected to be around 290 days.

Most children make good progress and attainment for children in care remains above national children in care average.

**Practice - quality and impact**

A key priority in our CARES practice framework is to keep children at home or within the family network when it is safe to do so, as we believe children should grow up with people who know and love them. We have driven improved permanence planning across the system and the impact has overall brought about improved outcomes for children. There has been a reduction in length of care proceedings, more children placed with fathers or in connected family arrangements. For those who need to be in care, less are placed in a residential setting with the majority placed with a LBBD foster carer who is local. Bi-monthly monitoring of permanence arrangements via the permanence taskforce highlights children are being long term matched, by the fostering panel, with carers who are a good match and show commitment to the child staying in their care until their majority, giving them a sense of belonging.

Children entering care on police protection remains too high and is a key line of enquiry. Heads of service keep rigorous oversight when a child has been taken into police protection in order that we gain an understanding of the key drivers for this high number. The director of operations has single oversight via the need-to-know notifications where heads of service provide an analysis and view on whether the police protection could have been averted. The reasons are varied with some being issued by police due to the fact the young person was present in the station, rather than a means to offer protection from a parent/carer pending social care intervention e.g. a looked after child on a care order who has been found after a missing period, or an unaccompanied minor presenting as homeless. In those instances, the police are not, where it is appropriate to do so, routinely exercising the ability to end the police protection at the point the child is collected by the social worker.

Other themes include single mothers being found in the community with children under the influence of substance misuse or children found in chronic neglectful home circumstances. On a few, we have concluded that timelier use of the GCP2 assessment may have led to earlier identification of risk and purposeful safety planning.

Audits of police protections highlight children are seen by a social worker within 24 hours, strategy meetings are being convened, and appropriate decisions being made including consideration of care proceedings being required to safeguard the child. The high number of police protections has been escalated to police senior leaders and a joint workshop with social care and police is being convened in the spring 2025.

With higher rates of children in care, it is important to test whether the right children are coming into care, and whether children are coming in at the right time. A recent audit on the last 10 children entering care highlighted that where there had been pre-proceedings, pace and decision making was of a good standard. For children where police protection was a feature, social work teams (including EDT) responded with appropriate safeguarding arrangements and were timely. For some, EDT played a pivotal role in the decision-making and subsequent actions. The handover between EDT and the social work teams was effective and enabled next steps to be taken seamlessly. For all 10 children, the threshold for coming into care was met and appropriate, under the circumstances of the individual families. However, there was one child reviewed

where edge of care support earlier in the process to avoid entry into care would have been beneficial. For some children, there was room for improvement with the quality of recording.

The audit on the last 10 children exiting care between December 2024 and February 2025 was positive. Threshold for children leaving care was appropriate in all 10. Intervention support varied from case to case, but in the large majority a Family group conference was part of the exiting care plan and used effectively. Where care proceedings were a feature during the lead up to the care episode, those children had continued statutory support post exit from care. Good evidence of directive management oversight in most of the children audited.

Overall, practice in the area of children exiting care is of a good standard with clear evidence-based practice tools being used to support the decision for reunification. In most cases there was evidence of good dual planning to ensure that children were not experiencing long delays unnecessarily. Social workers were exploring options in the wider family as part of routine practice and families were offered temporary support, permanence or being part of FGCs and written agreements.

The most recent monthly practice audits (January 2025) focused on children in care. 22 out of 29 audits (76%) were rated as good or outstanding with a lower number and proportion requires improvement and no inadequate audits. Nearly all (93%) had good evidence of multi-agency collaboration and involvement; the voice of the child was evident in nearly all (97%) audits; effective monitoring and progression of the child's plan continues to improve with over 85% of all those audited showing evidence of this. An improvement (where appropriate) of risk assessment tools such as the CCE, CSE, DARAC and GCP2 being used. Areas identified for improvement related to the timeliness of supervision, permanence planning and strategy meeting. All those areas are tracked regularly across children's social care, with improvement plans in place and continue to improve.

Placement stability continues to be a challenge due to children having complex needs and some challenging behaviours. We have sought to understand the reason for our declining placement stability performance. Most children experiencing placement changes are due to the child needing a more specialist resource due to their complex presentations. Some placements have also had to end due to foster carers personal circumstances. Creative support plans are usually put in place to try to stabilise and support placements. The specialist intervention restorative intervention offer is effectively used to stabilise fragile foster placements to prevent placement breakdown. Audits regularly report on the specialist intervention service interventions having a clear and positive impact on families and case planning, diverting children from care, reunifying children home or providing placement stability. The dip sample of placement changes highlighted some placements have changed for a positive reason e.g. the child has returned home / wider family or stepped down from a residential placement to a foster placement.

A higher number of children are placed with parents currently and around 2 in 5 are adolescents. Children returning home have up to date assessments and plans and are supported well. The director of operations has oversight and sign off of all placements with parent arrangements. There are occasions those arrangements are determined by the judge in care proceedings and therefore the director is informed immediately afterwards. There has been an increase in courts wanting to test periods of children being placed back with parents under an interim care order rather than agreeing supervision orders.

The FGC model provides a high standard of practice in the borough and submission is being completed for FRG accreditation (March 2025).

Whilst the number of children subject to care proceedings is reducing and timeliness is improving, we have a way to go with 61% of families in proceedings being over 26 weeks. The average to conclude proceedings is 61 weeks (outside of Waltham Forest, LBBD is a better performing borough compared to the rest of NEL boroughs). However, rapid whole systems improvement is required which is why the president of the family division has set out a clear position on timeliness of care proceedings requiring a change of approach by parents' solicitors, guardians, social care and the judges where there will be fewer hearings, and fewer expert assessments.

We remain mindful that any delays can and do impact permanence outcomes e.g. younger children who become too old for adoption as the court process has been significantly long with parents being given multiple opportunities.

Inexperienced social workers and frontline managers together with staff turnover in the family support and safeguarding service has impacted on some achieving better permanence outcomes for children in care proceedings. However, alongside this we have received several commendations from judges on some strong skilful and sensitive social work practice being evident through court proceedings.

The permanence taskforce has set out a clear protocol, practice guidance and a tracking and oversight framework. The head of corporate parenting and IRO manager have delivered training sessions on good permanence planning, embedded by the court progression manager and principle social worker.

The detailed weekly permanence tracker provides single oversight on the prevalence and timeliness of permanence plans for all children in care. Whilst all are not in timescale, the weekly dashboard has been an excellent tool to support managers in improving timeliness considerably. Data shows excellent progress has been made with timelier PPMs. When PPMs are not in time scale, the delay is purposeful e.g. waiting for an expert assessment to be completed.

Audits are consistently highlighting that the specialist intervention services compliment social work activity offering targeted interventions aimed to reduce risk and strengthen assessments to enable more timely permanence for children.

Thematic audits on permanence planning report children's experiences are central and identity and cultural needs are considered and met with appropriate provisions of services, including SIS therapeutic support. PPMs have good multi agency attendance contributing to education, placement, health and emotional needs being considered and met. IRO oversight and the impact of child looked after reviewing has shown strengths - meaningful planning; IROs attending PPMs or recording views, practice is consistent with midways, effective in escalations, using discussions to ensure meaningful change; is warm, child focused and recorded with changing recommendations and summary discussions over time.

The regularity of supervision is important to help progress permanence planning. When this occurs and is aligned to PPMs, there is evidence that we are moving at pace and considering the changing complexities in real time, especially when in care proceedings. We need to achieve consistency, as there are a few managers who are not always aligning the PPM planning with supervision planning.

Ongoing work is needed to further strengthen parallel planning where adoption is a likely outcome. Too many child permanence reports start too late in the process with social workers being overly driven by the courts who work in a more sequential way with a series of assessments. Whilst there has been some excellent adoption planning noted by the ADM, consistency of practice is still impacted by the lack of experience that front line social workers and managers have in this area.

More children are being placed in kinship placements, special guardianship and connected persons. The use of preferred pool of ISWs has resulted in good quality special guardianship and full Reg 24 assessments. However, the understanding of parallel planning and the need to gather as much family information at the very outset can at times impact on the timeliness of special guardianship assessments being concluded.

The majority of children in care are visited regularly and the majority of reviews are timely with a good range of people attending including children enabling them to express their views. Children are encouraged to chair their own reviews, and some do this with real confidence. IROs ensure views are obtained and recorded for those children who do not wish to attend. The director of operations has quarterly meetings with the IRO service to hear directly on their views on practice and how they contribute to improvements being made e.g. IROs led on the new child centred care plan template and the innovative approach to strengthening participation with children in care.

The family time contact team provides good quality arrangements for family time and support for children in care. The team is an intervention rather than just an observation team, a positive development. Families have reported feeling supported. The ADM has commented on the sensitive and caring approach the family time contact workers have facilitated 'goodbye for now contacts' when parent/s are seeing their child for the last time ahead of adoption.

Our independent visiting scheme continues to be a strength, supporting children and young people in care, providing them with a trusted, non-social worker adult

to befriend and spend time with, fostering positive relationships and experiences.

Our in-house fostering service is strong and recruitment of foster carers in a challenging sufficiency context is also robust. The service uses the mockingbird programme, supporting placement stability and is a big draw for foster carers as they benefit from peer support. The feedback from carers, children and the fostering network are extremely positive. Our model is considered a national leader. At the end of February 2025, there are seven constellations with another one opening in the summer this year. This model has a significant impact on placement stability particularly helping foster carers who have children with neuro disability and complex presentations. The mockingbird carer can offer respite, as well as fun gatherings for a child who may not always be invited to parties. Mockingbird carers have also provided helpful bridging placements to support smooth transitions when there is a need for a placement move.

The SIS therapy team offer clinics to support foster carers to understand trauma and its impact on children and young people, and how it might manifest itself. This supports placement stability.

So far in 2024/25, 10 new foster carers have been approved, and ongoing recruitment remains a priority. In early 2024, LBBD confirmed its involvement with the Northeast London pilot for foster carer recruitment, alongside five other local authorities in this area, led by Waltham Forest. This was set up with a DfE grant for a year. The aim is to increase approved foster carers for these boroughs and to ensure that applicants progressing through the process are supported at each stage to minimise withdrawal from the process. The pilot ends in March 2025, but we are withdrawing from this arrangement due to lack of positive impact on recruitment.

The Barking and Dagenham Looked After Children Health Subgroup meets on a two monthly basis and addresses areas of concerning performance and Ofsted improvement plans relating to health. It has a wide representation from the ICB, NELFT, CAMHS and the Local Authority, and requests attendance of specific professionals when addressing topics e.g. sexual health and substance misuse.

Timeliness of initial health assessments has declined; the health subgroup scrutinises the performance with a view to understanding the reasons for this. We have a higher number of adolescents coming into care and they do refuse medicals which can impact on the performance figure. Children placed out of borough and the local health service not responding in a timely way to a child needing an IHA has also been a feature. Our business support service supports prompt completion of initial paperwork, and we now see very few medicals delayed due to completion of paperwork.

Availability of doctors is less of a feature with NELFT responding positively to efforts to improve performance. Workers need to be reminded of the need to ensure parental participation when the child is placed under Section 20 and to book interpreters in advance when needed as these issues can sometime impact on timeliness. The subgroup is driving improved dental check recordings in collaboration with foster carers and placement providers.

Children in care have access to therapy, which improves emotional well-being and contributes to lower scores on the strengths and difficulties questionnaire. SDQ scores are lower than average which is positive.

The number of Unaccompanied Asylum-Seeking Children (UASC) has increased to 25 but remains below the 0.1% threshold. This is despite LBBD being on the National Transfer Scheme and Pan-London rotas and taking extra young people from Kent when requested. Our young UASC tend to be later entrants to care and so require careful support to ensure they are ready for adulthood. We have reviewed our practice guidance to support social workers and leaving care advisors in offering the right level of timely support to children without confirmed immigration status and our work with this cohort was recognised within the OFSTED ILACS inspection.

The Aspire Virtual School (AVS) continues to be strong providing a robust offer of support for children in care and those transitioning on to further education, employment, and training post school age. Education outcomes for children in care have improved and are above the national average for our Key Stage 2 and Key Stage 4 results.

Most children in care are in good or outstanding schools. Overall absence from school and fixed-term exclusions for children in care remains below the national children in care averages.

Challenges remain with school availability for some children with complex needs such as ASD. There is also a lack of appropriate placements in specialist SEMH and ASD schools.

The majority of children have updated personal education plans driven by the AVS and good partnership working. The quality of PEPs has also improved with most graded as good or outstanding.

**Oversight of children's placements in unregulated children's homes.** Need to know notifications are sent to the Director for authorisation as soon as the care plan indicates a child requires a residential care setting. IRO, Virtual School, CAMHS and the placement team are expected to contribute, and the form needs to be accompanied by a recent PPM where relevant.

We continue to have children with very complex presentations coming into care where foster care has not met their needs. The placements team work hard to match the child with the right provision. The head of service for corporate parenting has close oversight to ensure matching is balanced with value for money and the right care package for the child.

The placements team work with providers to encourage application for registration and to be compliant with the change in law. Semi-independent Ofsted delays in inspecting homes has meant some of the recent provisions we have used remain unregistered and therefore unregulated.

Corporate parenting head of service continues to chair a well-established residential oversight meeting with scrutiny of permanence plans for those children. Permanence could be stepping back to foster care, into semi-independent or returning home to family/connected persons or transitioning to an adult's provision.

Since the inception of the oversight meeting, positive outcomes for children who have stepped out of residential settings in a planned way have been noted. There continues to be a concerted effort to avoid children's homes for young children and whilst we have not seen the same profile as we had in 2022, there are still a minority that require such settings due to their level of dysregulation. Interestingly, those have often been children who have had a SGO breakdown, attachment issues and an increased sense of abandonment, trauma and loss. We have also seen more recently adolescent girls with undiagnosed ASD presentations who are self-harming . They tend to require a Deprivation of liberty (DOL) order. A specialist TCLPM DOL panel keeps oversight of all children subject to a DOL ensuring we exit such arrangements when safe to do so.

The permanence protocol was updated to include expectations around visiting arrangements for under 16 children in unregulated settings. Performance reporting and Dip samples evidence most children in unregulated placements are visited with the required frequency. However, distance of placement impacts. Stronger management oversight has been noted, and permanence planning meetings are contributing positively to permanence for children in these settings

Placements team ensure Ofsted is notified as soon as a child is placed in such settings, and documentation is placed on child's file.

Our protocol has been updated with additional guidance on oversight and responses to 16 /17- year -olds in unregistered semi- independent placements which is now also unlawful. A new risk assessment has been devised, and the monthly oversight meeting will keep oversight of this cohort. Head of service and IRO manager have reviewed the current children and no concerns about placements or care provided were reported.

Since CYPD has joined children's services, transition pathways have been strengthened and transitions for young adults out of children's homes are better planned and timelier. This work is overseen by the transitions panel in corporate parenting where all 17 plus children with disabilities have an allocated leaving care advisor and an adult's social worker.

A monthly QA provider meeting keeps single oversight of placements that we use for our children – they are RAG rated based on the quality assurance visits undertaken by the team and feedback from social workers, IROs, young people and Ofsted.

Currently, the scoping of an in-house residential children's home is taking place focusing on young people whose pathway into residential has been via hospital i.e. those with high neuro-disability and mental health issues associated self-harming and dysregulated behaviours, resulting in parents not managing and young people not being able to access their education.

Barking and Dagenham continues to be part of Adopt London East (ALE) - the Regional Adoption Agency also covering Havering, Tower Hamlets, and Newham.

Whilst adoption numbers are low (9) this is similar to the national picture. We have seen instances where judges are overturning ADM decisions for adoption for very young children in favour of them staying in foster care in order to be with older siblings. We are also seeing more parental challenge of placement orders impacting on adoption timeliness. Other factors impacting adoption timeliness are family finding for children with additional needs. Babies born to mothers who have been using substances during pregnancy or parents who have identified learning difficulties impact on the availability of early permanence carers coming forward due to the uncertainties of development and the impact for the children's longer-term futures.

Our ALE offer strong support to our social work teams re completion of CPRs and helping social workers think through their contact plans in light of new directives around lessening letter box contact in favour of face to face. We have seen some wonderful matches between our children and their adoptive parent's where children's cultural needs and personalities have been carefully considered and matched.

Life story work has been strengthened with a recent thematic audit highlighting some outstanding practice. The impact of the specialist intervention service has been significant, with the therapeutic team delivering sensitive, trauma informed therapies to children with the most complex childhood experiences. Impact has children remaining in placements at risk of breakdown, children transitioning to an adoptive placement and some children remaining at home.

The wider SIS service compliments life story work with family support workers collating family stories and the lifelong links worker helping young people to reconnect with those people who were important to them.

The recent audit also highlighted quality life story books, genograms, and identity maps, as well as direct work sessions by social workers with children to explore identities and journeys into care. The impact of life-story work on children's understanding of their identities and journeys into care was mostly evident. Children were able to communicate their feelings better and engage in discussions about their past. There was evidence of social workers seeking SIS consultation and guidance to ensure the effectiveness of life-story work and to address the complex emotional needs of the children thus good evidence of collaborative working.

Consideration is given to the 'right time and right pace for the child' to complete life-story work. Importantly supervision records were seen to capture life-story work and monitor progress.

All four outstanding graded life-story audits were on work completed by the SWs who attended the three day therapeutic life story training delivered by SIS therapists, showing positive impact of the training and closing the loop on learning. Positively, in the audit of children in care, reviews consistently captured life story work.

Barking and Dagenham has also invested in the Caring Life App where foster carers, children and social workers can upload documents, awards, school reports, special cards and mementos. This becomes a memory book supporting children in understanding their journey , experiences and achievements through care.

**Plans for next 12 months**

- Continue to drive best practice on permanence planning (including focus on placement stability) so it is well understood and central to all aspects of our work with children in care.
- Refocus foster carer recruitment back in-house to ensure quality applicants progress to approval and have the skills to meet the needs of our children.
- Continued focus on step down planning for children in residential care and to ensure those who are placed are receiving the highest quality services to meet their needs.
- Continue to work with health colleagues to ensure compliance with IHA and RHA performance.
- Establish the participation offer for children in care and care leavers after the pilot year of increased resource.
- Work with CAMHS colleagues to improve the offer to children in care, which includes recruitment of the specialist post in their service.
- Refocus the preparation for independence offer for children in care at an earlier stage in conjunction with their carers following feedback from Skittlz.

- Embed the new support offer for kinship carers.

## 5. Experience and progress of care leavers

**What data and performance show us.**

The number of care leavers aged 18-25 is 330 – up from 307 at the same point last year, with the average caseload of a leaving care advisor (LCA) currently at 1:19 – no change from a year ago.

Exceptionally high level of keeping in touch with care leavers at 99%.

Most care leavers (58%) are in education, employment, and training, a slight dip on end of year (61%) but performance has remained positive and in line with the London average.

A large majority of care leavers (95%) are living in suitable accommodation (up by 4% on 2023/24 year end).

A large majority (93%) of care leavers have an up-to-date pathway plan, improving performance (90% at end of year 2023/24).

A large majority (98%) of care leavers aged 18 plus have had a timely supervision, similar to the end of year performance 2023/24.

**Practice – quality and impact**

We were pleased with the Ofsted rating of good for the experiences and progress of care leavers in the ILACS July 2023 inspection, demonstrating our commitment and ambition to improve services and outcomes for care leavers. This has continued in 2024 and 2025, and we are relentless in continuing to provide a good service to our care leavers.

Outcomes for care leavers remain strong given the national and local financial context and we are committed to our **Pledge to Care Experienced young people.**

Leaving care advisors build positive and trusting relationships with care leavers and this is reflected in the visits recorded as a letter to the young person capturing experiences and wishes. Care leavers have also taken the time to formally pass on their gratitude to their leaving care advisor, highlighting the support and care they receive. Skittlz, our children in care council continue to provide regular feedback on their experiences with a growing level of satisfaction about those that are working with them.

Most care leavers (58%) are in education, employment, and training, but this is an area we are determined to do more. The dedicated Education, Employment and Training (EET) coordinator for care leavers sits in the corporate parenting service providing focused support with EET and aspirations for care leavers. This role has started to make a real difference for young people with many examples of care leavers being given work experience opportunities, job interview experiences and jobs in the hospitality sector for example. The Aspire Virtual School compliments this role. We are proud to now employ one of our care leavers who was a previous apprentice, as our participation coordinator. This year, there are an additional three care leaver apprentice roles in children's care and support services, bringing added value to the business support service.

The **Aspire Higher** Programme continues to be developed alongside our **University Alumni**. The Aspire Higher Programme is organised in collaboration with local universities and the Careers Team in the council for an identified group of young people from Year 4 to Year 13. We now have 53 students identified on the Aspire Higher Programme and there are 15 care leavers at university.

Care leaver audits are mostly graded as good which is positive. Strengths identified in practice are positive relationships and support with close, caring, transparent working relationships, good insight into young people's lived experience, regular contact, effective intervention, inter-agency joint working, and strong transitional support. Effective pathway planning is also identified as a strength with clear and focused pathway plans, collaborative approach, strong management oversight, well-written reports and supportive meetings.

Areas for improvement relate to chronologies and case summaries not always up to date and supervision needing to be more robust, challenging and evidencing progression of pathway plans.

We have high aspirations for our care leavers, and they are increasingly involved in the development of services and their achievements are celebrated. We ensure that the local offer to care leavers is available to all eligible young people in various formats. A text messaging service and email service to keep young people updated on events, jobs and opportunities has been launched and the

Care Network and Quarterly Newsletter are now in place to increase participation and engagement.

In February 2024, we held our annual care leavers award ceremony where we celebrated the achievements of young people in the last year. We are planning a different type of celebration event for 2025/26 and are working with young people about what type of event they would like to take place.

We are proud to have an emotional wellbeing and mental health worker for care leavers as this is a coveted post by many leaving care services across the country. It was also positively noted in a What Works Centre for Childrens Social Care report on the emotional wellbeing of care leavers in the UK.

The emotional wellbeing and mental health worker provides one to one therapeutic sessions with care experienced young people aged 18 plus. The worker has been able to provide virtual and face to face sessions depending on preference and offers flexibility, working at the young person's pace. They also facilitate the Umbrellas group alongside our participation apprentice. This is a therapeutic group for a small number of young women who meet regularly at the Vibe. Having secured ongoing funding from the ICB to maintain this post means that it can be fully integrated into the corporate parenting service with no concerns about funding ceasing for the near future. We are already seeing an impact for individual young people who are attending sessions

The consultation offer from our mental health and emotional wellbeing staff to social workers and leaving care advisors has been well received, supporting them to work therapeutically with young people and advising them regarding other support services in the areas young people live. For those with higher level needs, the worker acts as a conduit into adult mental health services supporting more seamless transitions.

In recognition of the positive impact of physical activity/sport on emotional wellbeing, one LCA has led on a boxing initiative for Care Leavers. She linked up with a local gym and set up a male and a female boxing group that offered ten sessions per group. The feedback was very positive from young people who enjoyed the activity but also enjoyed meeting other young people. One young man who was experiencing mental health issues and very isolated has progressed so well, that he will be undertaking his first formal fight in the near future.

Our CareNet app promotes emotional wellbeing support services as well as other services and information that would be helpful for our care leavers.

Members Corporate Parenting Board Health Subgroup has worked hard to address the poor offer of health histories/ passports for our care leavers by producing the Care Leavers Health Summary which has been piloted and is now being evaluated. Progress has been made in the last quarter with all young people being issued with a copy of their health history at their Review Health Assessment with the option for a copy to be held on their social care file.

The named nurse for children looked after has been working with Skittlz to devise the best offer for care leavers for accessing health information. The NHS App contains all relevant information, and a LAC nurse will meet with young people around the age of 18 to show them how to use the App and to answer any questions. However, some young people would like a hard copy of their information, which has led to a new, concise health summary devised. This is subject to revision as there is a plan for NELFT to have the same version across their footprint and is currently in development. The NELFT LAC team has also designed a QR code to support care leavers in accessing health information.

The East London ICB in conjunction with St Barts Hospital has piloted an IHA health pathway for new UASC where young people have a two hour dedicated slot with a paediatrician to explore health needs and plan for any missing interventions such as immunisations, blood tests etc. This is currently being evaluated.

Progress has been made locally in the Northeast London area regarding the offer of free pre- payment certificates for prescriptions for care leavers. There has been good uptake from LBBD care leavers involved in the pilot since 2023 and the pilot is currently at evaluation stage.

The strong partnership with housing colleagues continues to impact positively on the volume and timeliness of care leavers moving on to quality homes. We recognise the need to have a stable home as a foundation for success in life. Barking and Dagenham has developed new and regenerated areas such as Barking Riverside and the Gascoigne Estate. Through the inclusive growth

agenda, care leavers in the borough have been able to benefit from access to newly built social rent (housing association or affordable rental) tenancies in the borough.

In 2024-25, with the support of the vulnerable housing programme, 35 care leavers moved out of supported accommodation into registered social landlords and 25 into own stock temporary accommodation to test out readiness for a permanent tenancy both of which are suitable housing.

The capacity of leaving care advisors has been increased, with the recruitment of a social work apprentice. This has enabled capacity to work with an increasing number of care leavers who are over 21 years-old, and to allow leaving care advisors to be co-allocated when children in care are 17 years-old (rather than 17 ½ years-old as in previous years).

In early 2024, we reviewed our approach and guidance for supporting care leavers who are 21-25 years old. This was in response to feedback from care leavers and included adapting the pathway planning process and moving from a 'open or closed' allocation arrangement to a 'stepping up or stepping back' model. The guidance aligns us with best practice and provides increased clarity for care leavers and leaving care advisors on how to work with this cohort and has improved consistency at this often anxiety provoking time for our young people.

Our grant funded LBBD lifelong links offer, includes befriending and mentoring. This money will be used to increase family group conference capacity and capacity to support children and young people (including care leavers) in re-igniting links with those people who were important to them.

**12 month plan**

- Review and update the Enhanced Local Offer which will include feedback from Skittlz and Leaving care advisors.
- Establish the EET worker in a permanent post to maximise the support and opportunities for our young people- develop the Family Business model .
- Establish the participation workers in post to enable us to make longer term plans for participation and engagement work with our children in care and care experienced adults.
- Provide additional training opportunities to our Leaving Care Advisors to develop their skills in working with young people e.g. Goldsmiths Creative Social Work short course, bespoke training for LCAs delivered by Become.
- Continue the positive work with our Housing Department to build upon the tenancy sustainment work which will enable young people to be supported into their long-term accommodation with increased confidence in their ability to sustain their tenancies.
- Revamp the independence skills preparation offer, to be developed in conjunction with young people.
- Implementation of the new staying close duties for care leavers.

## 6. Leadership and Management

Overall, experiences for children in need and child protection have improved since the last inspection, although there is more to do to ensure that all children receive consistent and timely services. Leaders and staff have worked together to support continuous improvement in key areas such as management oversight, neglect and PLO underpinned by a clear plan for improvement and an enhanced audit, quality and reporting framework. This has been alongside partnership wide initiatives, with the independently chaired, Neglect Working Group and reconfiguration of the council's best practice Specialist Intervention Service to better meet children and family's needs in line with areas of improvement identified in the last inspection.

The council has a clearly articulated strategic vision for children, via its Best Chance strategy, which provides the foundation for continuous improvement and system priorities. Since the last inspection there has recently been a new council Leader who is making child poverty his number one priority – given the adverse impact the cost-of-living crisis, health inequalities and unemployment rates has for local children and families. This political priority will underpin the political financial choices over the coming few years. Despite significant budget challenges for the council, there has been no cuts to children social care front line services and this area has not been subject to the council wide spend control processes, such as the recruitment freezes and is exempt from number of essential spend panel processes. Although, savings have been identified through changing the way we work such as specialist foster care recruitment, and better efficiency around the use of court order services and independent social worker,

as well as edge of care services. The challenging financial circumstances have not prevented us from continuing to improve and build on good practice and innovation, across all aspects of children's services.

**What data and performance tells us.**

The number of children and young people open to social has been on an upward trend since September 2024, rising from 2409 to 2613 as of February 2025- an extra 200 children (a real term increase of 8%). At the time of writing, the number of children open to social care was 2593 (as of 11th March 2025).

Average caseloads in social care are manageable across the service generally, with the Assessment and Intervention service at 1:19 (down from 1:21 at the same point last year), Family support and Safeguarding at 1:16 (up from 1:14) and Corporate Parenting at 1:12 (down from 1:13 last year). The average caseload per qualified social worker decreased from 15.3 to 14.9 between September 2023 and September 2024. (This figure is a simple average of cases over the number of case holding social workers and is not adjusted for part time or ASYE workers for example). We are now lower than national average (16.0) and the statistical neighbour average (15.5) but remain above the London average (14.4).

Supervision timeliness at 4 weeks has improved slightly from 68% to 73% over the last year, but we are still off our target of 90%.

Overall, the DfE children's social care workforce return (2023/24) was positive, with a slight growth in the workforce from 250 Full time equivalent (FTE) social work qualified posts to 257; a decline in agency social work qualified workers, an increase in permanent employed workers (from 192 FTE to 209 FTE) and a reduction in the turnover rate. The Local Authority recruited 54 social work qualified workers - up by 1 on the 2022/23 return. The number of leavers decreased from 50 to 39 over the same period.

The agency rate decreased over the last year from 22% to 19%, with the number of agency workers decreasing by 5 from 53 to 48. Agency rates remain significantly below the high point of 50% in 2015/16. The agency rate is lower than the London average (23%) and statistical neighbours (SN) average (21%) but is slightly higher than the national average of 18%.

The staff turnover decreased from 26% to 18% over the last year, which is good news. Despite this improved performance, we remain above the London average (17%), the national average of 16% and the statistical neighbours average (16%). The turnover rate is affected by the percentage of qualified permanent social workers leaving the Local Authority within two years of joining; 54% of qualified social workers who left the Local Authority had been employed for less than two years (21 in total). This is an increase on the 2022/23 figure of 40% (20 in total). This data is useful for the development of a sustainable and effective recruitment and retention strategy.

The number of days lost to sickness increased from 1455 days in 2022/23 to 2002 days in 2023/24 for all LBBD Social workers (including leavers). For those LBBD Social workers employed as of year-end 30th September, the number of days lost to sickness increased from 867 days to 1559 days. This increased our sickness rate from 1.8% in 2022/23 to 2.9% in 2023/24. Our absence rate is above the London Average (2.5%) and statistical neighbours average (2.7%) but remains below the national average (3.2%).

**Summary of improvements and areas of development**

Since the OFSTED ILACS inspection, senior leaders, partners, and members have continued to collaborate effectively on improving children's social care services despite a challenging financial and community context. We have worked across the council and with partners to develop our post inspection action plan and have a link DfE appointed Improvement Advisor. The DfE Improvement Advisor chairs the monthly children's improvement board and has delivered impactful training to managers on thresholds and defensible decision making. This input to our improvement journey has been positively received.

The statutory safeguarding partner Executive is being chaired by police, and although there has been some changes in partner leadership arrangements, the group has recently finalised MASA arrangements and is in the final process stages of recruiting a high calibre scrutineer. Significant work still continues, cross partners and cross council on our key safeguarding priorities, such as neglect, exploitation and child sexual abuse. The MASA development has refreshed our governance for learning from serious incidents, built on regional best practice, moving to a ONE panel approach. We are concluding a number of Learning

Reviews, with the highest profile and resource intensive reviewing taken up a significant amount of board resource as we work across LB Hackney (children's home borough) and Cambridgeshire County Council where both children and mother's history remains up to six weeks prior to their death.

Within the council, we have built on previous improvements to our QA model and have further increased its ability to support greater reflection on practice, impact, and outcomes of children's experiences. Additional auditors have been appointed resulting in a significantly higher number of audits being undertaken and thus a better understanding of practice and outcomes. This is proving more successful in engaging staff in critical challenge and review of practice, especially in relation to management oversight. Overall audits are showing an improving trajectory of practice each month, supporting practice improvement. The audits sit within a wider QA approach which includes regularly high volume, high frequency dip samples by heads of services, and multi-agency practice review such as in relation to MASH and more recently neglect.

We have recently refreshed our sufficiency strategy, and although have seen some local improvements and continued good performance in relation to local children in local family placements we still experiences those challenges faced nationally. Those children in care with complex needs, in particular, with SEND and mental health pose significant placement sufficiency challenges due to a lack of specialist foster care and residential placements across the country. Despite this, progress is being made locally against the LAC Sufficiency Plan 2022-2025. We have developed an approach based on improving commissioning and governance processes, work to develop the early help offer, fostering and residential supply and to improve our understanding through data management. We have recently submitted a bid to the DFE capital programme to provide a local solution to this, so we can meet our aspiration of keeping our most vulnerable children, closer to home.

We have developed the High-Need Placement Analytics group to ensure up to date understanding of the markets, to respond in a timely fashion and drive commissioning activity. This has created a new dashboard which is reviewing all spend by accommodation type, provider, and service level areas. This has resulted in developing a shared language between children's services and finances and alignment of data, and development of Continuity Placement Contract with local provider. Underpinned by a digital sufficiency toolkit to better inform the sufficiency of placements. Alongside this, we have reviewed and updated the Quality Assurance Framework for placements including updating specifications with three golden threads of consistency, continuity, and value for money. This has resulted in development of a single IPA across all placement types, and better oversight of these types of placements.

**The capacity, quality, consistency and impact of supervision and management oversight.** The supervision training programme for managers has been well received, and managers have engaged in regular action learning sets. Some positive movement with audits now consistently sighting stronger **management oversight and supervision**. Supervisions are timelier, more reflective , child focused and linking supervision to the child's plan. The impact being plans for children are progressing at better pace and permanence being achieved.

Heads of service consistently use the senior manager need to know notification forms ensuring their overview of the cases that fit the N2K threshold. This allows for immediate remedial action if needed and supports the right decisions at the right time for the child. It also means the Director has regular oversight of areas where we have a 'key line of enquiry ' e.g. police protections and adolescents coming into care.

Audits consistently identify good senior manager oversight on files impacting on the progress of the plan and quality of practice. IRO and CP practice alerts support improved practice and particularly pick up on delays in progressing plans and key non-compliance issues. The panel's pack is now signed off and shared at all service sessions - to support workers in understanding the array of panels/ senior manager oversight meetings, and support managers in aligning supervision to decisions being made in other forums.

Against a backdrop of improvement in management oversight, we have experienced some turnover of staff at team manager level in the assessment and intervention and family support and safeguarding services. This naturally has impacted on consistently good supervision, as we have addressed poor quality locums and staff. One service has experienced significant sickness issues, which has further compounded this area, although we have tried to mitigate where possible, for a small number of children that has meant their planning has been impacted. Permanent and stable managers work hard to mitigate risk in this

area, but vacancies have put pressure on managers with a higher manager: social worker ratio. Senior managers have also had to step down to support practice at front line manager level. We also seen significant improvement in children with disabilities following changes in leadership.

Building on the successful establishment of the **CARES Practice Framework, the CARES QA academy** is coming to the fore having recently been agreed. This service will drive the CARES practice framework and best practice through providing evidence based auditing, staff development and training opportunities, strong IRO/CP chair oversight and support a targeted recruitment and retention strategy. Consultation phase commenced in January 2025.

Much of the CARES academy infrastructure is in place with a CARES intranet site – a repository for best practice, policy and procedures. An induction calendar enables all staff to have a consistently good on-boarding and induction experience.

Our CARES Practice framework is well embedded, and we are proud of the impact our shared values and ethos has had on practitioners and the children and families they work with . We see these values shining through practitioner and managers behaviours .One of the most significant impacts of the CARES practice framework being embedded via the academy work is how social workers talk and write about the children they are working with. All audits now comment on the child focused approach on file records, showing sensitive, trauma informed practice where the child's voice is evident. This in turn means plans are more attuned to the child's needs and experiences.

Overall staff morale is good, they report that they feel well supported and cared for by managers and feel listened to and heard by an approachable and relatable senior leadership team. Staff benefit from a comprehensive training offer and a clear career pathway. We have seen many staff progress from students, some who are now managers as we have a 'grown your own ' approach to support retention. We have welcomed apprentice social workers into the service and have a steady flow of students and ASYEs who want to stay once they have qualified. We have also recruited over 20 social workers from South Africa and Zimbabwe over the last two years. Those workers were provided with a rich induction and pastoral care to support transition to social work in the UK.

We are on the eve of launching our CARES QA academy which will bring a strengthened approach to workforce recruitment and retention so we can achieve our ambition of staff seeing LBBD as a place they want to work, stay and develop. We are heartened every time a colleague who has left the service returning. Most report they wanted to come back as they felt cared for in LBBD and enjoyed the diversity of the workforce and community.

Our ambition in Barking and Dagenham is to continue to develop the conditions where social work can thrive and children, young people, their families and wider network are supported to ensure children know they are safe from harm and loved. National reform is an important part of achieving our ambition, and a programme we are undertaking with determination, with engagement with stakeholders and co-production at its heart. To date we have focussed on putting in place the key enablers for successful reform, in particular establishing the CARES Academy, which will take the lead in ensuring that we have an equipped and effective workforce to drive change. We are engaging with Pathfinder authorities to understand their approach and how their experiences might be applied to the particular demographics and needs of children and families in Barking & Dagenham. We are keen to ensure that we plan this extensive and far reaching system change carefully, and that we take the time needed to get it right, placing an emphasis on clear and consistent communication with our workforce, partners and the wider community.

**Plans for next 12 months.**

- Stabilising a permanent workforce particularly at team manager level in assessment and intervention and family support and safeguarding services - tackling variability/stubborn 'top ticket' practice issues.
- Implement the CARES QA Academy.
- Continued development of front line managers and service managers, achieving a common understanding of roles and responsibilities at different levels to reduce stepping down.
- Embark on the social work reform change programme, with a focus on Family help model, expert court assessment team, reunification offer feedback loop/assurance reports on findings, themes and impact of oversight panels.
- Roll out next phase of partnership wide neglect improvement plan.

- New TOM which continues to build an increased focus and strengthening of management oversight and capacity.

## 7. Performance Management and Quality Assurance - How we know it?

Through a robust and well-established performance management framework, and monitoring arrangements, children's care and support has an accurate and systematically updated understanding of the overall effectiveness of our services.

An extensive suite of performance data and dashboards are produced and accessible to directors, heads of service and managers through Liquidlogic, our electronic social care record and Business Objects reporting. Performance dashboards and analysis is provided at service, team, and worker levels to give granular level information on performance across children's care and support. This is used to drive improvement of the quality of decisions and the provision of help to children and young people.

Performance information is shared at monthly Lead Member portfolio meetings where the Lead Member brings challenge.

Children's performance data and reports are presented at the LBBD Children's Safeguarding Partnership meeting. Bespoke datasets and reports are provided for other key partnership meetings supporting the partnership in understanding the profile and needs of our children and their families, for example, Corporate Parenting Board, MASE, CEG, Youth Justice Board, Legal SMT, and the Child Sexual Abuse Delivery Group.

A monthly Children's Performance Leadership meeting co-chaired by the Director of Operations and Head of Performance brings additional scrutiny and reflection on progress being made on key performance areas. This includes analysis of statutory returns and how we compare to similar areas, London and nationally. The increased scrutiny and expectation that Heads of Service provide monthly detailed feedback, supported by dip sampling activity has impacted positively on almost all performance areas. The performance meeting identifies areas of improvement and key lines of enquiry, informing what practice audit activities or more in-depth data analysis is required.

Daily automated dashboards for each service to enable operational teams to see outstanding tasks that require immediate action as well as have oversight of general performance against monthly performance targets.

Operational managers and social workers receive a host of daily automated management reports to support management of workload, case allocation, timeliness of visits, key practice meetings and supervision. Team managers hold weekly performance meetings to support staff in the interpretation of data and performance and in achieving improved responses. Performance colleagues have provided additional training and support those meetings. The Business Support team have been instrumental in using dashboards to support performance improvement in key areas such as strategy meetings, permanence planning meetings, supervision, and initial health assessment timeliness.

In our aim to tackle disproportionality our performance team provides detailed data analysis to support further understanding of the needs and outcomes for our children.

There is clear guidance in place regarding the instances where managers and social workers need to inform senior leaders about children in specific circumstances. The well-established Director Need to Know notifications protocol has brought about strengthened management oversight, scrutiny, and practice improvement for the most vulnerable children e.g., those coming into care on police protection, children needing residential placements, ongoing missing, serious youth violence incidents, homeless 16/17-year-olds and children returning home following Section 20 placement.

**Quality Assurance (QA) Journey of Change**

The QA service aims to enhance outcomes for children by assessing the quality of practice and services that children and families receive. Our ethos is that effective quality assurance involves the systematic monitoring and evaluation of practices, policies, and procedures to improve our services and achieve better outcomes for children and their families. The QA teams' objective is to embed the delivery and ownership of effective quality assurance activities within Children's Care and Support as well as evaluating and monitoring the impact of this practice, which is crucial for achieving improved outcomes for children. This objective necessitates the need for a robust quality assurance process that

provides evidence of effective service delivery and adherence to standards that safeguard and promote children's welfare.

These expectations and drivers for the service are integrated into the outcomes and expectations outlined in the current Improvement Plan. Their influence and expertise are being utilised to enhance practice, acting as a critical friend to highlight good practice and support the identification of areas requiring improvement.

The QA service has recently undergone numerous changes in staffing and processes, including shifts in our culture and way of working. Historically, the team was understaffed, limiting QA activities to only monthly audits, with occasional thematic audits that did not meet the service's needs or provide a comprehensive QA offer. To achieve the service's ambitions, the QA Team introduced two new QA Leads to join the two existing QA Officers, thereby increasing capacity across the service. Since their introduction, thematic audits have been conducted with specific areas of focus through a detailed and comprehensive QA audit programme, outlining QA activities for the coming year.

In August 2024, an updated audit tool was developed and shared across the service. The revised audit tool includes checklists in each section, enabling auditors to provide both qualitative and quantitative data. This has allowed the QA service to offer more detailed information to senior leaders about the quality of practice within the service, addressing gaps that were present in previous iterations.

Quality Assurance produces audit analysis reports monthly, covering key themes such as areas of strength, areas for improvement, the impact of practice on outcomes for children, identified learning, and "closing the loop" activities with the Principal Social Worker.

The report encompasses all audits completed in the month by Team Managers, Service Managers, IROs, and CP Conference Chairs. These monthly reports support service areas in engaging in continuous self-reflection, ensuring that their interventions have a meaningful impact on the lives of children and their families. They also enable operational teams to measure their progress against wider performance data and previous audits covering the same areas of practice.

In addition to the monthly audits, the QA team conducts several thematic audits, such as the quality of strategy discussions and multi-agency responses to neglect. This audit activity is part of our regularly updated QA audit programme, developed against the key areas of improvement identified in the Children's Care and Support Improvement Plan.

The QA team provides regular support to auditors through training and direct advice, enabling them to use the audit tools effectively, understand how to complete the audits using the enhanced audit tool, and identify areas of good practice and areas needing improvement. Auditors are shown how to complete the audits in a balanced and relational way, focusing on restorative and strength-based approaches that can be understood and followed by the workers.

The team produces a quarterly analysis report, which primarily focuses on trends observed in the preceding months and assesses progress against the areas of improvement identified. This supports the planning of training programmes by the service and the Principal Social Worker, ensuring that appropriate resources are directed where necessary.

Our audit and moderation approach continues to play a significant role in governance, practice development, and improvement activities. This enhanced audit activity provides assurance and an opportunity to pause and reflect on the quality of our work and the impact of the support we provide on positive outcomes for children, young people, and their families.

**Monthly QA newsletters**

To reinforce good practice, the QA team has developed a monthly newsletter to disseminate the learning from audits. This newsletter highlights areas of good practice that the service should continue, as well as identifying persistent wicked issues and areas for improvement that require workers' attention.

**Closing the Loop**

In all of our QA activities, we strive to highlight how we can translate the learning from audit activities into meaningful insights for operational Social Workers and managers. This is achieved through collaboration between the QA team, the Principal Social Worker, and Workforce Development. Together, we extrapolate the learning from audits and formulate practice-focused learning opportunities

for the social work teams. These opportunities are then tested in subsequent audits to determine if the learning has led to improved practice. We consider the loop closed only when we see improvements in persistent areas of practice.

In addition to focused training, the Principal Social Worker, along with the QA leads and officers, presents the QA activities and learning at service-wide manager events each month. The messages are shared with managers, who are then required to relay them to their respective teams.

**Feedback from children and families.**

As part of the audit framework, auditors are required to seek feedback from children, young people, and parents/carers. While many auditors attempt to obtain this valuable feedback, responses from young people and parents/carers have not always been forthcoming. However, some feedback has been received, with many workers being praised by family members for the work they have undertaken and the relationships they have built with the family.

- ✓ ***A grandmother stated that she felt "Supported by social care but frustrated that the support is just not working,***
- ✓ ***Anything else we could do to help, a foster carer stated "The only thing would be life story***
- ✓ ***A child in care "expressed feeling pleased with social care support and feels professionals have been good to him."***
- ✓ ***A care experienced young adult stated, "L helps her as she consistently checks in with her, gives her updates and goes out of her way to say things and recommend things ... she agreed L really cares and wants to find the best for her."***